Die Mittellinie in der Osteopathie

- ein Balanceakt zwischen Struktur und Spiritualität

Master Thesis zur Erlangung des Grades
Master of Science in Osteopathie

an der **Donau Universität Krems**
niedergelegt
an der **Wiener Schule für Osteopathie**

*von **Monika Dunshirn***

Wien, Dezember 2006

Übersetzt von Mag. Martin Schwarz und Mag. Gudrun Meddeb

Eidesstattliche Erklärung

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

Alle Stellen, die wörtlich oder sinngemäß aus veröffentlichten oder nicht veröffentlichten Arbeiten anderer übernommen wurden, wurden als solche gekennzeichnet. Sämtliche Quellen und Hilfsmittel, die ich für die Arbeit genützt habe, sind angegeben. Die Arbeit hat mit gleichem Inhalt noch keiner anderen Prüfungbehörde vorgelegen.

----------------------------- ---

Datum Unterschrift

ACKNOWLEDGEMENTS

I would like to thank many people for the accomplishment of this work. They were either a source of inspiration for me or helped me in one way or another. Without them, I couldn't have written this work as it is now. I would like to mention a few people in particular here even though I am not able to thank each and every person involved.

Special thanks go to my family. They have been the "ground under my feet" and without them I couldn't have followed this particular path. First of all, I would like to thank my parents who accompanied me with unfailing aid, encouragement and help. My father in particular helped me with the tiring transcription work.
I cannot stress how much my husband helped me; he not only tolerated my quest for answers for years, he also supported me throughout it with his great strength. He was my most thorough and critical reader, he smoothed out all the technical obstacles and translated the whole text. Most of all, he helped me to get through my darkest, desperate moments. Thanks also go to my two sons, who cheered up their mother and brought her down to earth again when she was sometimes lost in reverie; using words such as "the Midline shall be with you!" or speculating whether jedi-knights from "star wars" were something like osteopaths.

I also owe a lot to my teachers at the Wiener Schule für Osteopathie, especially those who taught us regularly: Bernard Ligner, Sarah Wallace, Hanneke Nusselein and Jean Arlot. Their way of imparting their knowledge of osteopathy, be it through theoretical lectures or through the stories they told us as well as the experience of their "thinking" hands will always accompany and shape me.

I would like to especially thank the many patients who gave me the opportunity to gain experience and encouraged me verbally or non-verbally to follow my chosen path.

My friends and osteopathic colleagues who accompanied me for years and talked things over with me patiently and devotedly should also be thanked wholeheartedly.

My special thanks go to Dr. Gerd Eichberger, who helped me in many ways. He assisted me by patiently fathoming my inner resistances with detailed work and greatly helped me analyse and overcome them. His objective, analytical scrutiny of the osteopathic midline helped me see this phenomenon from different angles and gain further understanding and insight.

At this point, I would like to thank my interview partners Patrick van den Heede, Torsten Liem, Hanneke Nusselein, Tom Shaver, Alexander Toth, Karl-Heinz Weber and Christian Wutzl very much. Without them, this master thesis wouldn’t have come about. They are all very busy osteopaths. Nevertheless, they found the time to talk about this complex and tricky subject.

For their scientific support, I want to thank Mag. Adelheid Clementi and Mag. Katharina Musil sincerely.

Special thanks go to Mag. Gudrun Meddeb for proof-reading and fine-tuning the text.

Monika Dunshirn

Die Mittellinie in der Osteopathie

- ein Balanceakt zwischen Struktur und Spiritualität

ABSTRACT

This study discusses the following questions: what exactly do osteopaths mean when they say they work with the midline? Does a generally validated definition of the osteopathic midline exist, and is it possible to describe the midline scientifically as a phenomenon at all? What significance do terms like structure and spirituality have for the midline?

These issues are researched by means of a qualitative approach and focussed interviews are used as investigative tools. Seven experienced osteopaths who have expert knowledge of midline osteopathy were interviewed. The analysis of the interviews revealed different possible approaches.

For this reason, the results of the interviews were structured in five sections: embryological approach, structural approach, functional approach, spiritual approach, and psychotherapeutic approach.

Midline osteopathy seems to have no confined concept; it rather seems to be an individually formed method depending on the osteopath involved. The interview partners agree that open-mindedness, impartiality, critical self-reflection, and profound anatomical knowledge are basic requirements for an osteopath working with this concept.

The analysis was hampered by the fact that no standardised, precise definitions of terms exist; a common language has yet to be found.

Keywords:

Midline, qualitative study, embryology, notochord (Chorda dorsalis), coccyx-ethmoid, fulcrum, spirituality, stillness, long tide

Monika Dunshirn

Die Mittellinie in der Osteopathie

- ein Balanceakt zwischen Struktur und Spiritualität

ABSTRACT

Diese Studie beschäftigt sich mit den Fragen: Was meinen Osteopathen, wenn sie sagen, sie arbeiten mit der Mittellinie? Gibt es eine allgemein gültige Definition der osteopathischen Mittellinie, und ist das Phänomen der Mittellinie überhaupt wissenschaftlich darstellbar? Welche Bedeutung haben Begriffe wie Struktur und Spiritualität für die Mittellinie?

Anhand eines qualitativen Forschungsansatzes und mittels leitfadengestützter Interviews als Erhebungsinstrument wird diesen Fragestellungen nachgegangen. Sieben erfahren Osteopathen, die mit der Mittellinien-Osteopathie vertraut sind, werden befragt. Die Analyse der Interviews zeigt, dass verschiedene Denkansätze möglich sind.

Aus diesem Grund werden die Ergebnisse der Befragungen fünf Punkten zugeordnet: Embryologischer Ansatz, Struktureller Ansatz, Funktioneller Ansatz, Spiritueller Ansatz, und Psychotherapeutischer Ansatz.

Es scheint sich bei der Mittellinien-Osteopathie um kein fixes Konzept zu handeln, sondern je nach ausführendem Osteopathen, eine sehr individuell geprägte Methode zu sein. Übereinstimmung herrscht unter den Interviewpartnern darin, dass Offenheit, Unvoreingenommenheit, kritische Selbstreflexion und profundes anatomisches Wissen des Osteopathen zu den Grundvoraussetzungen für dieses Konzept gehören.

Die Analyse wurde durch den Umstand erschwert, dass es unter Osteopathen offensichtlich noch keine einheitlichen, präzisen Begriffs-Definitionen gibt, und eine gemeinsame Sprache erst gefunden werden muss.

Keywords:

Midline, qualitative study, embryology, notochord (Chorda dorsalis), coccyx-ethmoid, fulcrum, spirituality, stillness, long tide

TABLE OF CONTENTS

1. INTRODUCTION 1
1.1. INSTRUCTIONS FOR THE READER 3
2. PRESENTATION OF THE METHOD 4
2.1. SCIENTIFIC OBJECTIVE 5
2.2. DESIGN OF THE STUDY 5
2.2.1. THE QUALITATIVE APPROACH 5
2.2.2. THE FOCUSSED INTERVIEW 7
2.3. INTERVIEW GUIDE AND GUIDING THEMES 9
2.4. REALISATION OF THE STUDY 11
2.4.1. CHOICE OF INTERVIEW PARTNERS 11
2.4.2. PREPARATION OF THE INTERVIEW 12
2.4.3. THE INTERVIEW SITUATION 12
2.5. DATA EVALUATION 12
2.5.1. THE TRANSCRIPTION 12
2.5.2. SEPARATE INTERVIEW ANALYSIS 14
2.5.3. QUALITATIVE CONTENT ANALYSIS ACCORDING TO MAYRING 14
3. REPRESENTATION OF THE RESULTS 16
3.1. THE STATUS OF THE ML IN THE CURRENT OSTEOPATHIC DISCUSSION 16
3.1.1. MAIN TOPIC OR SECONDARY TOPIC? 16
3.1.1.1. Summary and critical review 20
3.1.2. ML AND SCIENTIFIC ANALYSIS – A CONTRADICTION? 22
3.1.2.1. Summary and critical review 24
3.1.3. THE ML: A SUBJECT FOR BEGINNERS AND/OR FOR ADVANCED STUDENTS? 26
3.1.3.1. The OSTEOPATHIC EXPERTS' TEACHERS 26
3.1.3.2. ML in Basic Osteopathic Training 29
3.1.3.3. Summary and outlook 31
3.2. HISTORICAL DEVELOPMENT 33
3.2.1. FROM A.T. STILL (1828-1917) TO TODAY 33
3.2.2. WHAT WAS BEFORE STILL? ONE OF MANY EXAMPLES: FRANZ ANTON MESMER (1734-1815) 35
3.2.3. SUMMARY AND DISCUSSION 38
3.3. DEFINITION OF THE ML 40
3.3.1. EMBRYOLOGICAL APPROACH 41

3.3.1.1. Patrick van den Heede's "Theory of the Tripartition ML" 42
3.3.1.1.1. Summary 46
3.3.1.2. The Germ Layer Theory and its similarities with Van den Heede's Theory 47
3.3.1.2.1. Summary 51
3.3.1.3. Similar ML-theories by other authors: Franklyn Sills and Jim Jealous 52
3.3.1.3.1. Summary and review 57
3.3.1.4. Interviews in comparison 59
3.3.1.4.1. Summary 64
3.3.1.5. The germ line or: The ML as a time machine? 65
3.3.1.5.1. Summary 68
3.3.2. STRUCTURAL APPROACH 69
3.3.2.1. Significance of Anatomy 69
3.3.2.2. Which structures can be related to the ML? 72
3.3.2.3. Can purely structural techniques lead to the ML? 77
3.3.2.4. Summary 80
3.3.3. FUNCTIONAL APPROACH 82
3.3.3.1. The terms "function" and "structure" 82
3.3.3.2. The "Fulcrum" 85
3.3.3.3. Summary and discussion 89
3.3.4. SPIRITUAL APPROACH 91
3.3.4.1. Stillness - Stillpoint 94
3.3.4.2. Love 96
3.3.4.3. Faith – Religion - Ersatz Religion 99
3.3.4.4. Death 105
3.3.4.5. Long Tide - Potency - Breath of Life 108
3.3.4.5.1. „Long Tide": 108
3.3.4.5.2. „Potency": 110
3.3.4.5.3. „Breath of Life" (BoL) 111
3.3.4.6. Summary and Discussion 113
3.3.5. PSYCHOTHERAPEUTIC APPROACH 114
3.3.5.1. Working on oneself 115
3.3.5.2. Projection, Transference, Counter Transference 117
3.3.5.3. ML as "Spiegelfunktion" ("Mirror Function"), Mirror Neurons 123
3.3.5.4. Systemic Psychotherapy 128
3.3.5.5. Summary 131
3.4. THE ML IN OSTEOPATHIC PRACTICE 132
3.4.1. HOW TO ADMINISTER A ML THERAPY? 133
3.4.2. "ÉCOUTES" 136
3.4.3. MEDITATION – CONCENTRATION - AWARENESS 138
3.4.4. VISUALISATION 143

3.4.5. THE ML IN HORSE OSTEOPATHY 147
3.4.6. SUMMARY 148

4. SUMMARY OF THE WHOLE STUDY AND OUTLOOK 149

5. LIST OF ABBREVIATIONS 152

6. BIBLIOGRAPHY 153

7. APPENDIX: ORIGINAL QUOTES 159

1. INTRODUCTION

The starting point for his study was a dramatic experience during my first lesson in cranio-sacral osteopathy at the end of my first year of training. We were asked to "simply hold our training partner by the feet and see what we perceive". This "simple" attempt at perceiving became an experience of enlightenment.

The condition in which I abruptly found myself, and for which I was unprepared, was totally inexplicable to me at the time. I was surrounded by vibrations and lost my sense of time and space. It was a moment of devotion, a feeling of entering a sacred room filled with silence. This feeling was accompanied on the one hand by deep tranquillity and catharsis, but on the other hand by profound agitation. A cosmic, magical, magnetic "ancestral feeling" began to spread inside of me.

Afterwards, I asked myself many questions: what had happened to me? And how could I communicate it? From then on, I turned to my osteopathic teachers for possible explanations. The term "Midline" (ML) was mentioned almost casually soon after. I intuitively understood that this could have something to do with my disturbing experience. Various lecturers gave me hints now and then in regard to it, but I could not discern a congruent osteopathic concept. We were taught various practical techniques but the teaching methods varied greatly. To me, the best possible approach to the ML within the osteopathic concept seemed to be the cranio-sacral approach.

Over the years, the number of concepts and terms that we had to integrate as students in regard to the ML increased significantly: "Breath of Life", "Primary Respiratory Mechanism", "Stillpoint", "Neutral", "Fulcrum", "Ignition", "Midline", "Tide" … all this sounded very exciting and mysterious. Multifaceted, interesting definitions were offered, but there was always something blurred and inexplicable to us students. In the embryology lectures, a concrete structural term was finally introduced that was put in relation to the ML: the notochord. This seemed an indication to me that a deeper connection between the ML and embryology might exist.

In the practical work, the explanatory models and terms seemed to be irrelevant. "It simply works, you'll just have to wait!", "The system will tell you what to do!", "The

more you want it, the less you will perceive it!" – a student often hears these or similar sentences. For those students for whom it doesn't "simply work", a problem will arise. It is as if they weren't awarded the grace of being let on to this "secret knowledge". And how should one explain and argue these things that happen here to a non-osteopath?

The relevance and topical nature of the ML question was also shown at a presentation of theses at the Wiener Schule für Osteopathie in September 2004: five out of seven theses mentioned "working on the ML" as an osteopathic technique. I was there in the audience and asked myself what each of the graduates meant by it exactly.

The qualitative scientific approach seemed to be the method best suited for my questions. By using focussed interviews as a tool to investigate and by offering an ample scope for questions and answers I hoped to collect a lot of information about the ML from my interview partners.

This study aims at finding answers to the accumulated questions and at gaining more insight on the discussed topics. The motivation behind it is on the one hand my personal need to clarify the terms and to understand the processes that happen during an osteopathic treatment more profoundly; on the other hand, I also see the increasing necessity for osteopathy in general to discuss these issues. This study can thus be seen as a contribution to the ongoing discussion: "What is osteopathy? Science – Art – Philosophy?" However, I am fully aware that the "clarity" I am seeking may remain a subjective term forever.

1.1. INSTRUCTIONS FOR THE READER

- All verbatim quotes from interviews or from books are written in italics.
- The names of the interview partners are written in capitals whenever they are quoted literally or in form and content in context with the interviews. Thus, LIEM is written in capitals when quoted from the interview, but not when quoted from one of his books. Similarly, VAN DEN HEEDE is only written in capitals when quoted from the interview he gave me, but not when quoted from other interviews or course scripts.
- Quotes from the interviews are indicated with the page number and line number from each transcription.
- The two interviews that were done in English are quoted in the original; the other five interviews were translated into English by Mag. Martin Schwarz and Mag. Gudrun Meddeb.
- The transcriptions of all interviews in original wording plus the analyses of all interviews are included in a CD–rom that is attached to the back cover of this study.
- All quotes from sources originally published in German were translated into English by Mag. Martin Schwarz and Mag. Gudrun Meddeb; to maintain a readable text, these quotes are marked with a footnote and the original German quotes can be found in an appendix (chapter 7. "appendix: original quotes").
- Abbreviations that are used repeatedly are listed in the list of abbreviations. When only used once or twice, they are directly explained. "Midline" is always abbreviated as ML in the singular and as MLs in the plural.
- Whenever addendums to verbatim quotes were necessary from my point of view, they were set in brackets and non-italic (standard) text layout.
- Omissions in verbatim quotes are indicated by three dots in square brackets.

2. PRESENTATION OF THE METHOD

*"**Of Science's Aim -***
What? Should the ultimate objective of science be to give Man as much delight and as little aversion as possible? What if delight and aversion were bound together by a rope, so that one who wanted to experience the most of the first would also have to bear the most of the second? So that someone who wanted to learn sky-high-cheering would also have to be prepared for deadly sorrow? […] The stoics did believe in this, and therefore sought as little delight as possible to experience as little aversion as possible from life. […] You still have a choice today: either as little aversion as possible - in short: absence of pain – or as much aversion as possible as the price to pay for an increasing richness of delicate and rarely tasted delights and pleasures! If, as in the first case, you decide to lessen the pain of Man, you will also have to lessen his ability to feel delight. In fact, you can accomplish either aim through science! Until now, it may be better known for its ability to take away delight from Man and make him colder, statue-like and more stoical. But it might also turn out to be the greatest way of relieving pain; and then, its great counterforce might be discovered as well – its incredible ability to light up new universes of delight!" (Nietzsche 2000, p. 48-49)[1]

The following chapter will first discuss the scientific objective. Then the reasons that made me choose a qualitative study will be explained and the focussed interview method will be described.
Then, the interview guide and the guiding theme will be introduced. The way the study and the data evaluation were carried out will be described subsequently.

2.1. SCIENTIFIC OBJECTIVE

Two questions form the basis of this study.

- Is the ML a balancing act between structure and spirituality (Is it really a balancing act or are the scales tilting to one side?)?
- What exactly do osteopaths mean when they say that they work with the ML?

2.2. DESIGN OF THE STUDY

2.2.1. THE QUALITATIVE APPROACH

"I think the time has come to give other schools of thought more say in the scientific field. This doesn't imply that the analytical-quantitative way of thinking is wrong and should be replaced by a synthetic-qualitative one; it should only be made clear that today's predominant quantitative thinking is one-sided and should be complemented by trying to understand functional interrelations, vital wholeness and qualities to re-establish contextual human action. Qualitative terms are often less clearly definable than those derived from systems of physical measurement; rather one has to circumscribe them and try to understand them intuitively, like a human being whose nature can't be described in its wholeness but needs to be understood in a circumlocutory and intuitive manner." (Rohen 2002, p. 11)[2]

Dr. Johannes W. Rohen who was a professor of anatomy at the universities of Marburg/Lahn and Erlangen-Nürnberg and is the author of numerous textbooks gave this description of the nature of qualitative research. His research covers functional anatomy and the history of human development. I chose to put this quote at the beginning of this chapter because I believe it explains the specificities of the qualitative approach very accurately. It is all about the understanding of functional correlations and the intuitive, perceptive comprehension of a topic or a human being. My topic is the ML in osteopathy, a complex and hardly comprehensible phenomenon in the osteopathic world from my point of view. The descriptive ways

of working that the qualitative research offers and the open, non-standardized interview form as a tool to collect data qualify this method for the analysis of the topic in my opinion.

Flick, Kardorff and Steinke (2003) write about qualitative research: *"What constitutes the particular appeal and modernity of qualitative research in general? It is more open in its approach to the phenomena at hand and therefore often gets 'closer' than other research strategies which use a lot of figures and work […] with strongly standardized, objectivistic methods. […] Standardized methods need a determined idea of the object of the research for the conceptual design of their investigative instruments (e.g. a questionnaire); whereas a qualitative investigation can remain open to new aspects of the object of the research, to the unknown within the seemingly known."* (Flick, Kardorff, Steinke 2003, p. 17).[3]
The first goal of this qualitative study is to understand what an individual experienced osteopath means when he talks about the ML or what he perceives when he works with it. On the basis of the individual subjective reactions of my interview partners I will try to determine whether correlations, generalizations and trends can be deduced after meticulously analysing all the interviews, and how relevant this discussion is for the practical work of an osteopath. It is a long and laborious road from phrasing the questions to drawing a conclusion, as Froschauer and Lueger (2003) describe: *"The amount of work that qualitative interviews entail is often underestimated. Often standing behind this is the wrong assumption that it is sufficient to talk to people and to summarise their statements to gain a qualitative analysis. That may contribute to common perception, but disregards the analytical potential of qualitative analysis. Most often it is not the ostensible statements themselves that lead to greater understanding, but the accurate analysis of the structure and original conditions in which the interview statements were made. Therefore, sophisticated investigative and analytical strategies are required."* (Froschauer, Lueger 2003, p. 8).[4]

2.2.2. THE FOCUSSED INTERVIEW

According to Hopf (2003), different variants of qualitative interviews exist. These variants show in the *"orientation of pre-formulated questions that possibly also determine the course of the interview; or whether the interview is held very openly on the basis of a few pre-defined questions or directions of questioning. The variants of qualitative interviews most often used in research lie between these extremes and can be described as relatively flexible used, partly standardized interviews: the researchers steer the interview according to a guideline that leaves enough free space for the formulation of questions, inquiry strategies and for the progression of the questions."* (Hopf 2003, p. 351)[5]

For this study, a focussed interview guideline with written-out questions, which will be discussed in detail in the next chapter, was compiled. Here, I would like to go into the structuring of the interview. Hermann (2003) speaks of the "*Interview-Drama*" and its *"anxieties, traps and obstacles"*: *"For the interview, certain* ***requirements*** *have to be fulfilled. At first, the interview partners must be convinced and the time, place and content of the discussion must be arranged. A fruitful interview atmosphere must be established, and the use of a recorder must be agreed upon. The interview partner must know in which capacity he is being questioned, and the aim of the interview as well as the expectations of the interviewer should be made clear to him. Finally, the interview must be conducted methodically and must end at a certain point. Thus, the requirements for structuring the 'interpersonal drama' are numerous, as are the possible traps."* (Hermanns 2003, p. 361)[6].

Further on, he speaks of the uncertainties the interview work can cause in a beginner. The uncertainties have firstly to do with the *"'**dilemma of vagueness**'. On the one hand the guidelines for conducting the interview are often very vague, on the other hand the interview is supposed to contribute significantly to the scientific objective. A second difficulty can be called the* ***'dilemma of fairness'****: the requirement and interest of the interviewer to gain as much personal information as possible from his interview partner conflicts with the claim of dealing with him fairly. Finally, a* ***'dilemma of self-representation'*** *can emerge: to conduct the interview well, one must not show all the knowledge and experience one believes to have."* (ibid)[7].

According to Hermanns, the interviewer plays a *"double role"* in this *"drama"*: *"On the one hand he distinguishes himself through* ***empathy*** *by trying to put himself into the position of his interview partner to understand the way he experiences and interprets the world. But at the same time, he must establish a different attitude towards his interview partner by showing that he hears the words but isn't sure about the true meaning these words have for the interview partner. He doesn't know the underlying conditions that his interview partner associates with his or her words and must be conscious of the* ***foreignness*** *of their presentation. He must put himself in a position of deliberate naive*
ty and ask the interview partner to explain his or her way of seeing things that should really be known to him. Meanwhile he has to communicate the impression of being an interested and relaxed listener." (ibid., p. 364)[8].

Froschauer and Lueger (2003) put forward the important consideration that contradictions within the context of the interview may make sense. Even *"misinformation"* is not given accidentally but has a meaning that should be researched. The ideal approach of the interviewer to a research interview is to remain open, curious and inquisitive. To quote them directly: *"It is important to engage in something new and unknown in the process of researching. […] A rash categorization of topics, persons and valuations bears the danger of simplification and diminishes the space for perception. […] Listening is thus an active process of following the general train of thought."* (Froschauer, Lueger 2003, p. 59-60)[9].

2.3. INTERVIEW GUIDE AND GUIDING THEMES

The interview guide was developed from a great variety of questions and considerations around the phenomenon of the ML in osteopathy. It works as a kind of red thread around which the discussion can be orientated.

The progression of the questions is not always identical depending on the course of the interview, the answers of each interview partner and the available time.

The phrasing of the questions is adapted to the particular interview situation and is decided upon by the interviewer. Sometimes new issues turn up in the course of a discussion that result in new additional questions; sometimes questions have to be abandoned because time is running short.

The guide for this study is centred on three guiding themes that cannot be clearly isolated, but often intertwine.

- **Definition of the ML**: A discussion about how the ML can be defined; whether a generally applicable osteopathic ML concept exists; when and how each interview partner came in contact with the ML; how significant anatomy and embryology are, and so on …

- **Practical relevance of the ML discussion**: Here the question is whether one can reach an osteopathic diagnosis via the ML; whether concrete recommendations and guidelines exist on how to approach and experience the ML and whether the ML should already be introduced during basic education or post-gradually, if at all.

- **Personal experience**: A discussion about whether a particular preparation or mentality is necessary for ML osteopathy; and which physical or mental reactions ML treatment can reveal within the therapist and within the patient.

From these guiding themes, eleven guide questions were deduced.

The interview guide:

1) Is the phenomenon of the Midline (ML) a typical osteopathic issue that should be of importance to every osteopathy student, or is it a secondary topic that only concerns osteopathic freaks?
2) When did you hear about the osteopathic ML for the the first time, and when did you start to investigate it?
3) Could you name one or two case histories where your work with the ML brought astonishing results, even for you?
4) How important is a certain mental disposition of both the therapist and the patient for work on the ML? How much knowledge / preparation is necessary?
5) Which particular value do structure and anatomical knowledge have for work on the ML? Which structures could be representative for the ML?
6) What do you think: is it possible to treat the ML by using structural techniques only?
7) What is the ML? Is it a condition? An energy line? A structure? A process? Do you personally have a certain inner picture (idea) of the ML? How does it feel? How do you treat it (handholds) ?
8) Do differing qualities, variations, deviations and pathologies of the ML exist? How do they feel?
9) How, where and when does the ML begin and end?
10) A student in osteopathy asks you for your help to be able to understand and to feel the ML. What advice would you give him from a practical and theoretical point of view (any reading suggestions)?
11) What happens within yourself when you are working on the ML of a patient?

2.4. REALISATION OF THE STUDY

„Open research discussions (semi-structured interviews) don't begin with the first question, but already in the planning and first-contact phase; they don't finish with the end of the interview but with the concluding documentation of the interview situation." (Froschauer and Lueger 2003, p. 63)[10]

2.4.1. CHOICE OF INTERVIEW PARTNERS

Choosing my interview partners and preparing the interviews was a process that took more than two years. Already in my last year of training (2002/2003) at the WSO I got in touch with six of the seven interview partners about this matter and announced my plan. All of them showed willingness and interest.

I had got to know four of the interview partners as teachers during my osteopathic training (Nusselein, Shaver, Van den Heede, Wutzl). I chose them because they had mentioned the ML in some form during the lectures. I met two other interview partners (Weber, Toth) in the course of their work as assistants at the WSO, and they also talked about the ML to us students. I found my seventh interview partner (Liem) via an advertisement for a congress. His subject was: "The concept of the ML in osteopathy".

To summarize, one can say that five out of seven interview partners teach regularly at osteopathic schools; all of them are experienced osteopaths who have dealt with the term of the ML in osteopathy or with related similar topics for years.

The interviewees come from different countries: among them are an American, a Belgian, a German, a Dutch-born Englishwoman and three Austrians.

2.4.2. PREPARATION OF THE INTERVIEW

The interview partners were contacted by phone/mail, and an interview date was agreed upon. Six of the interviews were carried out in Vienna and one in Hamburg, from December 2004 to August 2005.

2.4.3. THE INTERVIEW SITUATION

The average duration of each interview was approximately 60 minutes.
Two interviews were carried out in English, all the others in German. The interviews were recorded on tape.

2.5. DATA EVALUATION

2.5.1. THE TRANSCRIPTION

Processing is the first step when analysing qualitative data. That means the interviewer has to transcribe the recorded tapes following the interview.
Kowal and O'Connell (2003) define a transcription as a graphic account of selected aspects of the communicative behaviour of people taking part in an interview.
Transcripts are necessary to secure the availability of transient communicative behaviour for later analysis. The intention here is to give a description as accurate as possible of the expressed word orders and their oral shaping - and also of non-verbal behaviour such as laughter – to uncover the particulars of an individual interview (Kowal, O'Connell 2003, p. 438). It has to be mentioned here that writing down and structuring spoken words necessarily lead to a certain loss of realness. The recorded tape can only capture a part of the conversation; facial expressions and gestures remain unconsidered.

Froschauer and Lueger (2003) write: *"The transcription of an interview should when possible be made retaining the exact dialect and spoken peculiarities without fine-tuning to literary language."* (Froschauer, Lueger 2003, p. 223)[11]

One of my main concerns was to reproduce all quotes from the interviews that were used in the study as authentically as possible. That required scrupulous and precise preliminary work with the transcriptions:

- The text in the transcription wasn't transformed to literary language because of this.
- The transcription was made verbatim; affirming and understanding comments by the interviewer such as "mh" or "yes" were enclosed in the written transcript.
- Word order was only changed when absolutely essential for the comprehension of the text.
- Unintelligible sentences were marked in brackets as "unintelligible".
- Non-verbal utterances such as laughter were marked in brackets.

The interviews have consecutive numbering for each interview; so every interview starts with page 1 and ends – for example – with page 28. In the individual transcripts the lines on each page were numbered; so every page has a line numbering from 1 to 34, for example.

Number of pages of all seven transcriptions: 94

Number of words of all seven transcriptions: 44.825

2.5.2. SEPARATE INTERVIEW ANALYSIS

Following the transcription, the next step was editing and evaluating each interview. The text material was *"systematically fragmented"*, as Froschauer and Lueger describe it (2003, p. 106), and the statements of the interview partners were assigned to thematic focuses. These focuses were predetermined by the guiding themes on the one hand; on the other hand they evolved on the basis of the transcriptions. By and large, these focuses complied with the guide's topics but were complemented by several new themes (for example, embryology wasn't an autonomous item in my guide; it emerged as a main topic in the course of transcribing).

This phase seems to be especially demanding at first sight. But Froschauer and Lueger (2003) give us an explanation of why it is necessary: *"This methodical provision is necessary to avoid the questionless application of previous knowledge. Fragmentation separates the part of the text that has to be analysed from the context and creates the necessity to explore and thus to recontextualise the specific particularities and the general dynamics of the world that lies behind these statements without any previous knowledge of the context […] in the course of the interpretation."* (Froschauer, Lueger 2003, p.106)[12]

This differentiation of themes helped shape the chapters of this study.

Number of pages of all seven interview summaries: 119

Number of words of all seven interview summaries: 63.301

2.5.3. QUALITATIVE CONTENT ANALYSIS ACCORDING TO MAYRING

It is during this phase that the study truly begins. This means that everything presented in chapter 3 ("Representation of the results") was derived from this content analysis. Individual transcription and analysis were only a preparation for this final interpretation.

This last step of data processing included a qualitative content analysis according to Mayring. Mayring (2003) defines the systematic editing of communicative material as

the objective of content analysis. Content analysis claims to be used in a multitude of scientific fields today.

"Modern content analysis no longer only aims at the content of verbal material; it can make formal aspects as well as latent meanings its subject-matter. The fundamental idea of qualitative content analysis consists of retaining the systematics [...] of content analysis for qualitative analytic steps without applying hasty quantifications." (Mayring 2003, p. 468-469)[13]

As a consequence for this study, all interviews were set in correspondence to each other to determine potential common grounds, possible generalisations and any trends or discrepancies. Relevant text passages from specialist literature were incorporated concurrently.

3. REPRESENTATION OF THE RESULTS

3.1. THE STATUS OF THE ML IN THE CURRENT OSTEOPATHIC DISCUSSION

3.1.1. MAIN TOPIC OR SECONDARY TOPIC?

All interviewed osteopaths are of the opinion that the ML is a main topic in osteopathy:

VAN DEN HEEDE: *"It's a main topic."* (2/12)

LIEM: *" In my opinion, it is an osteopathic topic of general interest, to which every osteopath should pay attention."* (2/21-22)

NUSSELEIN: *"It is primary."* (2/9) *"Every student needs to know about the ML-function."* (1/39)

WEBER: *"For me, it shouldn't be only a main topic for osteopaths but also a main topic in classical medicine."* (1/42-43)

WUTZL: *"One of the main topics of osteopathy"*(1/52).

TOTH: *"The ML [...] is of course a general osteopathic phenomenon."* (1/30-31)

SHAVER: *"It's quite fundamental in terms of being ... it's a fundamental concept ..."* (1/45-46) *" ... the content of the ML is the content of our entire perceptional feeling"* (1/38-39)

To explain the reasons for this, several interview partners point out the basic principles of osteopathy. To make things a little clearer for the reader, I will discuss these principles shortly here. According to Van den Heede, there are four principles for treatment in osteopathy:

1) Body-Mind-Spirit form a unit (holistic approach of osteopathy)
2) Self-healing forces are at work in the body
3) Structure and function are mutually dependent
4) These principles mentioned above must be adjusted to each other and be harmonized

   (Van den Heede, 2003 - 2005, and VAN DEN HEEDE 2005, p. 8/7-10).

These principles go back to the founder of osteopathy, the American physician Andrew Taylor Still (1828-1917) who described his method of healing in his extensive works. Jean Arlot, an osteopath who practices and teaches in France, describes this development as follows: "*Faced with the failures of traditional medicine of his time, and under the strong influence of the iatromechanic movement represented by Descartes in France and by William Harvey in England with his works on blood circulation, Dr.Still became convinced that the laws of the universe as described by Galilei, Newton and Kepler could be applied to human beings and animals. Like them, he believed that living creatures consist of different 'parts' that have to function in harmony and whose vitality is dependent on blood circulation. Every obstruction to this circulation diminishes the supply to these 'parts' or structures and leads to disease.*" (Arlot 1998, p. 4)[14]
Jane Stark, a Canadian osteopath who thoroughly studied Still's work and life, expresses Still's reasoning like this: "*His message is worth the struggle. Why? Because Still's ambition was to create a system of knifeless (no surgery) and drugless medicine. He did cure disease, but he did not record how. Instead he offered a philosophy of medicine that did not involve adding anything to or taking anything away from the body - it was just a matter of having the body deliver it to the right place in sufficient quantities and then removing all waste. A philosophy that he trusted that WE would put in good use and continue his work.*" (Stark 2005, p. IX)

For VAN DEN HEEDE, it is a logical consequence for every osteopath who thinks about osteopathic laws and principles to come across the ML. The ML is a basis for every osteopath who thinks causally. Even if the cause can't be palpated, it is still important and should be taken into consideration: "*Well, I think it isn't a secondary topic for osteopathic eccentrics, but a final result for somebody who thinks about osteopathic principles and laws and moves on to the functioning of fascial or cranial techniques. He will then automatically come across a principle where he should integrate the ML. I think it is a final result where every osteopath should think causally. Even if he can't palpate the result, it still matters! So it's not something for eccentrics. It is a main topic.*" (2/6-12)

Also NUSSELEIN speaks of the self-healing forces in Man as part of the osteopathic concept. To be able to understand the following statements, some other terms from

osteopathic vocabulary need to be explained: the terms ′fulcrum′ and ′Primary-Respiratory Mechanism′ (PRM), which is also called ′Involuntary Mechanism′ in English-speaking countries, were used by one of Still's pupils, William Garner Sutherland (1873-1954). Sutherland is seen as the founder of Craniosacral Osteopathy. He applied Still's principles to the cranium and developed his own therapeutic concept. His written works are also part of classical osteopathic standard literature today. Sutherland described a special movement of the cranium, namely the ′Primary-Respiratory-Mechanism′. He ascribed certain characteristics to the PRM and postulated legalities. As ARLOT points out in his script ′Cranial Osteopathy", this PRM can be found throughout the body, is subconscious and can be seen as a kind of permanent *"background noise"* that effects the whole human being. The PRM expresses the potency of a human being (Arlot 1998, p. 10-11).

A ′fulcrum′, according to Liem, is a point of stillness or the (variable) centre of a movement. A fulcrum can be found not only in the human organism, but also elsewhere in nature (Liem 1998, p. 277). I will further discuss the term ′fulcrum′ in chapter 3.3.3.2.

NUSSLEIN identifies the PRM with the self-healing forces of Man and describes the ML as a fulcrum for the PRM: *"Well, if we think about the function of the ML that that is actually a fulcrum to our involuntary mechanism and our involuntary mechanism is our self-healing force, which is part of the concept of osteopathy, I think every student needs to know about the ML function."* (1/37-39)

LIEM also talks of a fulcrum in relation to the ML. In this case it stands for direction, centring in the present, as one of many possible definitions of ML. For him, the ML is a universally applicable osteopathic topic because the understanding of formation and dynamics of tissue structures is essential for every osteopath. Here, he refers to the evolutionary dynamical interpretation of the ML: *"... because every student should occupy himself with the development, the formation of structure, because the formation of structure is paramount for the understanding of the whole structure, and for the understanding of the tissue, and of course this is the field of osteopaths. And if they miss the evolution, then an important part will be missing for the osteopath to understand the dynamics of tissue ... "* (2/26-30). Further on in his explanation why the ML should be

a main topic, LIEM refers to a holistic aspect of the osteopathic concept. For him, 'holistic' means a combination of psychology and work on the tissue: *"These different levels ... the more you manage to combine psychology and working on the structure, the more holistic you will be in my opinion."* (13/40-42)
In his statements, WEBER also puts the holistic aspects of osteopathy to the fore. He refers to the definition of health as given by the WHO (World Health Organisation): according to the WHO, health means well being on a physical, psychological and spiritual level. All three categories must be present: body – mind- spirit. For WEBER, the 'body' category is distinguished by the presence of palpable and measurable elements that are also easier to access by scientific exploration. For him, the psychological dimension is neither palpable nor sensually perceptible. Between these two categories of a palpable body and an impalpable mind lies the third category, the soul. The soul mediates between the categories. WEBER expresses his concern that this specific wholeness might be lost: *"I'd like to point out that it should be a main topic for medicine but that it has become more and more marginal, and I fear that also in osteopathy, it might go in this direction by putting the focus on the purely physical areas. And I would esteem this very dangerous, because then we couldn't call ourselves holistic. Generally, physicians don't do it any more. But we do, and so we should place it even more at the centre of our work. We would only have to try to sort out the terms."* (3/8-14)

WUTZL uses the term of the holistic concept in the same way and is contemplating whether osteopathic education should not refer to it much earlier. At the same time he stresses the importance of the biomechanical und structural concept of osteopathy: *"The question is if one shouldn't start with a holistic concept in osteopathy, and present it in this way from the beginning. This wouldn't interfere with also applying all the biomechanical concepts. I, for example, also do thrusts, so it's not about leaving behind structural osteopathy. But for the overall clinical concept it would make an important difference."* (2/11-16)
"It was important for me, for example, to get to know this concept after three years, because the biomechanical osteopathic concept didn't give me full satisfaction in the profession, to tell the truth." (2/24-27)

3.1.1.1. SUMMARY AND CRITICAL REVIEW

In this chapter I examined to what extent the ML discussion is an important issue in osteopathy for my interview partners.
The short quotes that I put at the beginning of the chapter clearly show that they all agree that the ML is a main issue of osteopathy, but the reasons given already show signs of vagueness and confusion. As a consequence, I tried to explain the osteopathic terms that seem important for the understanding of this reasoning.
The classical principles of osteopathic treatment are mentioned right at the start. Even trying to explain these to a non-osteopath is a dilemma: who postulated and wrote down these principles of treatment, when and where? And what were the original terms? A whole master thesis could be written about this alone.

I then decided to use the explanations given by Van den Heede. I could just as well have quoted Bernard Ligner (1993) who names not four principles like Van den Heede, but five in his book "Gelenke der unteren Extremität - Mobilisation und Korrektur ". Besides the self-healing principle, the holistic principle (unity of body-mind-spirit) and the principle of interaction of structure and function, Ligner names the law of the arteries (free fluctuation of all body fluids as a therapeutic goal) and the postulate: life is motion (mobility as a primary diagnostic criterion in osteopathy) (Ligner 1993, p. 17-24).
Similar, but not identical, are the five principles described by Pierre Delaunois (2002) in the book "Leitfaden Osteopathie". Only the fifth principle sounds different here: the osteopath should focus his attention on the patient and not on the disease (Delaunois 2002, p. 35-42).
All of them more or less refer to Still with their principles, although he never summarized them in written form to my knowledge.
Once one is acquainted with these principles one can truly understand the various explanations of my interview partners (at least I hope so).
For VAN DEN HEEDE, this contemplation of the osteopathic rules and principles leads directly to the ML, and it has to do with the central osteopathic philosophy.

NUSSELEIN places the self-healing forces in the foreground and identifies them with the so called 'Involuntary Mechanism' and the 'Primary-Respiratoric-Mechanism'.
The ML represents the 'fulcrum', the centre of these forces (these terms from standard osteopathic vocabulary cannot be defined precisely either). TOTH, WEBER and VAN DEN HEEDE also mention self-healing forces in relation to the ML.
VAN DEN HEEDE, LIEM, WUTZL and WEBER make a connection between the holistic claim of osteopathy and the importance of the ML concept. In other words, one would have to integrate the ML concept if one wanted to give a patient a holistic treatment (as requested by the principles).

3.1.2. ML AND SCIENTIFIC ANALYSIS – A CONTRADICTION?

Take a moment to think about this sentence: *"It's not thinking, it's sensing!"* (Shaver, 2005, p.14/25)

The explosive nature of this question was made clear to me in a remark made by an interview partner after the tape recording was interrupted: he warned me of possible reactions that this study could lead to in the osteopathic community. I seemed *"... like a red cloth being waved in front of a bull"*, and *"they are all going to go against you ..."* he said in these exact words.

Today, now that one year has gone by, I realise that this 'red cloth' stands for a scientific, systematic approach to a theme that seemingly appears to evade analysis at first sight. How can you scientifically explain the paranormal, the transcendent? As WEBER puts it: *"Whereas the soul looks in both directions. On one side is the body that is the sensorial part, which I can perceive through smelling, feeling, touching, through palpation. On the other side the soul looks to where it can't perceive any more, where it reaches the supernatural that can't be perceived by the senses, and that is the transcendental."* (2/24-29).

"The immanent relates to the ability of sensory perception, the transcendent relates to the ability of extrasensory perception. And both belong here. We know that we can't perceive everything with our senses. The phenomenologist Husserl speaks of "Korrelationsapriori" ("correlational apriori") that we have to know; that the things we can't perceive belong to our reality all the same. It is a scientific mistake, says Husserl, to eliminate and disqualify things that elude sensory perception. That way one mutilates the world, so to say, and not only one's own world but also the world of connections" (2/31-39)

"And I think that the interesting thing is that a science that wants to comprehend everything, has not understood the most important thing, namely that one can not comprehend everything [...] I call it a 'holistic imperative'. We have to concede to ourselves something that we can't comprehend." (2/44-48)

SHAVER calls osteopathy a spiritual science (2/32). He describes the development of osteopathy in America after Sutherland's death, from the early fifties to the seventies. At this time, all the remaining States gave full professional licensure to osteopathic doctors. Osteopathy defined itself solely by a purely biomechanical, physiological, anatomical approach. Mainly the desire to gain public acceptance led to a situation where spiritual or subtler energetic aspects were not discussed (6/48-50, 7/1-12).
SHAVER is afraid of a similar development today. He offers criticism of the osteopathic curricula (5/40-48), and expresses his concern that *"...the heart and the spirit"* of osteopathy might be lost (2/8-11). He sees this dilemma worldwide (5/46).
It seems incompatible to SHAVER to place osteopathy on a scientific basis and to recognise all the spiritual and energetic aspects at the same time. His quote mentioned before can be understood in this context: *"It's not thinking, it's sensing!"* (14/25). His position expresses a certain exclusiveness. Analytical thinking and subtle sensing seem to be a contradiction to him.

LIEM says that a common definition of the ML doesn't yet exist: *"Depending on how you see it – and it hasn't really been defined correctly so far - there are different kinds of ML, and all are important for students in my opinion"* (3/9-11). The desire for more differentiation in the present ML discussion prompted Liem to plan a speech about the 'Concept of the ML in Osteopathy'. He expresses it like this: "*My speech is about the embryological ML, and about evolutionary dynamics [...]. And I think it is important, because people have a wrong perception of the ML and very simplistic ideas, and almost no knowledge of how it evolves. That is the motivation for this speech. It doesn't have to do with ... on the contrary ... it's because I see the danger that they will try to integrate everything esoteric they have ever heard into terms like ML that I want to make this speech ... to be able to differentiate a little and to present it more differentially. And, as I said, spirituality and emotionality, and vitality and also causes or causal consciousness not only have to do with the ML, but have to do with me and the patient as a whole, and with every kind of touch. [...] And the ML is completely overloaded with all these differentiated contents, the interaction between structure, energy and conscience, for example.*"(14/1-11,15-17).

The question whether a ML concept will stand up to a critical, scientific analysis could also be a subtitle for this study. I find the justification of these questions confirmed by Peter Sommerfeld (2005): *"Instead, analysis should lead us to asking questions, in spite of all pragmatic scepticism of theory. It should encourage a discourse that faces questions that could make the reasons for the Why and How of our clinical practice clearer [...]. I therefore suggest questioning the basic terms of our osteopathic thinking and acting. This means not only questioning these basic terms but also the fundamentals upon which they are based. What is life? What is health? What is disease? What is healing? What is pain? All these questions converge in one focus: what is being human? [...] All this questioning means that one should be patient, ask the questions with consideration and not expect quick answers."* (Sommerfeld 2005, p.17-21)**[15]**.

Dr. Paul KLEIN, an osteopathic professor specialized in biomechanics at the university in Brussels, Belgium, uses similar arguments in his preface to the book 'Leitfaden Osteopathie' by T.Liem and T.K.Dobler: *"From a philosophical point of view, contradictions may occur inside a paradigm like that of osteopathy. Once scientific experimental examination contradicts traditional expert opinion, questioning and even calling into question is unavoidable and necessary. Such a development finally speaks for the sanity of osteopathy."* (Klein 2002,VIII-IX)**[16]**

3.1.2.1. SUMMARY AND CRITICAL REVIEW

Two different points of view can be distinguished in the statements made by my interview partners: on the one hand a critical attitude against the efforts to represent ML osteopathy - which can be seen as identical to the subtle energetic, psychological and maybe also spiritual aspects of osteopathy in this context – by scientific means (keyword: 'red cloth').

On the other hand, more clarity and differentiation is demanded in the current ML discussion, namely because *"some people mix everything esoteric into it"* as LIEM and WUTZL put it.

The variety of arguments for and against a scientific review of, as WEBER calls them, *"transcendental"* topics that are so difficult to ascertain is very wide.

SHAVER speaks of a *"spiritual"* science and foresees a dramatic development in Europe, in the course of which *"the heart and the spirit"* of osteopathy might get lost in favour of scientific explanations and political acceptance.
WEBER also expresses criticism, but not as pointedly negative. The transcendent and supernatural (and also the ML) are integral parts of his osteopathic understanding, but cannot be explained scientifically. He says: *"Science is what works!"* (14/33). Even if one can't perceive it sensually, it should not be eliminated.
For me, this issue is a great challenge. The prospect of being a red cloth in front of a bull was not exactly encouraging and gave me quite a bit to think about. Finally, it was precisely this experience that showed me the importance of scientific research, especially into these issues. And in my opinion, a qualitative study is an ideal instrument for such analysis.
Further on in this chapter I quote Klein and Sommerfeld, because their demands to reflect and question clinical practice and traditional expert opinions were like balm for me and gave me further courage to research.

3.1.3. THE ML: A SUBJECT FOR BEGINNERS AND/OR FOR ADVANCED STUDENTS?

3.1.3.1. THE OSTEOPATHIC EXPERTS' TEACHERS

Overview of all the osteopaths mentioned in this chapter:

- William Garner Sutherland: 1873-1954 (USA), founder of craniosacral osteopathy, student of Andrew Taylor Still, author of several books
- Rollin E. Becker: 1910-1996 (USA), student of Sutherland, author of several books
- Anna Slocum: (USA), student of Sutherland
- Elliottt Blackman: (USA), well known for his midline-courses
- Jim Jealous: born in 1940 (USA), founder of biodynamic osteopathy, known worldwide for his courses; worked with R. E. Becker and was a pupil of Ruby Day for years, who herself was a student of Sutherland
- Tom Shaver: born in 1951 (USA), student of R. E. Becker and A. Slocum, teaches biodynamic osteopathy in several countries following Jim Jealous' curriculum
- Sue Turner: (England), worked with J. Jealous, lives and practises in England, teaches in several countries, was the teacher of H. Nusselein
- Stuart Korth: (England), worked with J. Jealous, is director of the Osteopathic Centre for Children in London and teaches osteopathic paediatrics
- Peter Armitage: (England), teaches osteopathic paediatrics
- Jean Arlot: (France), lives and practises in France, teaches cranial osteopathy in several countries
- Louis Rommevaux: (France), lived and taught in France as well as several other countries
- Anthony Chila: (USA) teaches in several countries
- Patrick van den Heede: born in 1954 (Belgium), lives and practises in Belgium, teaches in several countries, devised the „theory of the tripartition ML"

Out of the seven osteopaths interviewed, three had already heard about ML osteopathy during their basic training. These three are graduates of the Vienna School of Osteopathy (WSO). Among the teachers at the WSO, all three name Tom Shaver as the first one to talk about the ML and as having a major influence on them.
WUTZL describes his encounter with Tom Shaver as *"... a raindrop in the desert"* (3/31-34).
WEBER also has vivid memories of the courses with Tom Shaver: *".... the first courses with Tom Shaver gave me the feeling that my bones were not moving around an axis inside of me, but that I was lying on an axis, or that I was embedded in this axis as a whole, that there is an overall axis."* (3/31-34)
"Somehow this is a thought that also touched me deeply once. That I rest on this axis... this axis always remains the same in everything I do, it never changes. And this axis is a precondition of our identity." (4/1-3)
During his first years at the WSO, WUTZL had already heard a speech by Patrick Van den Heede that had a lasting influence: *"... a single speech by Patrick van den Heede that really thrilled me – because we didn't understand a word, but something inside of me knew exactly that this is what osteopathy is all about."*(2/35-40)
TOTH still remembers that Louis Rommevaux (3/15-16) and Jean Arlot (3/15-16) spoke about the ML during his basic osteopathic training at the WSO; Stuart Korth and Peter Armitage mentioned it in their courses for paediatric osteopathy. But it really was Tom Shaver who triggered his impulse to turn in this direction (3/7).
The major influences for WEBER were his postgraduate courses with Jim JEALOUS. He describes this encounter as follows: *"... and my key experience was in the courses with Jim Jealous, where I experienced this stillness as an abundance that reaches the limits of the universe, so to speak, exactly as Novalis puts it - infinity is closest to the spirit. That you can feel something that is not related to the body but [...] resting [...] in between the cells, as Sutherland says: 'The space in between'. This space in between the cells, in between the body's cells is unlimited and untouchable. How could one violate it? And that is why it is the centre of health."* (5/2-9)
These courses with Jim Jealous were also of great significance for WUTZL. He says: *"I seem to be a person that has an immediate essential experience when I get to know something new that really interests me. I experienced the ML right away, and that put me in*

a big emotional turmoil; so a strong emotional connection to this concept was established." (4/1-5)

The four other osteopaths found their way to the ML concept through various different approaches only after their basic training. LIEM relates that he didn't have any deeper experiences in connection with osteopathy: *"I had my deeper experiences outside osteopathy, not within it. Experiences that touched me happened rather in meditation or in psychotherapeutic training, and less so in osteopathy"* (4/40-42). He also mentions the courses with Jim Jealous as an important experience.

NUSSELEIN is the only one of my interview partners who participated in a ML course by Elliott BLACKMAN: *"I did a course about the ML not with Jim Jealous but Elliott Blackman. And that opened really a big thing for me. What was interesting in that course … we treated nearly everything, but we went back always to the embryology. So important is the ML. Because if you look at the embryology that is actually the force of healing … sits in there and we start from the ML. That is the first thing that appears. And then we know, okay, this is the way we need to go to. Through that force, if we still have that, we can contact that, we can heal every part of the body."* (3/16-22)

She also learned a lot from Sue TURNER, who again was one of Jim Jealous's confidants.

VAN DEN HEEDE talks of his postgraduate courses with Anthony CHILA: *"It actually was at the courses of Anthony Chila. We discovered the concept that the body initiates this ML–thought-function without really speaking about the ML. He spoke of centre and periphery, how the body builds lesions via the periphery and how that reaches the centre, or how lesions are built from the centre in the periphery."* (2/33-37). VAN DEN HEEDE also refers to the written works of Sutherland and Becker and stresses the importance of embryology: *"Once you have read these books by Becker and Sutherland, you get the similar information on an osteopathic conceptual level, and once you have studied embryology, you know that this ML was mentioned long before and was present long before without being an osteopathic term. Only the combination of osteopathic concept and ML on an embryological level secures the ML as a perceivable result, and not only a conceptual result, so that it doesn't remain a concept. And you really could say that Anthony Chila brought on this level."* (2/37-43)

Tom SHAVER attended various courses at the SCTF (Sutherland-Cranial-Teaching-Foundation), e.g. with Rollin Becker and Anna Slocum (who were both Sutherland's pupils). He describes his encounter with these 'old', seasoned teachers like this: *"So they have to guide us into things ... ah ... the real teachers ... have to kind of bait us and hook us und guide us into things that are way beyond what we can understand ... but maybe we can get some experience of it."* (6/23-25)

3.1.3.2. ML IN BASIC OSTEOPATHIC TRAINING

We have to ask ourselves whether the ML concept is important enough to be given a place in basic osteopathic training. The answers to this are ambivalent:
On the one hand the interview partners agree that the ML is a fundamental osteopathic subject; on the other hand no consensus has been reached on how and in which context it should be taught. LIEM says: "*Depending on how you look at it – and it hasn't really been defined yet – there are various kinds of midlines, and all are important for students in my opinion*" (3/8-11). And, further on: *"Because every student should occupy himself with the development, the formation of structure, because the formation of structure is paramount for the understanding of the whole structure, and for the understanding of the tissue, and of course this is the field of osteopaths. And if they miss the evolution, then an important part will be missing for the osteopath to understand the dynamics of tissue ... "* (2/26-30).
I will now present quotes by LIEM to show where he saw problems in his own osteopathic studies as well as in his present occupation as a school headmaster and teaching osteopath: *"I think the reason why I didn't experience it so often in osteopathy was that it is partly too clinical, or because the esoteric part isn't taught well enough or regularly enough and the emotional part is only alluded to verbally."* (4/46-48)
"... that on the one hand, the emotional work and the natural connection of emotional levels of being in the tissue are seldom alluded to during education, hardly put into practice methodologically, that there are few authorities in the field of osteopathy that could teach this well. And on the other hand: [...] that continual training of this kind of conscience-building hardly exists." (5/3-9).

"Dunshirn: Well, you are a teacher yourself. Do you incorporate this in your lessons to make it more visible? Liem: "Yes. But that's not so easy, because those interested in learning osteopathy mostly want to become more effective and are more interested in the practice and techniques of osteopathy, and don't come into the training directly because it has a lot to do with self experience. And I am confronted with this as a teacher, I have noticed this, because one can give small instructions... once it gets more profound, you notice a certain unrest in the class, because some want to get into to it but some don't. Whereas when you get into overtly psychotherapeutic training or a meditation retreat, you know that you will be practising ten days of silence, for example, and it isn't like that in osteopathy for the moment. That is why I proceed carefully." (5/16-28)

"From my point of view it is fundamental to integrate it if you want to call osteopathy a holistic therapy method. Otherwise it won't be enough to simply verbalize it before giving a tissue-function-unity background, when working only with tissue and the probable psychotherapeutic, emotional fields of experience are included as functional aspects. You will really have to have subjective experiences and work with them methodically to integrate and connect them, and that doesn't work if you only palpate." (5/33-39)

"It is mentioned, of course. We don't do it in detail so far; we are in the process of changing that. But until now, it hasn't been done in detail, because the students need a lot of time for other contents, and there really hasn't been too much room for it, and I wanted to avoid them going on a 'drivel trip', as you may call it; a trip which is hardly very profound, because my priority is to have them learn the basics of osteopathy first ... " (8/49-51, 9/1-3)

So there seems to exist a certain fear of the 'drivel-trip' (LIEM 2005, p. 9/2), straying off into the esoteric (WUTZL 2005, p. 9/2). On the other hand, emphasis is placed on the point that osteopathy would loose an essential part of its understanding on how tissue dynamics work without the ML concept. And osteopathy would be less satisfying (WUTZL 2005, p. 2/26-27) and less interesting (NUSSELEIN 2005, p. 5/34-35). As LIEM impressively portrays in the quotes mentioned above, the endeavours of osteopathic students to gain higher efficiency and quicker results in therapy have an influence on the decision concerning the time at which ML osteopathy should be taught. He mentions a shortage of osteopathic authorities that could put the ML

concept into practice, and that is another reason why it's not easily integrated into basic training.
WUTZL suggests introducing the ML concept in context with embryology lessons. That would be in the last years of education. But he also thinks about starting the training with a more holistic approach from the beginning (2/8-16).
WEBER would like to integrate basic philosophical terms into the training. ML osteopathy would be more accessible if it was embedded in a philosophical context (15/26-41).
For SHAVER, *"the heart and spirit"* of osteopathy have already been lost. Osteopathic curricula are too focussed on biomechanics. In his opinion, osteopathy is a *"spiritual science"*, and to teach it differently would mean to no longer teach osteopathy (2/8-11, 32-33).
Like LIEM, SHAVER says that there are not enough competent people to teach the curriculum, while at the same time there are more and more schools and more people who want to learn *"true"* osteopathy and are going to be disappointed (5/41-48).

3.1.3.3. SUMMARY AND OUTLOOK

This chapter first examined how each one of the experienced osteopaths – the majority of them are teachers (five out of seven interview partners) – made his or her way to ML osteopathy. Afterwards, the 'ifs' and 'hows' of integrating the ML concept into a basic osteopathic training were discussed.
The three Viennese osteopaths (WUTZL, WEBER, TOTH) had already heard about the ML during their basic training, all the others had later. The name of one osteopathic teacher stands out: Jim Jealous. He is the only one who is mentioned by all seven interview partners in connection with various issues. It can be rightly said that Jim Jealous is the founder of 'biodynamic osteopathy', which seems to be closely connected to ML osteopathy. One could discuss here to what extent the two approaches are identical or how they differ (I have not done that here because it would go beyond the limits of my study).

W.G. Sutherland follows Jim Jealous in the ranking of teachers and authors who are often mentioned as being important for ML osteopathy (five out of seven mentioned him), and by A.T. Still and Tom Shaver (each mentioned by three interview partners). All the other people are only named by one or two interview partners.
It can generally be said that all interview partners support the integration of the ML concept into basic osteopathic training. No consensus can be found on when and in what context this should take place. There are different suggestions: at the beginning of the training as some kind of introductive idea, or in connection with embryology lessons, or embedded in a philosophical context. 'Introduction to philosophy' as a new subject in the osteopathic curriculum? That is, at the very least, a fascinating thought.
Because my own first contact with the ML was made early on (at the end of the first school term), and although that was as disturbing for me as it was captivating and enflamed my passion for osteopathy for good, I could imagine an early introduction to ML osteopathy (I didn't know then what it was that I had come across. I realised much later that it was the 'ML' as I call it today, or the famous 'Breath of Life', the 'Spirit', the 'Long Tide' ...).
I don't think that the effectiveness of osteopathic techniques would suffer if philosophical, psychological, psychotherapeutic, natural-scientific or other, related topics were presented every now and then. I don't believe that students would run away, either. On the contrary, it could become a very fruitful addition to conventional teaching.

3.2. HISTORICAL DEVELOPMENT

"The significance of portraying the historical development lies, amongst others, [...] in the ability to expose dogmatic or even almost sect-like attitudes and outdated aspects of osteopathy and to be able to question them, based on historical comprehension"
(Klein 2002, VIII)[17]

The term 'historical development' in relation to the ML was used by VAN DEN HEEDE in his interview (2/22). Referring to this, I composed a separate chapter: in section 3.2.1. I will represent the historical development of ML osteopathy (which can't be separated from general osteopathy here), drawing a long curve from Still up to today (Jealous, Sills ...).
The explanations can only be fragmentary here because otherwise the limits of my study would be exceeded. It would in fact be possible to write a whole book about the historical roots of osteopathy.
In section 3.2.2., the breeding ground out of which Still's osteopathy was able to grow will be examined on the basis of an example: to illustrate the many other healing methods and schools of thought from the time before Still, I will mention Franz Anton Mesmer.

3.2.1. FROM A.T. STILL (1828-1917) TO TODAY

Quotes by PATRICK VAN DEN HEEDE are the main statements in this chapter, but some of the other interview partners also gave related hints. The ML concept is a foundation of our present osteopathic thinking for VAN DEN HEEDE. It is a logical consequence for every osteopath who reflects on the osteopathic principles and rules to come across the ML (2/6-12). He adds that maybe because of the great workload that osteopaths have to learn, not enough time has been spent on this aspect so far. (2/14-17). The energetic principle in osteopathy has only existed for ten years in Europe according to VAN DEN HEEDE. Before that, the mechanistic principle was in the foreground (3/14-19). The "old meaning" of the ML concept represents structure;

the “new” meaning represents function (see also 3.3.3. “Definition of the ML – “Functional Approach“). Here, VAN DEN HEEDE refers to the statements of Franklyn Sills (2001, 2004), an English craniosacral therapist and author of the two-volume work “Craniosacral Biodynamics“ (3/25-27).

For VAN DEN HEEDE, the historical development starts with A. T. Still (1828-1917), continues with W. G. Sutherland (1873-1954), Rollin E. Becker (1910-1996) and Robert Fulford (1905-1997) (2/22-23). All these osteopaths left their mark on the development of osteopathy, and they *“[...] really built a historical line that leads to this electrical level, to this ML-level, to this potency-level!“* (2/24-25). Jim Jealous, Franklyn Sills and others are following this path today (2/25-26).

SHAVER also names Rollin E. Becker and Anna Slocum, who were both pupils of W. G. Sutherland, as his ′true′ teachers: *“the real teachers [...] have to kind of bait us and hook us and guide us into things that are way beyond what we can understand.“*(6/23-25)

Today, SHAVER works with Jim Jealous and teaches the ′biodynamic osteopathy′ concept that was designed by Jealous (7/17-29). This concept is ideal for him: *“There is actually genius in the design. It accomplishes so many things at so many levels [...] it′s a vibe, it′s constantly changing and growing and shifting and becoming more and more effective and efficient.“* (7/35-37)

In a different context, SHAVER speaks about a continual osteopathic line that was initiated by A.T. Still and pursued by Sutherland and many others. To work with it is a very exciting perspective (8/19-26).

NUSSELEIN explains that Elliottt Blackman, with whom she did a ML-course, also spoke about Sutherland: *“Especially what Sutherland was telling students when they ask, ′what are you actually doing, doctor?′ And he said, ′be still and know and you feel the presence of God‘.”*(4/8-10)

WEBER compares the ′biomechanical model′ with a ′fluid model′: *“And that‘s why I think this biomechanical model is not sufficient and the “fluid model“ that goes back to Dr.Still is more plausible to me.”*(10/36-38)

All in all it can be said that osteopaths turn to the pioneers of osteopathy time and again when they try to explain something. The fascination that Still and Sutherland exude seems to be unbroken even today. Five of the seven interview partners mention them more than once in the course of the interview.

3.2.2. WHAT WAS BEFORE STILL? ONE OF MANY EXAMPLES: FRANZ ANTON MESMER (1734-1815)

"In a historical context, Still's osteopathy was – as far as technique and principles are concerned – hardly new. In his time there already existed principles and techniques that we can understand as 'cranial' or 'structural'. For us, it is simply important to find out what inspired him." (Abehsera 2002, p. 25)[18]

The nineteenth century must have been a very exciting time as far as evolving healing methods and schools of thought are concerned. Especially in America 'healers' seem to have found a liberty that one could only dream of in Europe. That was definitely advantageous for Still and osteopathy (this also applies to Mary Baker-Eddy, who lived from 1821 to 1910 in America, almost at the same time as Still, and is regarded as the founder of 'Christian Science').

The physician Franz Anton Mesmer (1734-1815), who lived in Vienna, was undoubtedly a predecessor of Still. He is regarded as the inventor of the so-called 'magnetic healing' method. Before calling his healing method 'osteopathy' in public, Still had advertised himself as a 'magnetic healer' (Delaunois 2002, p. 15).

In the following explanations I refer to the statements made by Alain Abehsera in "Leitfaden Osteopathie" (2002), by Stefan Zweig in "Die Heilung durch den Geist" (1931), and by Gerhard Wehr in "Die großen Psychoanalytiker" (1996).

Franz Anton Mesmer studied philosophy, theology, law, and, finally, medicine. He worked as a physician in Vienna in the second half of the eighteenth century, and famous personalities were his patients and friends (like the Mozart family, for example).

He believed in the existence of a particular healing force that fills the whole universe, the 'fluidum', which he also called 'animal magnetism'. The application of magnets was supposed to strengthen this force in human beings (Wehr 1996, p. 23 and Abehsera 2002, p. 19-20).

The more he developed his theories, made them public and put them into practice, the more irritated the Viennese medical community became. Finally, he had to leave Vienna (Zweig 1931, p. 67-69).

The principles that Mesmer formulated seem very familiar to any osteopath (Abehsera 2002, p. 19-20):

1. The life force corrects itself.
2. The fluidum connects everything, like stars, plants, human beings ...
3. The fluidum fluctuates spontaneously and has various rhythms. Inside the body, the tissue swells and contracts periodically. Healers may put their hands on a patient or keep them in a close distance to perceive these tides.

These healers were called 'magnetiseur' or 'mesmeriseur' after Mesmer. Mesmer's lasting significance, even today, is reflected by a word that is commonly used in the English language: 'to mesmerize someone' means to fascinate someone. 'Mesmerism' is translated as 'hypnosis' (Pons. Großwörterbuch für Experten und Universität. Englisch-Deutsch, Deutsch-Englisch. 2002).

According to Abehsera (2002), Still called himself 'magnetiseur' for several years and experimented with 'mesmerism': *"The study of Mesmer's principles and practices corresponds with studying the techniques and beliefs of Still at the beginning of his career."* (Abehsera 2002, p. 19-20)[19]

What Mesmer writes about the 'fluidum' reads like this in Still's work: *"... the cerebro-spinal fluid is one of the highest known elements that are contained in the body, and unless the brain furnishes this fluid in abundance, a disabled condition of the body will remain. He who is able to reason will see that this great river of life must be tapped and the withering field irrigated at once, or the harvest of health be forever lost."* (Still 1902, p. 44-45).

And for Sutherland: *"Within that cerebrospinal fluid there is an invisible element that I refer to as the 'Breath of Life'. I want you to visualize this Breath of Life as a fluid within this fluid, something that does not mix, something that has potency, as the thing that makes it move. Is it really necessary to know what makes the fluid move? Visualize a potency, an intelligent potency, that is more intelligent than your own human mentality. You know from your experience as the patient that the Tide fluctuates; it ebbs and flows, comes in and goes*

out, like the tide of the ocean. You will have observed its potency and also its Intelligence, spelled with a capital I. It is something that you can depend upon to do the work for you. In other words, don't try to drive the mechanism through any external force. Rely upon the Tide." (Sutherland 1939, p. 14)

The similarities in this way of thinking are clear here. It seems all the more astonishing that neither Still nor Sutherland ever refer to the source of their knowledge in their written works. Only at one point in Still's extensive work have I found a comment on his contemporary Mary Baker-Eddy, and also on his 'predecessor' Franz Anton Mesmer. In his typical poetic style, he briefly and precisely expresses what makes the difference between osteopathy and other healing methods in his opinion: *„ If because I denounce drugs you call me a Christian Scientist, go home and take a dose of reason and purge yourself of such notions. If you consider me a mesmerist, a big dose of anatomy may carry that thought away."* (Still 1908, p. 234)

At the end of this chapter I want to point out that in Still's time spiritism and hypnotic practices besides mesmerism were known in America. Delaunois (2002) writes: *"In 1865, Still tries in a questionable way to gain contact with his deceased children, whose deaths greatly distressed him. He starts to practise [...] spiritism."* (Delaunois 2002, p. 15)[20]

We can draw a line – in a geographical sense to Europe, and in a historical sense to the 'post-Still-era'- from hypnosis to another world 'parallel' to Still's, and interestingly we end up in Vienna again. Wehr writes that *"... mesmerism, the spiritism that came up before the middle of the century in the USA, and the hypnotic practices that were tried in a medical context were used as ways to explore the darker zones of the psyche in the course of the nineteenth century. Especially the use of hypnosis - that the majority of medicine disapproved of as much as of magnetism - was bound to produce insights namely at France's famous Salpêtrière in Paris; and the founders of psychoanalysis knew how to use it to their advantage. Freud as well as Jung went to Charcot's (1825-1893) school [...] for a short time."* (Wehr, 1996, p. 24)[21]

Thus Sigmund Freud, the founder of psychoanalysis, in a wider sense is also part of the context and the time in which osteopathy was born.
I will discuss in which way Freud may have something to do with ML osteopathy in chapter 3.3.5. “Psychotherapeutic Approach”.
The list of ’parallel’ fields could be extended.

3.2.3. SUMMARY AND DISCUSSION

According to VAN DEN HEEDE, the *“historical development”* of ML-osteopathy began with Still and Sutherland, continued with Becker and Fulford and finally led to Jealous and Sills in our time. These two represent - as VAN DEN HEEDE puts it - the *“potency- or ML-level”* in osteopathy (2/22-27). He sees this development also as an alteration of the understanding of the ML from a *“structural”* to a *“functional”* approach (3/23-27). This particular development will be discussed in detail in section 3.3.3.(”Functional approach”).
The “historical development” of ML osteopathy and general osteopathy seem to be almost impossible to separate.

In this chapter, Still’s environment was examined through a selection of extracts to illustrate the agars? from which he derived his “new” healing method, osteopathy. Mesmerism, spiritism, Christian Science, hypnosis and psychoanalysis (which wasn’t yet discovered at the time) were mentioned in this context. Many “parallel” worlds were depicted that existed approximately at the same time and probably had more influence on each other than one might have thought.
To illustrate the chronological order of events, I would like to present a few dates of birth and death here:

- Franz Anton Mesmer: 1734 - 1815
- Jean Martin Charcot: 1825 - 1893
- Andrew Taylor Still: 1828 - 1917
- Sigmund Freud: 1856 - 1939

- William Garner Sutherland: 1873 - 1954
- Carl Gustav Jung: 1875 - 1961
- Robert Fulford: 1905 - 1997
- Rollin E. Becker: 1910 -1996
- Jim Jealous: *1940
- Franklyn Sills: *1947

This whole chapter on the historical development of ML osteopathy can only give a brief overview of a wide and complex subject area. The intention here was to arouse the osteopath’s curiosity, to encourage you to look into the context of the time in which Still founded osteopathy and to find interconnections with other healing methods and areas of science. Osteopathy is definitely not Still’s “invention”. He had predecessors as well and was a “child of his time”.

3.3. DEFINITION OF THE ML

This chapter is the core of my study.
It shall examine what an osteopath means when talking about the ML, and whether these statements can be systemized. My interview partners offered many different views in this respect.
From the diversity of issues that were partly brought up by the focussed interview questions and additionally during the interviews, five main approaches can be derived:

- Embryological Approach
- Structural Approach
- Functional Approach
- Spiritual Approach
- Psychotherapeutic Approach

I chose the word ′approach′ because it seemed most appropriate to express the inherent diversity of any ML definition. I would like to point out that this list does not claim to be complete or final. These ′approaches′ are meant as guides to help you find a path through the jungle of explanations and different ways of looking at this subject. The proclamation of new osteopathic principles or laws is not the issue here, but rather if possible a neutral representation of different aspects that come into play when we try to define the ML. The following descriptions of each ′approach′ consist of the statements of my interview partners and will be supplemented by course scripts, articles from osteopathic magazines and literature. I will try my best to remain understandable and clear for the readers and – hopefully - to arouse their curiosity.
I will start with the ′Embryological Approach′ for a clear reason: although my concept did not include an explicit question about embryology it became a primary issue in the course of reviewing the interviews. This is why I grant embryology such a prominent place in my study.

3.3.1. EMBRYOLOGICAL APPROACH

"The forces of embryogenesis become the forces of healing in the adult!" (Jealous 2003, p. 48)

The Vienna School of Osteopathy has a fixed place for embryology lessons in its curriculum. Students hear introductions to embryology in their last years of education and sometimes hear about the embryologic history of the formation of an organ, for example during lessons in visceral or paediatric osteopathy.
The reason for this is the importance of embryologic knowledge for any osteopath, even if he doesn't practise ML osteopathy or paediatric osteopathy. This statement will be underlined by many quotes in the following text. Besides trying to find out how important embryology is for ML osteopaths in particular, I was confronted with the following question:
Could embryology be a bridge between a more biomechanical orientated osteopathy and ML osteopathy? In other words: is embryology the 'point of balance' between structure and spirituality (see title of this study)?

The discourse will be organized into five chapters:
3.3.1.1. Patrick van den Heede's 'theory of the tripartition ML'
3.3.1.2. The germ layer theory and its similarities with Van den Heede's theory
3.3.1.3. Similar ML theories by other authors: Franklyn Sills and Jim Jealous
3.3.1.4. Comparing the interviews
3.3.1.5. The germ line or the ML as a 'time machine'?

I am starting with Patrick van den Heede's 'theory of the tripartition ML', because it is currently maybe the most important and best-known theory on the osteopathic ML. To illustrate this theory, I used my interview (2005), an interview that was published in the magazine "Osteopathische Medizin" (2002) as well as handwritten course scripts from his speeches at the WSO (2003-2005). This is followed by chapter 3.3.1.2. ("The germ layer theory" - this is the theory about the ancestry of tissue from the three germinal sheets) where I will point out parallels between Van den Heede's

theory and the germ layer theory. In the next chapter (3.3.1.3.), Van den Heede's theory will be compared to similar theories by other authors. Here Franklyn Sills and Jim Jealous will be quoted. Chapter 3.3.1.4. ("Comparing the interviews") will summarize the statements made by my interview partners. Finally I will write about the so-called 'germ line' (3.3.1.5.) that seems to me to be interesting in the context of the ML discussion, although it was only mentioned by one interview partner.
To remain understandable for non-osteopathic readers I will include additional explanations from embryological books whenever it seems necessary.

3.3.1.1. PATRICK VAN DEN HEEDE'S "THEORY OF THE TRIPARTITION ML"

"Embryology gave me the explanation of the construction and function of the ML. Ever since, I have tried to 'reharmonize' patterns and to come as close as possible to each point of balance in direction of the ML of the actual body function." (Patrick van den Heede 2002, p. 26)[22]

This theory is based upon embryological formation processes and is widely recognized among osteopaths. Van den Heede did not personally publish this theory but he teaches it all over Europe, and two of my interview partners refer to it directly (Wutzl and Liem).
He calls his theory a hypothesis on which more work should be done in the future (5/3-4). It is a summary of his examinations and embryological studies related to the dynamics of development and the organisational forces of the tissues (1/42-46).
Van den Heede explains in an interview that he gave Liem for the magazine 'Osteopathische Medizin' why every osteopath is necessarily drawn into embryological processes, sometimes without knowing it. He speaks of moments in embryological development in which certain 'points of support' evolve. (The term 'point of support' can be replaced by the osteopathic term 'fulcrum' that has been mentioned before - author's note). Further on he says that an osteopath who is not aware of these embryological processes could misinterpret these 'fulcra' and see them as mechanical points of support. But they are in fact an expression of much

more profound layers. Profound in this context means "*... not body profoundness, but profoundness in time. That means certain lesions give the impression that they have not built up over a short period. These lesions cannot be released by means of a mechanical point of balance, but only if the anatomical knowledge of the development that has taken place inside the body is integrated into the treatment."* (Van den Heede 2002, p. 26-28)[23]. For Van den Heede, this dimension of time is the fourth dimension: *"Three-dimensional information is not sufficient. The dimension of time must be integrated into the treatment to recognize possible embryological information. Function is only an improved repetition of embryology which is also motion."*(ibid.)[24]. The idea that cells have a memory is an essential precondition for osteopathic thinking and acting. Van den Heede (2002) puts it like this: *"The disruptive factor which may go back to an embryonic stage is a kind of knowledge that can be stored as neuro-sensorical knowledge or in the subconscious.*
Once you enter into these motions or tensions as an osteopath and find a point of balance, the consciousness may change and the tissue may receive a different direction through this level of consciousness, a freedom that wasn't there before, because it had been hampered at a certain moment in its earlier development. This is like a computer where you click on an icon and a whole picture opens. And this picture allows further development." (ibid.)[25]
So for him, a successful osteopathic treatment means finding the right point of balance, the right fulcrum for the patient. In the process he tries to get as close as possible to the ML. He also calls this *"the re-harmonizing of patterns"* (ibid.).
I will discuss Van den Heede's "theory of the tripartition ML" in detail now and try to elaborate references to anatomical structures. I found most of the statements referring to it in course scripts from the years 2003 to 2005. In this case, they are indicated as: (2003-2005). Additionally, statements from an interview in the magazine "Osteopathische Medizin" are appended, which are indicated as: (2002) plus page number. Finally, passages from the interview I carried out will be used; in this case VAN DEN HEEDE will be written in capitals and the date is (2005) plus page and line number. Every time only page and line numbers are indicated, the quote comes from the interview with me.

Van den Heede (2003-2005) speaks of a tripartition ML. The three parts are:

1) ventral ML

2) dorsal ML

3) anterior ML

The order of this list is derived from embryological development, referring to the order of origin. The ventral ML stands for the *"the old"* and he also calls it *"air-line"*. Its main representative is the notochord. Its formation must be induced before the so-called dorsal ML can evolve. He also calls the dorsal ML a *"fluid-line "* because of its close relation to the neural tube and its contents, the cerebrospinal fluid. It stands for *"integration"*. The evolutionary youngest is the anterior ML, and its main function is *"adaptation"*. He also calls it *"line of immunity"*. These three lines *"wrap up life"* (Van den Heede 2003-2005 and VAN DEN HEEDE 2005, p. 4/10-43, p. 5/4-13).

1) ventral ML

The ventral ML is the first embryonic formation as a ML and is thus the *"oldest"* of the three MLs (5/13). It is represented by the notochord and leads to the building of the spine (4/39-42).

According to Rohen and Lütjen-Drecoll (2002), the notochord is in a certain sense a primitive axis of the evolving embryonic body. The notochord evolves from the primitive streak that is formed on the 16th/17th day of embryonic development inside the embryonic disk by cell movement and proliferation (Rohen and Lütjen-Drecoll 2002, p. 21-24). Rohen (2002) also describes this development very vividly in another book called 'Morphologie des menschlichen Organismus'. For him, the primitive streak marks the future centre of the body. With this, the right-left dimension of the embryo is constituted. At the front part of the primitive streak the primitive knot is formed, behind it the primitive groove. With it, a first up-down orientation is established. The head appendix that grows out to the front marks the end of the head, while the primitive streak that gets shorter marks the tail region, that is the caudal ending of the future germ. Through the primitive groove, the cells that will later form the notochord grow to the front. This again induces the first organic system of the embryo, the formation of the neural tube and the nervous

system (Rohen 2002, p. 63-66). According to Van den Heede, these two elements already belong to the dorsal ML.
The ventral ML reaches to the diencephalon and to the base of the Os sphenoidalis and ends at the ethmoid. Caudally this line continues to the Os coccygis (4/39-42). As mentioned before, Van den Heede also calls this line an "air-line", for which I could not find any explanation. My personal association with this term is related to the structure of the ethmoid (author's note). This bone, according to Van den Heede, is very fragile, light and "airy" and is connected to the respiratory tract (Van den Heede 2003-2005).
Within adults, remnants of the notochord can be found in the Nucleus pulposus, in the Lig. apicis dentis, in the basis of the Os sphenoidalis, in the sacrum and in the coccyx (Van den Heede 2003-2005). According to Liem, the point of balance for the ventral ML is the heart (Liem 2004, p. 639).

2) dorsal ML

The dorsal ML is related to the neural tube and its contents: the central nervous system and Liquor cerebrospinalis with ventricle system. After the neural tube is closed, fluid remains inside the tube, the Liquor cerebrospinalis. This is the reason why Van den Heede calls this line a "fluid-line". It also stretches from coccyx to the ethmoid, where it opens *"like a fountain"* (Van den Heede 2003-2005). This line is of an integrating nature (5/13). According to Rohen (2002), *"the neural tube represents the formation of the whole information system"*(Rohen 2002, p. 64). According to Liem, the balance point for the dorsal ML is the "Sutherland-fulcrum" (Liem 2004, p. 639).
At this point I will expand a little to explain a term that is in common use among osteopaths and unknown to any non-osteopath: what is the "Sutherland-fulcrum"?
Liem puts it like this: *"To guarantee the equilibrium of membrane motion and tension in all directions, these membranes have to operate from a fulcrum, a still point. This still point must be suspended in order to move automatically and to secure a regular physiological motion of the cranial bones when changes occur [...]. The centre of this intra-cranial membrane system is a fictional point that is located at a spot in the course of the straight sinus (Sinus rectus) and is formed by the unification of the Falx cerebri with the Tentorium cerebelli and the Falx cerebelli. This still point is also known as the 'Sutherland-fulcrum' or as 'automatic shifting*

suspended fulcrum'. At this point the dynamic forces that affect the membranes are brought into balance." (Liem 1998, p. 186)[26]

3) anterior ML

From an evolutionary point of view, the anterior ML is the youngest ML. It is supposed to re-adjust permanently to new influences and to be adaptive and reactive (5/13-14). It is not so genetically determined nor pre-programmed (4/16-24). VAN DEN HEEDE also calls it "line of immunity", because organs of vital importance for the immune defence rest upon it. Points of reference for this anterior ML are: the mandibule, the hyoid, the thymus gland, the myocardium, the suprahyoidal muscles, the sternum, the Linea alba, the symphysis, the uterus, the prostate... (4/28-35). LIEM describes the Hyoid as a balance point for the anterior ML (Liem 2004, p. 639).

3.3.1.1.1. Summary

Van den Heede (2002) stresses the importance of the so-called "fourth dimension". He refers to the time-factor that is of great significance for the building of an osteopathic dysfunction. For him, this time-factor is embryology. If an osteopath did not integrate embryological processes into his treatment, it could lead to misinterpretations. In other words, it is important to recognize "fulcra" – points of support that were formed in the embryonic stage - as such. If one did not do this, one could see them as purely "mechanical" points of support. And that would lead nowhere in his opinion. Ideally, the right point of balance, the right fulcrum should be found and brought in corresponding relation to the ML (Van den Heede 2002, p. 26-28).

I tried to explain Van den Heede's "Theory of the tripartition ML" as clearly as possible. Unfortunately, the time that Van den Heede offered for the interview was very short (two breaks during a seminar). I am nevertheless grateful for this personal information. In combination with the course scripts and a newspaper interview, I was able to compose a chapter about his theory.

The three lines in short:

1. ventral ML: "notochord-line"; stands for the spine, "remnants" within adults are e.g. Nucleus pulposus; "air-line", represents the "old".
2. dorsal ML: stands for the neural tube and the liquor system; "fluid-line", represents the ability to integrate.
3. anterior ML: "youngest" line, "line of immunity", represents the ability to "adapt".

I would like to make some personal remarks at the end:
Van den Heede's cognitions may seem very 'theoretical' at first sight and hard to understand, but they are of great relevance, even of great help in practice. It makes a big qualitative difference when holding the sacrum of a patient or working on the coccyx, for example, or visualizing the ethmoid, when you have a connection to the midlines mentioned above – that is to embryology - or not. And embryology as a whole becomes more structured and clearer by means of this "tripartition".

3.3.1.2. THE GERM LAYER THEORY AND ITS SIMILARITIES WITH VAN DEN HEEDE'S THEORY

While working on Van den Heede's theory I often noticed similarities between his description of the midlines and the description of the three germ layers and their derivates that can be found in any book on embryology. Then I tried to find correlations. On the one hand I was interested in anatomical structures that can be attributed to a certain germ layer; and interested in finding out whether there were any correlations with the structures that Van den Heede allocates to his midlines. On the other hand, I was interested in functions that are attributed to a certain germ layer or a ML. The question behind this examination was: do the three germ layers and their derivates correspond to the three parts of Van den Heede's ML?
Before talking about the three germ layers more specifically, I would like to take a closer look at their evolutional history.

According to Rohen (2002), the point of origin for the formation of the three germ layers is the germ disk, a *"highly potent embryonic area"*. (Rohen 2002, p. 62).

The development of the embryo's body itself starts on the 16th/17th day, when a longish depression appears through the motion of cells in the middle of the germ disc: the primitive groove or primitive streak. A certain process of invagination takes place. Through this process of invagination, a third layer between the epiplast and the hypoplast – we could also say between the inner and outer germ layers that formed the germ disk before – is constructed. This third germ layer that is pushed in between is called the mesoderm, the outer layer is called the ectoderm and the inner one the endoderm (Rohen, Lütjen-Drecoll 2002, p. 21-28 and Rohen 2002, p. 64-71).

Rohen and Lütjen-Drecoll (2002) describe the evolution of the three germ layers as follows: *"In theory, dispositions for all elementary functional areas of the embryonic organism are established with it. So the structuring in three layers is not coincidental, but reflects the elementary functional structure of the future organism. The ectoderm provides the dispositions for everything related to information processes (nervous system, sense organs etc.); the endoderm provides material for metabolic organs; the mesoderm for the inner and outer motional processes (circulation, musculature, motional organs etc.). These are elementary functions that already existed in the trophoblast; but now they have moved into the embryonic body and divided in three big parts that will also appear as main functional areas in the future body (exchange of information, metabolism and circulatory rhythmical processes) (so-called functional tripartition). The significance of the germ layers only becomes clear once you look at it from a higher level. The evolution takes place from the whole to the parts, not the other way round."* (Rohen , Lütjen-Drecoll 2002, p. 28)[27]

This description relates to the development of the functional systems of the human body. In other words, the tissues start to differentiate, and each tissue is given a different assignment. This is a "functional tripartition ", as mentioned above.

Another "tripartition" concerns the sterical development of the embryo. In a chapter called "Elementare Entwicklungsphasen des menschlichen Embryonalkörpers" ("Elementary evolutionary phases of the human embryonic body"), Rohen (2002) vividly describes how the growing germ conquers the three dimensions step by step. For Rohen, the first dimension is the bilateral symmetry, where cell movements start to the left and right of the primitive streak that marks the future median level.

With the formation of the primitive knot and the primitive groove, an up-down orientation is established. The head appendix that grows to the cranium marks "up", and the shortening primitive streak at the caudal end stands for "down". The front – rear dimension only comes into play through the middle germ layer, the mesoderm, out of which the somites form. Caused by the somites' disintegration and the formation of mesenchym a three-dimensional body evolves that swims without gravity in the amnion cavity at first. We are now approximately at the end of the third embryonic week (Rohen 2002, p. 67-68).

All these processes seem important to me for the understanding of the ML in osteopathy. That is because for all functional processes as well as for the evolvement into the three-dimensional space a centre seems necessary, a point of reference, a "fulcrum", as an osteopath would call it. The ML could fulfil this function (as one of its many functions).

I will now confront the three germ layers with the tripartition ML of Van den Heede. The following combination seems possible: The mesoderm is compared with the "ventral ML", the ectoderm with the "dorsal ML", and the endoderm with the "anterior ML". In the following I always write about the particular germ layer and its derivates first and list the anatomical points of reference that Van den Heede allocates to his midlines afterwards. (This comparison doesn't claim to be complete or final. Van den Heede did not publish these attributes as far as I know. To give these indications, I researched the course scripts of three years (2003-2005) with reference to these attributes and supplemented the results with the quotes from my interview.)

When writing about the germ layers and their derivates, I refer to statements from three books: "Morphologie des menschlichen Organismus" by Rohen (2002), "Funktionelle Embryologie" by Rohen and Lütjen-Drecoll (2002) and "Medizinische Embryologie" by Sadler (1998).

1) Mesoderm - ventral ML:

The mesoderm is associated with: notochord, somites, somatic pedicles, side plates

From these evolve, among others, the following structures

1. supporting connective tissue (connective tissue, cartilage, bones, tendons)

2. muscle tissues
3. myocard
4. lymphatic and blood vessel systems (blood, vessel, heart, spleen, lymphatic glands, medulla)
5. urogenital system (kidneys, urinary tract connection system unto the bladder, gonads, uterus, …)
6. adrenal cortex
7. coating of the visceral: visceral layer (applies to the endoderm), parietal layer (applies to the ectoderm)

According to Van den Heede (2003-2005), the ventral ML has developed first and its main anatomical representants are the notochord and the spine that evolves from it. According to Liem (2004), the point of balance for the ventral ML is the heart (Liem 2004, p. 639). With this, analogies end.
As far as function is concerned, the Mesoderm stands for the "rhythmical system" in the body according to Rohen (2002) because of the cardiac system and the musculosceletal system (Rohen 2002, p. 64). According to Van den Heede, the ventral ML is an "air-line".

2) Ectoderm - dorsal ML:

From the Amnion epithelium evolve among others:
1. central and peripheral nervous system
2. sensorial epithelium of nose, eyes and ears
3. epidermis including hair and nails
4. sebaceous, perspiratory, scent and lactiferous glands
5. hypophysis
6. adamantine

According to Van den Heede (2003-2005), the dorsal ML represents the neural tube and its contents; these are the central nervous system and the ventricle system with the liquor cerebrospinalis. We find a clear correspondence in the anatomical

structures here. As far as functions are concerned, Sadler (1998) writes about the ectoderm:

"Generally speaking one can say that organs and structures evolve from the ectoderm that establish contact to the outer world." (Sadler 1998, p. 77)[28]

Also Rohen (2002) sees *"…the neural tube as the disposition of the whole information system"* (Rohen 2002, p. 64)[29].

For Van den Heede (2003-2005), the dorsal ML is a "fluid-line" and is of integrating character.

3) Endoderm - anterior ML:

From yolk sac and allantoids evolve:

1. gastro-intestinal tract including the corresponding glands (liver, bile duct and pancreas)
2. oesophagus and oral cavity (posterior part)
3. respiratory organs (lungs, bronchial tubes, trachea, …)
4. uro-genital system (urinary bladder, ...)
5. thyroid gland, thymus, tympanum, Tuba auditiva, ...

(Listing not complete)

There is a marginal anatomical correspondence: Thymus, oesophagus and trachea, hyoid, posterior part of the oral cavity, … Liem (2004) describes the hyoid as the point of balance for the anterior ML (2004, p. 639).

As far as function is concerned, Van den Heede sees the anterior ML as a representative of immunity and adaption; from an evolutionary point of view, it is the youngest line.

For Rohen, the endoderm (the primitive foregut) represents the disposition of the metabolic system.

3.3.1.2.1. Summary

The idea to confront the three lines of Van den Heede's theory with the three germ layers may seem a bit farfetched. Despite the fact that only parts correspond in

comparison, the coherences are so obvious that I decided to create a separate chapter about this topic. In this summary I would like to point out a main idea that seems important to me: The various “tripartitions” of Rohen and Lütjen-Drecoll (the “functional tripartition” and the “sterical tripartition”) and Van den Heede’s “tripartition ML” lead to one commonality: They all need a “fulcrum” (a point of balance, a point of support, a point of stillness, a point of reference – in my opinion different words with a common meaning).

Summarizing all the statements we can conclude that the ML seems to fulfil this function (as one of its many functions).

Conclusion:

1. ML is a function.
2. ML is a fulcrum.
3. ML is a line of orientation for the entire physical development of the embryo in three-dimensional space.
4. ML is a line of orientation for all vital functions (information processes, metabolic processes, motional processes) not only for the embryo, but also for human beings in general.

3.3.1.3. SIMILAR ML-THEORIES BY OTHER AUTHORS: FRANKLYN SILLS AND JIM JEALOUS

Franklyn Sills

Franklyn Sills is a cranio-sacral therapist and psychotherapist in England. He is co-director of the "Caruna Institute", a centre for postgraduate cranio-sacral biodynamic courses and psychotherapy. He has written the two-volume work "Craniosacral Biodynamics" (2001 and 2004). In his works he repeatedly refers to three great men of osteopathy: William Garner Sutherland, Rollin E. Becker, and Randolph Stone.

All following explanations and quotes refer to statements in his book "Craniosacral Biodynamics" (2004).

Sills (2004) speaks of four different midlines:

1. "Primal Midline"
2. "Fluid Midline"
3. "Long Tide"
4. "Quantum Midline"

1. "Primal Midline"

This corresponds approximately with Van den Heede's ventral ML. For Sills, it is the main axis for the development and organisation of tissue in the embryo. It appears as an ascending force along the ML of the germ disc and induces the formation of the primitive streak and the notochord. The "Primal ML" will become a "line of organisation" around which structure and function can develop. The vertebral bodies and the spinal discs form around the notochord. He also sees the Nucleus pulposus as a remnant of the notochord. This "Primal ML" begins at the coccyx and ascends through the vertebral bodies to the base of the cranium, through the corpus of the sphenoid to the ethmoid. He also sees this line as "airy". He describes it like this: "*The primal ML is the axis around which structure and function orient. This axis can be palpated as a subtle midline arising force that seems to disappear at the ethmoid into the biosphere, or energetic field, around the person being palpated.*" (Sills 2004, p. 22). One can perceive it like "*... an empty air shaft in which hot air is always rising. As you catch the 'air in the shaft', you may sense that you are carried upward as potency ascends within the midline.*" (ibid., p.23). Sills also quotes Randolph Stone, who called this ML a "*fountain spray of life*" (ibid., p.20). The quality of this line is "*air and fire*" (ibid., p.23).

2. "Fluid Midline"

This corresponds approximately with Van den Heede's dorsal ML. For Sills, this line evolves behind (dorsal) the "Primal ML" through the formation of the neural tube. It triggers the evolution of the nervous system and the ventricle system. He describes it like this: "*The fluid ML is the organizing axis for the fluid tide and the motility of fluids in general. It is located within the neural tube of the embryo and the ventricle system of the fully formed person.*" (ibid., p. 22).

The liquor cerebrospinalis that flows along this line has a special significance for Sills: It is a certain kind of transmitter substance for the "*breath of life*" and the "*potency*". These are two particular terms that are well known to osteopaths and cranio-sacral therapists, but need to be explained to outsiders. I will do so in chapter 3.3.4. ("Spiritual approach") in detail. In Sill's (2004) description of the third ML, the "*long tide*", a short explanation is given with the following quote: "*This fluid ML becomes the organizing ML for the expression of potency within the cerebrospinal fluid. From this ML, the intentions of the Breath of Life clearly manifest as an organizing potency within the fluids. Cerebrospinal fluid is considered to be the initial physiological recipient of the Breath of Life. This is an intelligent biodynamic force that generates the fluid tide and orders the structure and organization of cells and tissues.*" (ibid., p. 19-20)
This line feels "*watery*", and more "*embodied*". Its quality is "*water and earth*" (ibid., p.23).

3. „Long Tide"

Sills (2004) writes about this ML: *„The Long Tide generates a quantum-level ordering matrix. This matrix is the blueprint for the form and organization of the human system.*" (ibid., p. 22)
The "long tide" is a slow, rhythmical motion that reminds one of the maritime tides; it permeates everything and is omni-potent. The "breath of life" produces this "original motion" – the "long tide"- and the "long tide" again produces a bioelectrical field or the "matrix". This ML becomes an organising axis for the formation of the embryo. The notochord and the neural tube are established in relation to this "long tide".
According to Sills (2004), the Tibetans call it "*The Winds of the Vital Forces*" (ibid., p. 17).

4. „Quantum Midline":

This ML, which Sills (2004) also calls "central canal" originates inside the matrix mentioned above. It can be perceived as a "ray of light" in the centre of the body. *"It aligns the being with the source of its creation!"* (ibid., p. 22) and is directed towards this source and is oriented by it. All other midlines can be deducted from it. Sills (2004) offers a quote by R. Stone here, who wrote about this ML: *"The quantum ML has a*

primary orienting and ordering function within the human system. It is an expression of a primary energy that builds and sustains all other energies and forms within the human system. [...] It is the 'ultra-sonic' core, a core of high vibrational quality that is the 'primary life current of being'." (ibid., p. 21-22)

Sills (2004) repeatedly stresses the particular significance and practical relevance of the ML. Due to *"tuning into"* these midlines, the system can find a new orientation and the processes of healing can be triggered (ibid., p.24). To perceive the ML helps a practicing therapist to gain more clarity and overview during a treatment; and once the system heals itself, he will sense it (ibid., p.24). Sills (2004) believes that these organizing forces of embryology never leave us from conception to death. Engagement in these deep perceptions leads to an immense shift of clinical understanding. Once we have experienced it, *"a great joy may arise, joy in the remembering of something never lost, but perhaps forgotten"* (ibid., p. 22).

Jim Jealous:

"The main part of osteopathy has always remained a secret, because we don't know how various osteopaths have achieved it. They don't talk about it, but they have their own model. All I do is reveal something that has always been there." (Jealous 2002, p. 30)[30]

It is not a simple task to represent the theories of Jim Jealous, because no publications by him exist. The material I had was an audio CD recorded by him about the "Midline" (2001), interviews in the magazine "Osteopathische Medizin" (2002 and 2006) and course scripts (2003).

Jealous lives in America and was born into an osteopathic environment. At the age of thirty-three he met Dr. Ruby Day, one of the first students and later colleagues of Sutherland, who took him on as her only pupil until her death in the middle of the eighties. Also Rollin Becker was one of his mentors (Jealous 2006, p.4). This explains why he repeatedly refers to Sutherland and Becker in his statements. Other well-known osteopaths that he likes to mention are Robert Fulford and Randolph Stone, who influenced him.

Jim Jealous is seen as *"the most innovative, most wanted, but also most controversial representative of the cranial field in osteopathy at the moment"* (Introduction to the interview with Jealous 2002, p. 26)[31].

He has developed his own course curriculum: "The Biodynamics in Cranial-Sacral Osteopathy". All over the world, a handful of osteopaths that were chosen by him are allowed to teach this curriculum.

According to Jealous, the ML is difficult to represent as a concept, because "*the ML has so much of a wholeness in it and it is very difficult to take it apart*" (Jealous 2001). He also sees a multitude of MLs. On his audio CD, he at first talks about an embryonic ML, which is the first identifiable *"function"* of an embryo. In the centre of the germ disk that he sees as a pure, shaped protoplasm, *"something"* starts to vibrate and the primitive streak evolves. This *"something"* is like a *"fluid within a fluid"*, or a *"potency"* within a fluid, a bioelectrical field. He points out that we start out as a fluid, as an undifferentiated matrix that can become anything. This *"fluid within the fluid"*, or *"potency"* or *"bioelectrical field"* is not the ML, but a result of the ML. This first centre, this first evolving line, is not preconditioned by genetics, according to Jealous. No one knows where it comes from. It comes from a place where there is no cause and effect-principle; from a place that we can't enter with our intellect. This ML is a part of the miracle called *"life"*. It is ancient, it does not belong to us, it is not part of our identity and is has been present before our time on earth began. *"The cause is not a genetic force but some mysterious, omnipresent intention of a greater mind, one without causality!"* (Jealous 2001). With these words, Jealous expresses his believe in the work of a *"higher intelligence"*. This believe in a *"higher intelligence"* corresponds with the thinking of the "old" osteopaths; we can find it in the works of Still and Sutherland in many places, and it sounds like this, for example: *"We must see the great importance of the highest known intelligence that can be accumulated by the study of the human body from head to abdomen, because here we are in a city of living wonders pertaining to life."* (Still 1902, p. 73) Or: *"My spirit was overwhelmed with the unmeasurable magnitude of the Divine plan on which the universe is constructed."* (Still 1908, p. 312).

Sutherland (1990), who is repeatedly referred to by Jealous, puts it like this: *"Within that cerebrospinal fluid there is an invisible element that I refer to as the 'Breath of Life'. I want you to visualize this Breath of Life as a fluid within this fluid, something that does not*

mix, something that has potency as the thing that makes it move. [...] Visualize a potency, an intelligent potency, that is more intelligent than your own human mentality." (Sutherland 1990, p. 14)

In his course scripts, Jealous (2003) describes the ML as a bioelectrical *"potency"*, on which structures and functions can orientate and re-orientate themselves during their genesis, their entire life and during all healing processes. For him, the ML is a point of orientation for the *"long tide"* before it permeates the body functions, and also a point of orientation for all fulcra within the body. Jealous (2003) also sees a posterior ML - that refers to the notochord - and an anterior ML (Jealous 2003, p. 106).

I would like to end this chapter about Jim Jealous with another quote; I see this statement as one of his keynotes:

"The embryo is the perfect answer to the Breath of Life. It embodies wisdom, geometry, transcendence, is made to heal, with an abundance of love for all fellow travellers." (Jealous 2002, p. 29)[32]

3.3.1.3.1. Summary and review

Franklyn Sills

He speaks of four midlines:

1. The "primal ML" corresponds with Van den Heede's "ventral ML". It refers to the notochord and is a "line of organisation" for structure and function. According to Van den Heede, it stretches from coccyx to the ethmoid and is also called "air-line" by Sills.
2. Sills' "fluid ML" corresponds with Van den Heede's "dorsal ML", it is related to the nervous and ventricle systems and is a "fluid-line". But Sills much more emphasises the significance of this line as an orientating axis for the whole liquor system, especially for the liquor cerebrospinalis. In context with the liquor, Sills uses terms like "Breath of Life" and "Potency" (I will discuss these terms in more detail in chapter 3.3.4.5). Sills also describes the "fluid ML" as an organizing axis for the "Breath of Life" and the "Potency".

3. Sills' third ML, the "Long Tide", is omni-potent and "all-permeating" and creates the precondition for the formation of the notochord and the neural tube. It is an organisational axis that shapes and helps to form the embryo.
4. Sills' fourth ML, the "Quantum ML" reaches back to the origin of all being, to the origin of creation.

For me, the construction of Sills' explanations is not completely logical. The following statements cause confusion: The *"Long Tide"* creates a *"bioelectrical field"* or the *"matrix"*. The *"Quantum ML"* originates within this matrix and – this is a contradiction for me – all other MLs can be deduced from it. Now: Which can be deduced from which? In search of further explanations I found a somewhat more coherent explication about these processes in the book "Morphodynamik in der Osteopathie" (2006) edited by Liem. John M.McPartland and Evelyn Skinner (2006) write in a chapter called "Die ML bei metabolischen Bewegungen" ("The ML in Metabolic Processes") under the title "Die Bedeutung der ML in der Osteopathie" ("The Significance of the ML in Osteopathy"): *"Sutherland saw the cause of the PRM (Primary respiratory mechanism) in an omnipresent force that he called the "Breath of Life " (BoL). As his concepts seemed to contradict Newton's physics, many osteopaths disregarded them. Today, quantum physics is at our disposal for the explanation of his concepts. The BoL acts like a quantum field-force. When streaming through the body, it causes structured sterical motions that express themselves through fluid forces on a physical level (electromagnetic hydrogen compounds). The resulting bioelectric matrix directs the biological structures that react to the electric field when compressed or decompressed (e.g. piezo-electric crystalline materials like the phospholipids in the cell membranes or the collagen in the connective tissue. Thus structure follows function."* (McPartland, Skinner 2006, p. 319)[33]

The matrix evolves from the BoL that functions like a quantum field-force, and it controls the biological structures. According to McPartland and Skinner, the quantum field-force generates the matrix, according to Sills it is the other way round, as described above. I have to leave this contradiction as it is for the time being.

Nevertheless, Sills describes the practical relevance of the ML in his books very vividly. He emphasises that healing processes can be triggered already by just *"tuning into"* this ML.

Jim Jealous

His depictions of the ML include elements of all earlier statements: he also declares the existence of different midlines. The embryonic ML is one of them. He also sees it as beginning with the primitive streak and the notochord. He calls this "notochord line" also "posterior ML"; there is also an "anterior ML". He frequently uses the terms "Potency", "Long Tide" and "Breath of Life". ML is a point of orientation for the "Long Tide" as well as for all other fulcra in the body. Spirituality plays an important part in Jealous' statements. He believes in a "higher intelligence" and also in the existence of the ML before our life on earth began.

3.3.1.4. INTERVIEWS IN COMPARISON

Conclusively, I want to epitomize the significance that embryology has in relation to ML osteopathy for every one of my interview partners.

VAN DEN HEEDE

VAN DEN HEEDE places great value on embryology. He deducts the fundamentals of his ML theory from embryological evolutionary processes. I described his theory of the "tripartition ML" in chapter 3.3.1.1. in detail.

In general, VAN DEN HEEDE emphasises the fundamental importance for the osteopath of concerning himself with embryological evolutionary processes. This is conditional for *"converging the tissue with its origin"* (1/44) or, in other words: conditional for interpreting the signals given by the body. VAN DEN HEEDE puts it like this: " *'Basically, it needs … the student needs to know the patterns of physical development.' Dunshirn: 'The patterns of physical development; that is embryology again. Heede: 'Yes, to know embryology produces an understanding of Biodynamics and an ability to interpret the signals given by the body, not only mentally but also in his hands. So his hands will not only be focussed on the perception of motion but also on qualitative*

perceptions, epicritical perceptions with which he can sense a certain kind of cellular harmony. Density, tension, heat, coldness, absence of motion etc., vibration and with that he can sense a harmonic kind of – or a disharmonic kind of - exchange of tissue, of formation.' " (8/41-51)

He adds that the ML was a subject of embryology long before osteopaths made it theirs.

The combination of the osteopathic concept with embryological aspects is conditional for him to give ML osteopathy a meaning. (2/39-43).

LIEM

The statements given by LIEM sound very similar. Before talking about the embryological ML in detail, he emphasises that he is working with various MLs on different levels of being. It seems to him that the embryologic ML is "popular" at the moment. He shares Van den Heede's theory of the "tripartition ML":

"Because it's my opinion, or … my way of looking at it, that I work with more than one ML, on different levels of being, … we should talk about the very popular embryologic ML. Basically, this always is related to tissue und structure; this is why we are osteopaths. Then there are three embryological midlines - according to Van den Heede, and I share this view -, that probably have more significance than others. At first, there is the posterior–dorsal ML in the neural tube; the median ML that is anterior at the beginning and becomes the median ML in the notochord; and the anterior ML that evolves through the two others, through the tissue that develops anterior after the somites disintegrate." (7/26-34)

He also shares the view that it is indispensable for the osteopath to concern himself with embryology to understand the dynamics of tissue: *"... because every student should occupy himself with the development, the formation of structure, because the formation of structure is paramount for the understanding of the whole structure, and for the understanding of the tissue, and of course this is the field of osteopaths. And if they were missing the evolution, then an important part would be missing for the osteopath to understand the dynamics of tissue, and the genesis of tissue, and also... yes, as I said before, an important part would be missing for the osteopath, to really understand what defines a certain tissue in relation to other tissues, in relation to itself. And the ML belongs here, of course."* (2/26-30)

LIEM emphasises the significance of the notochord and the primitive streak in general: *"The popular ML we are talking about is the notochord that determines the left-right symmetry already in the third week. But already before that the primitive streak defines a ML, when a certain kind of asymmetry evolves in which the movement is shifted to the left and the cilia move slightly to the left, so that calcium-sensible cells are triggered with the result that the heart will relocate to the left side. But the notochord is an important point as a structural, dynamic evolutionary fulcrum of the ML."* (8/26-32)
For him, to work with the embryonic ML feels *"like a kind of … this is difficult to express phenomenologically … and it is very subjective … for me, I don't know if others feel the same, it's like 'coming home' … arriving at the median structure of the former notochord, it's like an orientation, maybe a kind of force that suddenly assembles in this area and distributes itself evenly throughout the body."* (10/17-21)

WUTZL

WUTZL concretely suggests the introduction of ML osteopathy into embryology lectures (2/22-24). Generally speaking, exact knowledge of anatomy, physiology, embryology and neurology are very important, because *"often the 'Long Tide', if you want to call it that, works very precisely, also in the anatomical structures, and therefore it would be advantageous not to enter a diffuse energetic level"* (4/5-7). Besides, precise anatomical knowledge helps prevent a *"sliding off into the esoteric"* (13/1-3).
Furthermore, ML osteopathy is an *"option to re-establish the autonomous basic, mostly embryonic forces in the body"* (6/41-42). And: *"The basic task of every ML is to establish a relation of individual structures to a centre. In fact, this is the definition of a ML."* (9/6-7). He stresses the importance of this thought for the work with twins, triplets, and so on. They often share a common ML and therefore must be treated together. I would like to quote this sequence from the interview:
"Dunshirn: 'So they had a common…. ' Wutzl: '- a common ML.' Dunshirn: 'And so it could feel as if one child wasn't inside the body, but displaced?' Wutzl: 'Correct. And if you don't incorporate the other one, you will not reach a therapeutic result.' Dunshirn: 'So you have to treat them together because they have a common ML?' Wutzl: 'Right. In the majority of cases, they become autonomous over the years to a degree that they can each incorporate themselves, in a manner of speaking. But this process of incorporation must not happen to

fast, because their interlinking connection can often be very important. This even more so if a third one died in the womb, for example. You also have to incorporate this one then.' Dunshirn: 'Then it gets even more complicated.' Wutzl: 'This is similar to a 'family constellation', and you simply have to work with the ML here as well. This is another special phenomenon of the ML."(8/29-51)

I would like to note here that this mention of a "family constellation" inspired me to include a separate paragraph called "Systemic Psychotherapy" in the chapter "Psychotherapeutic Approach" (see 3.3.5.4.).

WUTZL describes an anterior ML, amongst others, that is of great importance for asthmatic children and for children whose flexion position at birth has not been reduced and not been balanced enough; secondly, the dorsal ML that refers to the neural tube (7/38-46).

NUSSELEIN

She realized the great significance of embryology through the courses she did with Sue Turner and Elliott Blackmann. Her experience of Blackman's course is described like this: "*What was interesting in that course, we treated nearly everything, but we went back always to the embryology. So important is the ML. Because if you look at the embryology, that is actually the force of healing, sits in there and we start from the ML. That is the first thing that appears. And then we know, okay, this is the way we need to go to. So that force, if we still have that, we can contact that, we can heal every part of the body and if you look at every organ, or whatever, they start from the ML and they grow out. It's like our heart. Okay, it's more on our left but it actually started from the ML. And with the lungs it is the same. With the lungs or with the liver."* (3/18-25)

At the beginning of the embryonic period, the ML functions as a kind of *"conductor"* for the cranially directed development of the ventricle system and the spinal canal (7/50-51, 8/1).

She also sees the superior significance of the notochord: *"And then lots of things of that chorda dorsalis have disappeared, but it is functioning now as an energetic midline and may be from the beginning it has done that as well. It has energy to take everything with it. When it wasn't there, we wouldn't be here. An embryo that has not a good Chorda dorsalis can't survive."* (8/7-10). She speaks of an anterior and a posterior ML that form a kind of

loop around the *"real"* ML: *"We have not only really a ML, but we have also a ML anterior in the body and posterior. So they are important as well, and around the ML, there is a kind of loop. And you can sense that very well in children, that when that loop is starting to go, you know aha, that is the – that is also an energizing for the real ML you are talking about."* (2/47-50). The description of this *"real"* ML sounds very beautiful: "*I see that more as an energetic beam of light. And when the light is switched on, then it is like that's great. And if you see the light, it radiates and that is what I see with the anterior and posterior ML. The radiation is a kind of flow around that ML."* (9/44-46)

WEBER

Weber talks about the rhythms of evolution and growth of the embryo, and of an axis along which all organs develop. A human being lies on an axis that stretches from the beginning of life unto death (3/43-54). He describes it like this: *" 'Somehow this is a thought that also touched me deeply once. That I rest on this axis ... this axis always remains the same in everything you do, it never changes. And this axis is a precondition of our identity.' Dunshirn: 'Can I see this axis you are talking about as identical with the midline?' Weber: 'This is the midline. This is the main midline on which we rest. I think that there exists an initial orientation. And we can depart from this midline to a certain extend. Through injuries we are taken away from the midline ... that means we can never be removed from this midline, because this midline is the precondition for us to live. This midline and the relation of the embryo's movements represent hundred percent health and from the foundation of this health, we can develop.' "* (4/1-12)

With the following statement, WEBER leads us from the "embryological approach" of ML definitions to the "psychotherapeutic approach" that will be discussed in chapter 3.3.5. .

According to WEBER, the ML can function as a decision guidance provided that one is able to *"listen to his embryonic self"*: *"I think every human being feels whether he is setting actions according or disaccording to this axis. Actions that are corresponding to the axis feel meaningful; one can feel this right back into his embryonic self. Once the embryonic self gives its okay, one is connected to the axis. That is a 'yes' of the whole organism from deep within."*(4/34-37)

WEBER is the only one of my interview partners who speaks about the germ layer in relation to the ML. This is discussed in more detail in section 3.3.1.5.

SHAVER

For Shaver, embryology is *"an aspect"*. Embryology is important because it may show up in any treatment. The *"central ML"* (as he calls it) is the system of reference for the whole embryologic development: *„The reference system for the whole embryological development is the central midline and the parallel midlines from it. And I don't care about the way you want to look at it. But yeah … embryology is an aspect ... the embryology can show up in any treatment. So it's very important."* (3/42-48)

He also mentions the "notochord-ML" as the ML of the spine, and many other midlines: *"There's lots of structural midlines ... There's one in every bone. There's one in every function. There's one in every organ. For the spine, there's a midline, for the whole spine. We call it 'notochord midline' ... but it's not the central midline.'*

Dunshirn: 'Where is the central midline?' Shaver: 'Somewhere ... not to find by anatomy." (11/1-19)

TOTH

TOTH mentions embryology only in connection with reading advices for students (9/46).

3.3.1.4.1. Summary

The whole chapter being a kind of summary of individual interview statements on embryology, I would like to avoid making another summary of the summary, and move on to elaborating a kind of red thread that runs through all the interviews. Four conclusions can be drawn:

1. All interview partners point out that osteopathy differentiates between various midlines.
2. The embryonic ML is only one of many different midlines (although it is the most frequently discussed).

3. When talking about the embryonic ML, everyone emphasises the great significance of the notochord: it is the absolute front-runner when using embryologic terms. Generally, the notochord is seen in relation to a so-called "posterior" or "dorsal" ML. Furthermore, an "anterior" ML is generally mentioned (although it is not clearly associated with a definitive structure).
4. Osteopaths repeatedly point out that knowledge of embryological evolutionary processes is paramount for the work of the osteopath and for his understanding. I discussed this issue in detail in chapter 3.1. ("The Status of the ML in the current osteopathic discussion").

3.3.1.5. THE GERM LINE OR: THE ML AS A TIME MACHINE?

"We come across an elementary secret of all reproductional biology. [...] The germ plasma is passed on from generation to generation, while the evolving body will die at the end of life." (Rohen 2002, p. 172)[34]

"How old is Osteopathy? As old as the cranium itself!"
This quotation is originally from A. T. Still. Sutherland relates it in his book "Teachings in the Science of Osteopathy" (Sutherland 1990, p. 3).

While studying books on embryology, the description of the germ line and the so-called "original or primitive germ cells" repeatedly caught my eye. Although the explanations are not very detailed in the literature at my disposal, there seems to be a common understanding that the germ line is somewhat mysterious. Where do these germ cells come from? This seems to be unclear for the moment.
I will now describe the germ line as seen by embryologists. My sources of information were books on embryology by Rohen, Lütjen-Drecoll (2002) and Sadler (1998).
Ovary and sperm cells aren't "normal" somatic cells that have specialized in reproduction. They are not produced by the gonads, but have immigrated into these gonads as "original germ cells" and are equipped there with the necessary design for

their feduncation. To quote Rohen and Lütjen-Drecoll: *"The original germ cells are put aside during the earliest stages of embryogenesis (morula) in a manner of speaking, they don't take part in the embryonic development and settle in the gonads relatively late. We speak of a germ line, because the organism itself dies, but not the germ material, which is passed on from generation to generation. So a certain functional - and in some sense also material - continuity is evident, it reaches back to the primitive times of human phylogeny."* (Rohen, Lütjen-Drecoll 2002, p. 2)[35]

According to Sadler (1998), these original or primitive germ cells become visible in the human embryo in the third week. They are situated in the outer layer of the yolk bag and migrate from there - that is the outside - with amoebic motions into the gonads. They arrive there at the end of the fourth or the beginning of the fifth week (Sadler 1998, p.11).

While analysing the interviews and reading relevant papers by other authors, I asked myself whether the embryonic germ line has some relation with the osteopathic ML.

For example, Jealous says about the ML: *"Nobody knows where it comes from. The voice that speaks is not the voice of conception but the voice of eternity. [...] And this line of orientation has been appearing in all of life's structures and functions since the beginning of time. So this ML is part of the miracle of life. It's ancient."* (Jealous 2001)

The following quotations from my interviews lead to the conclusion that a continuum exists in a spatio-temporal sense and can be perceived during ML-treatment by the osteopath, and can also be described (although in other words).

SHAVER says: *"It's outside of time and space. It doesn't have a beginning and an end."* (3/25) and at another point: *"It goes to the limits of our perceptional fields."* (15/40-41).

WEBER was the only interview partner who spoke about the germ line. *"...the original germ cell really is an interesting thing, because it never changes. It always remains the same - over generations."* (12/44-53). Also his account of his first contact with the ML fits into this context: *"Somehow this is a thought that also touched me deeply once. That I rest on this axis ... this axis always remains the same in everything I do, it never changes. And this axis is a precondition of our identity."* (4/1-3). And also: *"… my key experience was in the courses*

with Jim Jealous, where I experienced this stillness as a richness that reaches the limits of the universe, so to speak, exactly as Novalis puts it - infinity is closest to the spirit."(5/2-5)

NUSSELEIN gave the following example of ML treatment. I have to mention here that I asked all my interview partners for examples of patients in ML treatment. From a great variety of examples that I heard, I found the following one the most remarkable. That is why I would like to quote it completely here:

"And it can be sometimes very strong. I never forget a patient – and you can sense energy coming in, a negative energy. Somebody who was beheaded. And you could sense her sitting on her knees. She came with a problem on her neck. She said I can't wash my hair any more. I can't lean forward. And you know, you can manipulate this. But actually by only holding her head and her neck you could see that man coming in, you know, in these early ages, when they did it in a cellar and she was sitting on her knees and he was coming with the axe and by that time I felt that the patient was shivering and the whole atmosphere in my room changed, because you could sense the mice walking around so I could even … and her hair, which she always was washing - because she was an existing patient - always smells very nice, because she has just taken a shower, was like she hasn't washed it for weeks, it was really dirty. And when it was all over and I could explain that to her, she said, 'I felt something, it was really strange'." (6/24-35)

"But that is something you are evolving. And when you are very much working with that midline or this spirit, the spirit actually says, I want to get out of this. This is a memory I don't like. And if you get that information in your hands, you are there to assist, to get that out of a patient." (6/37-40)

„Dunshirn: ' - you have to guide the patient through this …' Nusselein: 'That they are guiding me; I am more the helping hand. You don't need to be afraid; I am here to help you. Because when they show this in the praxis, that is meant to be, and it is not like I am afraid of this or I am not touching this. So I think that is the gift you get then from higher up like you are the person at the moment. And the person on the table can let it go now. So it will be glanced from that memory. And that is happening I will not say very often, when it is necessary for a patient to release that.' " (6/42-49)

With this account, NUSSELEIN wants to exemplify that such phenomena – or similar phenomena - can appear in the course of ML treatment (which she also calls *"working*

with the spirit"). She assumes that information is stored in the tissue and can have a negative effect on the well being, on the health of a person, even after hundreds of years. The body wants to get rid of these *"memories"* if they transport negative information, as mentioned above. An osteopath receives this information through his hands, according to Nusselein, and can help the patient to get rid of these *"memories"*. For her, this ability is like a *"gift from higher up"*, and the osteopath should not falter to extend a helping hand to the patient.
I would like to conclude this chapter with these remarks and come back to its title: "The germ line or: the ML as a time machine?". I hope I was able to clarify what I meant by it.

3.3.1.5.1. Summary

This particular chapter about the germ line is of great importance for my whole study. Three years ago (in the summer of 2003) I had to hand in a concept for my master thesis. Rather spontaneously, I decided to use the following title: "The ML in osteopathy – a balancing act between structure and spirituality". I don't believe that I knew exactly at the time why I had chosen the terms "balancing act", "structure" and "spirituality". Of course I had a general idea of what I was going to research (because many questions had preoccupied me over years), but the particular choice of words came to me rather intuitively. Now, when writing the chapter about the "germ line", the reason why I chose this title is much clearer. Embryology as a whole, and the germ line in particular, could represent this balancing act between structure and spirituality. On the one hand, the original germ cells are a genetic fact; on the other hand they take us back to the origins of life in a mysterious way, back to the "beginning of creation", as Sills puts it. This creates a junction between structure and a spiritual or philosophical idea. It seems to me that the ML lies at this junction, at this point of balance.

3.3.2. STRUCTURAL APPROACH

In this chapter, three questions in relation to structure will be discussed. In section 3.3.2.1., I will investigate how much significance my interview partners grant anatomical knowledge in relation to ML osteopathy. In section 3.3.2.2., I will discuss specific structures that can be attributed to the ML and in section 3.3.2.3., the question will be whether purely structural techniques can lead to results with the ML. The relevant statements about the "structural approach" will be summarized in section 3.3.2.4.

3.3.2.1. SIGNIFICANCE OF ANATOMY

"The osteopath must remember that his first lesson is anatomy, his last lesson is anatomy, and all his lessons are anatomy." (Still 1902, p. 12)

"What is osteopathy? It is a scientific knowledge of anatomy and physiology in the hands of a person of intelligence and skill, who can apply that knowledge to the use of man when sick or wounded by strains, shocks, falls, or mechanical derangement or injury of any kind to the body. An up-to-date osteopath must have a masterful knowledge of anatomy and physiology." (Still 1902, p. 18)

"The central ML is somewhere ... not to find by anatomy. So it will be really tough to then give it an anatomical reference point. It's silly." (SHAVER 2005, p. 11/13-19, 43)

I chose these quotations to demonstrate the wide spectrum of attitudes one has to face when asking about the significance of anatomy.
In theory, all interviewed osteopaths agree that anatomical knowledge is important. However, the emphasis on this point and the explanatory statements vary.
SHAVER, who is quoted above, makes two differing statements depending on which ML he is talking about. For the so-called *"structural ML"*, or, as he also calls it, *"weight-bearing ML"*, anatomical knowledge is important. Here, he refers to

statements by Still (see quotations above), who repeatedly emphasized that anatomy is the foundation of osteopathy (SHAVER 2005, p. 9/8-37). But according to SHAVER, this anatomical knowledge should be experienced as *"functional anatomy"* and not be a *"memorizing of structures"*: *"I have a place for anatomy and ... the place isn't necessarily about the names and about the structure of learning of it, but it's more about the experience of it, and experiencing functional anatomy. What is this thing doing and how does it work? You have to have some basis. So it has a place. It's a different kind of anatomy and it's a different understanding of anatomy. It's not memorizing structures."* (9/41-51). For the *"central ML"*, as he calls it, that lies outside time and space (3/25), anatomical points of reference have no relevance. It would be *"silly"* to try and give the *"central ML"* anatomical reference points (11/13-19,11/43).
In spite of this, he describes a relation between structure and the *"central ML"*: *"Structure is built with reference to the central midline and parallel midlines. Structure is the last formation in a series of growth."*(3/29-30)

NUSSELEIN also speaks of different MLs: she distinguishes a *"structural ML"* and an *"energetic/functional ML"*. The former is looked at every time a patient is examined in a standing position, before and after the therapy (1/39-44). She thinks that it is important for the osteopath to gain anatomical knowledge before entering a deeper and more energetic level: *"I think it is important to start with that structure and the anatomical knowledge. And then, later on, you can go further, into what is becoming more an energetic midline. You start more developing the depth of the ML."* (7/3-5). In osteopathic tuition, students should be guided to ML functions slowly via structure (12/6-9). The impressions that an evaluation of the *"structural ML"* and the *"functional ML"* give may even be controversial, according to NUSSELEIN. For example, a patient with scoliosis might be completely outside his ML in a "structural" sense, but be perfectly in his ML in a "functional" sense (12/6-9). In all cases, anatomical and physiological knowledge is important, because without it, one may possibly perceive something without knowing where one is working exactly at that moment, and not be able to attribute things correctly (5/29-34).

WEBER fully agrees with NUSSELEIN's last statement by saying: *"The osteopath always has to know where he ... where the treatment happens. For this, he needs anatomical knowledge ... very well founded knowledge ... he also needs to know what a bone looks like, and what a bone looks like when it is being parted from the midline. Because I wouldn't know whether I am at the beginning or at the end of the treatment process. I need to have a clear picture of the structure that I treat."*(18/3-10)

TOTH also thinks that fundamental anatomical knowledge is essential for working with the ML: *"This is basic knowledge, and everyone needs to have this knowledge. I also believe that one has to deepen and repeat it and look at it again and again; and that one will learn something new about the ML in the process."* (4/28-30)

WUTZL and LIEM share a concern about drifting off to a *"diffuse energetic level"* (WUTZL, 5/7) or into *"the esoteric"* (WUTZL, 13/2). LIEM puts it like this: *"... it's because I see the danger that they will try to integrate everything esoteric they have ever heard into terms like the ML [...]."* (14/5-7). Referring to the education of students, he emphasises that they should get acquainted with the basics of osteopathy from the start to avoid their *"going on a drivel trip"* (9/1-4). The *"rootage"* (WUTZL, 12/52) in anatomy, neurology and embryology is fundamental for the osteopath in WUTZL'S opinion (13/1-3) and can prevent the 'drifting off' mentioned before. Precise anatomical knowledge has a lot of advantages for WUTZL: *"The anatomical and physiological structures are very important, because [...] often the 'Long Tide', if you want to call it that, works very precisely, also in the anatomical structures, and therefore it would be advantageous not to enter a diffuse energetic level. Instead we have very precise anatomical … here, whether these are fluids or membranes or whatever doesn't matter. But I've seen repeatedly that once you give it enough room, you will get a very concise, precise therapeutic response that will be comprehensible. From this point of view: anatomy, anatomy, anatomy. It still remains what it is. Once you get into feeling things, you are in danger of losing the anatomical precision and of sticking to purely energetic areas. First of all, you'll lose the option of making a diagnosis at that moment, and secondly you'll get into real trouble when trying to communicate the therapeutic and diagnostic results to the patient."* (5/4-16).

WUTZL's statements are interesting in many ways: his explanations why anatomical knowledge is so important not only refer to the dangers of drifting off into a "diffuse, energetic level" without sound knowledge, but also that the therapist could lose the ability to make a precise diagnosis without it.

He also points out something else in this statement: he equates the ML with the "Long Tide". This "Long Tide" will be discussed in the chapter called "Spiritual Approach" (3.3.4.) later on.

Referring to this issue, Liem (2006) formulates it very clearly in the preface to the book "Morphodynamik in der Osteopathie", which he edited:

"The osteopathic therapeutic interaction can only be learned in steps. Here, fundamental knowledge of every tissue, its structure-function unity and the manifold interdependencies of tissue and organic systems are an indispensable condition, as well as the palpatory approach to each tissue and to the globality of tissue dynamics. These learning steps must not be skipped. An approach without these foundations will end in a pre-rational, undifferentiated palpation. Osteopathy should not try to gain intuitive insights into the organisation of the organism without being able to diagnose a dysfunction of the Omentum minus or the M.palmaris longus […]." (Liem 2006, p. IX)[36]

In short, another clear commitment to anatomy.

VAN DEN HEEDE emphasises that a student should know the *"patterns of physical development"*. Only then will he be able to understand *"Biodynamics"* and the *"signals given by the body"* (8/41-47). But this knowledge should be gained "*not only mentally but also in his hands"*. The hands should "*… not only be focussed on the perception of motion, but also on qualitative perceptions.*" (8/47-49).

He puts it very clearly: "*One should know anatomy.*" (Van den Heede 2002, p. 28).

3.3.2.2. WHICH STRUCTURES CAN BE RELATED TO THE ML?

The foundation of this question is a very practical one: I wanted to know whether experienced osteopaths pay particular attention to certain structures when treating the ML. In other words: do particular bones (or other anatomical structures) correspond especially well to the ML?

From the answers to these questions, according conclusions can be drawn as to how ML osteopathy should be applied in practice. Which handholds are recommended for ML treatment. I will summarize the statements with practical relevance in chapter 3.4. ("The ML in osteopathic practice"). Generally speaking, I have to say that my interview partners did not always answer this question very clearly or at great length at first. I attribute this hesitation mainly to the fact that after many years of experience with ML osteopathy, some osteopaths have integrated this kind of work fully into their subconscience; it has transformed from a certain technique that one could easily reproduce to a kind of "attitude".

NUSSLEIN, for example, says: *"Then, I think, it becomes more an unconscious thing that you are working with."*(5/38-39). By making a small "detour" I found a way around this problem in some interviews. When asking for concrete recommendations and support for students who want to get acquainted with the ML, I often got very precise answers.

The "hit list" when naming structures that can be allocated to the ML, the

- sphenoid leads with five mentions (to be more precise: in most cases the basis of the sphenoid in combination with the SSB=Synchondrosis Spheno-basilaris was mentioned); this is followed by the
- notochord (as an embryonic structure of which only remnants can be found in the adult) and the
- coccyx , both mentioned four times. After that, the
- sacrum, the
- neural tube and the
- Ncl. Pulposus, three times each. After that, the
- ethmoid and the
- third ventricle as well as the liquor system were all referred to twice.

VAN DEN HEEDE thinks that the two *"end points"*, the coccyx and the ethmoid, carry the "ML-memory" (of the embryonic structure) inherently (3/45-50).

Furthermore, *"every attachment of the 'dorsal ML', that is the medulla, to the osseus structure is an articulation, a joint connection of two levels"*(3/49-51). Here, VAN DEN HEEDE means that these "articulated joints" establish a relation between structural

and functional aspects of the ML. In his statements he stresses that *"the ML built structures that are not representative* [in the adult] *for what happened 'at the beginning'* [in the embryonic period]." (3/33-36) (Inserts in brackets are author's notes for better understanding).

Thus in some areas, this *"past"* is more present than in others. Besides the two bones mentioned above (coccyx and ethmoid), he specifies other *"points of attachment"*: one is situated around the second and the third cervical vertebra, one around the Cauda equina and the Filum terminale, and another one around the attachment of the Falx cerebri on the Crista galli (3/51, 4/1-2). At these points, one can *"… feel this delicate exchange, the impression of rhythms, or of the 'Potency' particularly well."*(4/2-3)

LIEM grants structures like the Nucleus pulposus, sacrum, coccyx, sphenoid and ethmoid an *„equally important significance"* (9/9-15).

TOTH remembers one of his teachers whom he met in the course of his paediatric osteopathy education: Peter Armitage advised his students to perceive the ML starting from the coccyx unto the basis of the sphenoid (3/32-35). Although the ML is *"present everywhere"* for TOTH (4/49), he would *"… start at the coccyx and follow the ML vertically upwards. This works best."* (9/25-27)

NUSSELEIN says *"It is not necessary to have the ML between your hands."* (7/31). Later, she nevertheless emphasises the significance of certain structures: *"It actually starts there at the tip of the coccyx. But of course it is nearly completely gone as an anatomical ML structure. But it is still there, it has a memory, it is like – you have two frontal bones and a metopic suture, but that is gone. But it still works as ... the dens is a structure ... the Lig. apicis dentis is a remnant, and the NcL. Pulposus is a remnant of the ML"* (7/10-18), *"and no wonder, that it actually finishes in the sphenoid, in the body of the sphenoid"* (8/2-3).

We see her agreement with TOTH here, who also mentions a connection from the coccyx to the sphenoid, and also with VAN DEN HEEDE, for whom this line ends at the ethmoid (the ethmoid adjoins anterior to the sphenoid – author's note).

WUTZL believes that the results of ML work can be deduced from the SSB and the sacrum particularly well. What is interesting here is that he grants the fluid level and the neurological level even greater significance in comparison to the bones mentioned above: *"But if I had to ascribe the strongest response of the ML to a tissue, it would definitely be at the fluid level or the neurological level. Especially the third ventricle,*

the eversion and the inversion of the third ventricle … yes, of the neural tube in general; whether there is an extension or a constriction … this is the place where I always put my hands to make a diagnosis, ... but also the place where I see whether the therapy has come to an end or not." (6/1-9, 5/42-47)

With terms like *"eversion and inversion"* as well as *"extension and constriction"* of the *"neural tube"*, WUTZL refers to expressions that are in use in cranio-sacral therapy to describe the "craniosacral rhythm" or the "Primary Respiratory Mechanism" (PRM). I have mentioned the PRM in chapter 3.1.1., but have not discussed the "rhythmical motion" ascribed to it there. I would like to do that here: according to Liem (1998), this motion is a *"rhythmic, involuntary motion of expansion and retraction in the cranium and in the rest of the body, and is also called the 'phase of inspiration/expiration of the PRM'."* (Liem 1998, p. 15-16). Liem quotes Cabarel and Roques, who assume that *"the rhythmical phases of inspiration/expiration lead to a phased increase and decrease of tissue permeability and viscosity of the matrix in the connective tissue. That means that more fluids and electrolytes flow into the cells and into the lymphatic system during the inspirational phase, and that fluids and dissolved substances flow out of the cells during the expiratory phase."* (Liem 1998, p. 354)[37]
Much earlier, around 1950, W. G. Sutherland (1873-1954), described the PRM like this in his lectures: *"The primary respiratory mechanism maintains an inherent, rhythmic, automatic, involuntary 'life and motion' cycle of mobility and motility ten to twelve times per minute in health. This produces rhythmic flexion of all midline structures in the body with external rotation of all paired lateral structures, alternating with extension of all midline structures in the body with internal rotation of all paired lateral structures. Every cell and all the fluids of the body express this rhythmic, involuntary 'life and motion' throughout life. This mobility and motility are important factors in maintaining health in the vital homeostasis of structure and function for the central nervous system, the endocrine system, and other units of function within body physiology."* (Sutherland 1990, p. X)

Coming back to WUTZL, I would like to summarize his words here: the third ventricle as well as the whole fluid system have a particular relevance for ML work. The perception of the third ventricle and its 'craniosacral rhythm' are used to make a

diagnosis, to control the progression of the therapy, and to recognise the right moment at which to end the therapy. I think that these ideas are of great practical relevance.

McPartland and Skinner (2006) seem to confirm WUTZL's statements in this quotation: *"The Lamina terminalis* [this is a kind of anterior boundary of the third ventricle – author's note] *marks the end of the tube's top end. The ML structure continues in the adult on top of the third ventricle. It is the pivot point of every neural motion. During the inhalation phase, but also during the exhalation phase of the PRM, the whole central nervous system converges in a spiral like movement on the Lamina terminalis. During the exhalation phase, all tissues move away from the Lamina terminalis.*" (McPartland, Skinner 2006, p. 357)[38]

I would like to render the following description, again by McPartland and Skinner in reference to Jealous, to make the connection of the coccyx-ethmoid clearer: *"The 'Breath of Life' (BoL) transforms into a motion of fluids (that is the 'Long Tide', the longitudinal fluctuation of the Liquor cerebrospinalis) that starts at the Os coccygis when inhalation begins, rises through the core-link and flows through the Foramen magnum in the middle of the inhalation phase. From there, it flows further to fill the posterior, central and anterior cranial groove with its potency. During exhalation, it descends from the area of the Os ethmoidale to the Os coccygis and finally completes its elliptical course."* (McPartland, Skinner 2006, p. 320)[39]

Jealous (2003) for once should be quoted here in his own words again. His statements about the coccyx seem very interesting to me, because they emphasise the apparent significance of this bone (not only in relation with ML osteopathy): "*If we approach the coccyx and its local resources, we find the ganglion impar; the 'tail brain' as I like to call it. […] Approach the coccyx as a miniature cranium with bones, you will find a world as small as a nickel with a whole 'field of life and activity'. Take a moment, treat the coccyx first […], only balance the 'contents' and biological forces in this nickel sized area. See what happens. Migraines, parasympathetic imbalances, dysmenorrhoe, et cetera, all respond*." (Jealous 2003, p. 111)

In Jealous (2003), I also found a reference to the navel as a relevant ML structure: *"The navel and the ML are linked, especially at birth via ignition."* (Jealous 2003, p.106). Liem also mentions a *"Navel-Occiput (Vertex)-ML"* that is particularly important in birth traumata and emotional traumata (Liem 2006, p. 310).

3.3.2.3. CAN PURELY STRUCTURAL TECHNIQUES LEAD TO THE ML?

All of my interview partners spontaneously answered *"yes"*, except for one: WUTZL said *"no"*, because I used the word purely in my question (6/22-27). For WUTZL, the *"energetic orientation"* that one uses when applying a structural technique, for example during a thrust (this is a manipulation technique that uses great speed – author's note), is the issue here. The issue is *"being clarified"*. He describes it like this: *"This is about the energetic orientation, whatever that means. It makes a difference whether I am focussed or not. It's like having an arrow and a bow. If I am not focussed, I won't hit the target. And through focussing, I already know whether the vertebra is okay or not. That means, once I notice that it won't fit in at all, once I have tried it and it didn't fit, I won't try it again, but rather do something else."*(7/29-34). WUTZL emphasises that he also does *"… thrusts; it doesn't have to do with leaving structural osteopathy behind you. But for the overall clinical concept it will surely make a big difference"* (2/14-16) whether one *"integrates the ML into one's therapy concept"* or not (2/3-4).

SHAVER puts it very clearly: *"I think that purely structural techniques can have profound effects on the midline."*(11/49-50). And, further on: *"I'm very comfortable with structural techniques, that was my hardest original training."* (12/12). The decision whether he will use structural techniques or not depends on what the *"system"* of the patient is telling him. An interaction between him and the patient's *"whole system"* takes place: *"It depends literally on the direction I receive from that patient's system. If I get the impression from their system that a structural technique is necessary for a particular articulation, I do that. And it's not so much about the patient, but about the direction I'm receiving from interacting with that patient's whole system."* (12/22-24). SHAVER adds that integrating

the ML knowledge into one's structural techniques as an osteopath will transform these structural techniques (12/3-4).

NUSSELEIN thinks that it is theoretically possible to treat the ML solely with structural techniques. A precondition for this would be to treat the structure very "respectfully", – it doesn't matter here which structure causes the primary problem – and to perceive the PRM very attentively. A PRM in the affected structure that can be perceived clearly after the therapy also indicates that the ML has been treated correctly. If no attention is paid to the PRM, the problem will probably recur (7/26, 7/31-37, 7/41-45).

VAN DEN HEEDE also thinks that an osteopath who exclusively works structurally can treat the ML successfully. But he points out that the osteopath might not be able to understand this success. The reason for this lies in the fact that a bone is part of an evolutionary process through which the ML is expressed both in an energetic and in a biodynamic sense; and that the body *"knows its lines"* and will find *"its way to these lines"* (7/5-19). VAN DEN HEEDE expresses his strong belief in the body's self-healing forces here. These self-healing forces and one's trust in them is one of the main principles of osteopathy (as described in chapter 3.1.1.).

LIEM thinks that structural techniques will help the ML in any case, if they are applied correctly (9/24-33).

TOTH joins this common consensus by answering my question with a clear *"yes, of course!"* (5/1). But he also immediately adds that the ML concept should always be *"present in the background"* (5/14).

WEBER answers the question like this: *"I think so. If someone has a heart for his patients, he will also be able to transport the midline in this form."*(11/23, 11/38-39). ML osteopathy is *"a principle of effectiveness, and when it's respected it will account for the effect in some way"* (11/24-26).

WEBER himself was deeply convinced that a decision was necessary at a certain point of his professional career. He changed from a "structural osteopath" to a "ML osteopath". In the following very straightforward account on the world of osteopathy, which is not always as serene as one may think, WEBER makes some statements and gives us some insights which had a great impact on this changeover:

"I have a patient, and I had a lot of trouble with her, because she used to come to me and always wanted me to do something. Before, I always applied normal structural osteopathy to stretch the diaphragm and set the vertebrae, I did muscular trigger points, and one day I came to the conclusion that 'letting the midline work' is the best way, because it is more complete. And I stress that the osteopath really doesn't have to do anything because the midline works on its own. [...]

The last time I set a vertebra was two or three years ago... but I think... when Sutherland says 'no force at all' - that the force that really is the matrix, that comes out of health starts to work. Many patients often are astonished when they are confronted with this. Oops, the osteopath doesn't really do anything anymore! Then they look at their watch. And that was four, five years ago, when I changed over, that this happened a couple of times, funnily not that often. You sit at the head, suddenly the head turns upwards and the patient looks at you with the unspoken question: what is happening here? Then you try to explain what happens, and I noticed that once patients know there is a concept which is about self-healing, and what interests me is not the arbitrary movement but the movements underneath this arbitrary level ... these are the instinctive processes, there are the metabolic processes ... that there are axes here and that these axes have to be oriented, [...] then the arbitrary movements will improve, get better. Once they understand this, they accept the treatment more easily and are then able to enjoy it.

And this patient, that put a lot of pressure on me and was hard to treat - I wondered - she continued to come. And she always looked at her watch and figured, one minute too late and she worked out what a minute of my time was worth and things like that, but there are treatments that are completed after ten minutes. We somehow struggled along and then suddenly, after she had been coming regularly for three years, and each time I had the feeling my stomach was contracting and my breathing got flat and I really didn't want to treat her, suddenly she was in 'neutral', after three years. This is simply fantastic. Since then, something in her has changed. She used to come on the dot, panting up the stairs with her

tongue out, she came and went in a rush, had car crashes umpteen times, and these things don't happen by accident. Now, she has changed her job, has a job that gives her time, more tranquility, where she integrates the midline into her life" (6/11-47)

3.3.2.4. SUMMARY

Anatomical knowledge is important for all of my interview partners (3.3.2.1.). But certain nuances and additions should be made to this statement. VAN DEN HEEDE emphasises that an osteopath must have experienced anatomy as a *"qualitative perception"* through his hands. SHAVER speaks of a "functional anatomy" which for him is not about memorizing names, but knowing what a structure does and how it functions. WUTZL and LIEM want to prevent drifting off into imprecise, intuitive working methods by acquiring fundamental anatomical knowledge. WUTZL also points out that without anatomical knowledge, an exact diagnosis is impossible, one cannot recognise the course of the therapy and its results clearly, or discuss it with the patient. Also quoted is Andrew Taylor Still, for whom exact anatomical knowledge was an absolute and fundamental precondition for every osteopath.
Further on it was made clear that some particular anatomical structures have a stronger relation to the osteopathic ML than others (3.2.2.2.). The coccyx, the sacrum and the ethmoid as well as the sphenoid have to be highlighted pertaining to osseous structures. They form the endpoints of a "central connective line" that McPartland and Skinner call the "core link", which is in close relation to the notochord (see section 3.3.1. "Embryological Approach"). For WUTZL, the fluid system, especially the third ventricle, has major significance for ML osteopathy. In this context, the "PRM" and the "Cranio-Sacral Rhythm" were discussed in detail. Other anatomical terms that were mentioned are the Lamina terminalis and the navel. The practical relevance of particular structures for ML osteopathy was indicated.

To conclude, one could say that the question whether purely structural techniques could lead to the ML (3.3.2.3.) was answered with a *" yes, but…"*. That means structural techniques can have a positive influence on the ML. Success depends on an

"energetic orientation", as WUTZL puts it, that an osteopath has during the application of a structural technique.

At the end of this chapter, WEBER, by recounting a patient's history, describes what can happen when an osteopath changes from structural to predominantly biodynamic working methods. In this context, WEBER also explains his personal motivations for this changeover.

Conclusion

An osteopath can treat the ML with structural techniques if he is well *"focussed"* (WUTZL), able to perceive the PRM (NUSSELEIN), and if he has a *"heart for his patient"* (WEBER).

3.3.3. FUNCTIONAL APPROACH

"Function" and "structure" are two great keywords that were mentioned time and again in the course of my interviews, which consequently explains their prominent place in my study. The preceding chapter discussed "structure", now the term "function" will be explained. The term "fulcrum" is closely related to "function". After analysing all the interviews and the relevant literature, it can be said that one main function of the ML seems to be acting as a fulcrum. In the following two chapters, I will closely examine this issue and try to prove this assertion with quotes.

3.3.3.1. THE TERMS "FUNCTION" AND "STRUCTURE"

"The ML is not only expressed in function but also in structure and form. "
(VAN DEN HEEDE 2005, p. 8/7-8)

"Midlines are a function inside a structure." (Paulus 2006, p. 197)

"The ML was structure, and not a function. That is the difference: in the old definition, the ML is structure, in the new definition [...] the ML is a function."
(VAN DEN HEEDE 2005, p. 3/25-27)

To remain understandable for the non-osteopathic reader here, I want to briefly review the osteopathic-historical background of the terms "structure" and "function". An ancient conflict exists in the osteopathic communitiy between the "structural" and the so-called "functional" approach to the profession. This discussion dates back to the times of osteopathy's creation, when its founder, Andrew Taylor Still (1828-1917), started to teach "his" method. Abehsera (2002) describes this in an essay called "Strukturelle und funktionelle Osteopathie - Die Teilung der Osteopathie" ("Structural and functional osteopathy – the rift in osteopathy") which was published in the book "Leitfaden Osteopathie":

"For about hundred years, the osteopathic profession has been repeatedly afflicted by the controversies of the 'structural' and the 'functional' factions, as the two parties call themselves and each other. Techniques that emphasise a dysfunction or exaggerate it are defined as functional, for example; 'structural' is equated with direct techniques which 'break through' a dysfunction by manipulation, for example. [...] The beginning of the conflict can be dated symbolically on the day when Still threw Littlejohn, the first dean of the American School of Osteopathy, out of Kirksville. The founder of American osteopathy, Still, believed that ***structure rules function****; the founder of European osteopathy, Littlejohn, found this notion absurd and believed that* ***function rules structure****. These contrary paradigms did not allow Still and Littlejohn to teach under the same roof any longer and so they had to part."*
(Abehsera 2002, p. 17)[40] (bold accentuation by author)
After leaving the U.S.A., Dr. Martin Littlejohn founded the British School of Osteopathy (B.S.O.) in London in 1917, the first European school (Ligner, Van Assche 1993, p. 18).

This old conflict is no longer relevant for the current ML discussion in my opinion. VAN DEN HEEDE'S statement mentioned above referring to an "old, structural" ML definition was only quoted to point out that a greater differentiation between structure and function was applied in the past.
Van den Heede sounds much more modern and diplomatic when he explains the osteopathic principles: *"Structure and form account for each other"* (Van den Heede, 2003-2005; see chapter 3.1.1.). Here, neither structure nor function are given priority. This principle was taught during my education at the WSO from 1997 to 2003 like this: *"Structure rules function"* (Ligner, Van Assche 1993, p. 17).
I would like to end this short excursion into another aspect of osteopathic history with conciliatory and compensatory words by Delaunois (2002). He writes in a chapter called "Osteopathische Prinzipien" in the book „Leitfaden Osteopathie":
"A foundation of osteopathy is the interdependency of structure and function. A healthy structure fulfils all its assigned functions. The functions of an organism can only be fulfilled when the structure is in a good condition. Through this coaction, structure and function go hand in hand. Motion is their common ground. Think of it like this: Structure is a consolidated motion and function is the energy of that motion." (Delaunois 2002, p. 35)[41]

I cannot spot a "conflict" between "functional" and structural" ML osteopaths in relation to ML osteopathy.

What can be said though is that some interview partners distinguish a structural (in other words weight-bearing) ML and a functional ML (as well as other MLs). This became obvious when some of my interview partners asked which ML we were talking about before answering a question: was it a structural, a functional, an energetic ML (see NUSSELEIN below); or was it a *"main ML"* (WEBER 2004, p. 8/4, 14/38), a *"central ML"* (SHAVER, below), a *"final ML*" (see LIEM below), and so on …

LIEM, SHAVER and NUSSELEIN differentiate repeatedly during the interviews. I want to give a short overview of the various ML terms that were used in the interviews:

- NUSSELEIN mentions terms like structural ML (1/39-45), anatomic ML (5/34), functional ML (5/35, 1/37, 1/39), energetic ML (7/4, 8/6-9, 9/10), *"real*" ML (2/50).

- SHAVER says: "*It just depends what ML we are talking about ...*" (10/7) and differentiates between a structural ML (6/19-20, 9/26-28, 9/23-25), a functional ML (3/6, 3/17, 4/27, 4/37) and a *"central ML"*. He says about this *"central ML"*: "*It has no beginning, no end, can't be destroyed* (5/31) *[...] and is not to find by anatomy*." (11/19). Within the structural ML, he even discerns several sub-categories: "*There's lots of structural MLs...* " (11/1).

- LIEM'S *"differing kinds of ML*" (3/10) shall be depicted here in short. He speaks of a structural ML that is connected to the upright position opposing itself against gravity and is important for diagnosis (3/5-8); of a ML as a "*centring in the present"* (2/45), of a ML of dynamics of development (2/44), of a ML as a median for all rhythmical phenomena within an organism (2/47-49), of a ML as a fulcrum (2/43), of an embryologic ML, which he calls *"the most popular ML at the moment*" (7/26-28), and of an *"ultimate ML"* or, as he also calls it, a "*final ML*" and a "*final fulcrum*" that is situated "*in the future*" (7/48-49), "*is called 'Nirvana' in Buddhism*"

(8/1) and is "*timeless and spaceless*" (12/42). Summarising, LIEM says: "*Depending on the point of view – it hasn't been defined yet – there are different kinds of MLs*" (3/8-11).

It gets harder and harder to find a way through this jungle of different MLs. LIEM, NUSSELEIN und SHAVER distinguish between the MLs mentioned above. WUTZL, WEBER, TOTH and VAN DEN HEEDE don't differentiate as much between various MLs as far as I understand. When asked about the ML, it seemed evident for all four of them that we were talking about "the ML". What I mean here is that the various aspects of the ML seemed to be amalgamated into one ML definition for these four interview partners. They discussed the ML with me without asking which ML I was talking about (however each one of them defines it and explains it himself). Despite many concurrencies, the definition of "ML" shows individual differences. And sometimes, when two people talk about the ML, it seems impossible for one to even imagine that the other could mean something completely different.

3.3.3.2. THE "FULCRUM"

"*Midlines are linear fulcra.*" (Paulus 2006, p. 197)[42]

The term "fulcrum" is Latin and is translated "support" (fulcrum, -i, n. = support); the corresponding verb is "fulcio 4.fulsi, fultus" and is translated "support, facilitate, uphold, affix, and keep" (specifications see "Der kleine Stowasser"- lateinisch-deutsches Wörterbuch 1979, p. 194-195).

I already mentioned the fulcrum in two sections of my study. In chapter 3.1. "The significance of the ML in the current osteopathic discussion" (in section 3.1.1. "Main topic or secondary topic?"), I quoted NUSSELEIN who used the term fulcrum right at the start of the interview: "*If we think about the function of the ML that that is actually a fulcrum for our involuntary mechanism and our involuntary mechanism is our self healing force, which is part of the concept of osteopathy, I think, every student needs to know about*

the ML function." (1/37-39). Fulcrum could be translated as a "line of orientation" in this context and NUSSELEIN clearly associates it with a function of the ML.
In chapter 3.3. "Definition of the ML" – here in section 3.3.1.1. "Embryological approach/ Van den Heede's 'theory of the tripartition ML'", the fulcrum is also mentioned quite often. Van den Heede is quoted here for he speaks of embryonic fulcra, of points of balance and support that form during the embryonic period (Van den Heede 2002, S. 26-28). He also mentions a fulcrum in connection with practical advice for a ML treatment: he applies his handholds in places where they can perceive the best possible fulcrum, the best possible *"point of support for setting the tissue free"* (9/19-23).

In this section (3.1.1.1.) I also mention LIEM who describes the so-called "Sutherland fulcrum" as a point of balance for the "dorsal ML" (Liem 2004, p. 639). A detailed description of the Sutherland fulcrum can be gleaned there. During the interview, LIEM says that the *"notochord* [is] *an important point as a structural, dynamic formative fulcrum of the ML"* (8/32-34). In another passage: "*ML is a kind of orientation for me, a kind of fulcrum in a dynamic formative sense of interpretation or in a sense of centring in the present"* (2/43-45). Further on he speaks of a *"final ML"* and of a *"final fulcrum"*: When talking of the *"final ML"*, he refers to an *"ultimate ML"* that is situated *"in the future"* (7/48-49). The term *"final fulcrum"* seems to represent a condition *"outside space and time"* here (12/42) that knows no *"polarities"* (12/37) and integrates *"consciousness and tissue"* to a degree that ends *"duality"* (12/22-23).
In my own summary of section 3.3.1.2. "Embryological approach – the germ layer theory: comparable to Van den Heede's theory?", the word fulcrum has great significance. I quote myself here: *"The various 'tripartitions' of Rohen and Lütjen-Drecoll (the 'functional tripartition' and the 'sterical tripartition') and Van den Heede's 'tripartition ML' lead to one common point : they all need a 'fulcrum' (a point of balance, a point of support, a point of stillness, a point of reference – in my opinion different words with a common meaning)."*
By summarising all the statements, we can conclude that the ML seems to fulfil this function (as one of its many functions).

In osteopathic literature, many references to a fulcrum can be found. The book "Morphodynamik in der Osteopathie" (2006) includes a chapter called "Das Erleben der Fulcren in der Osteopathie und das Entstehen der Stille" ("The perception of fulcra in osteopathy and the formation of stillness") written by Steve Paulus (2006). He writes that William Garner Sutherland first mentioned fulcra in connection with osteopathy. Sutherland himself seems to have borrowed this term from his friend and teacher Walter Russell (1871-1963). Paulus (2006) says about Russell: *"Russell was an architect, a sculptor, a novelist and an autodidactic scientist. Most of all, he was a mystic of a directly spiritual education. [...] He was an American spiritual master and founder of the university of science and philosophy in Virginia. Both William Sutherland and his wife Adah were strongly influenced by Russell's spiritual teachings. It is astonishing how much of osteopathy's cranial realm is derived from Walter Russell's spiritual doctrine."* (Paulus 2006, p. 195)**[43]**

Paulus (2006) also quotes Russell directly, and I want to include this quote here in its original form, because it proves that the term "fulcrum" wasn't invented by osteopaths (it is all the more remarkable that Sutherland never gave any reference to the origins of "his" knowledge of the "fulcrum" in his written works, as far as I know – author's note). Thus we read Russell in his original words: *"What is life? We imagine life as pulsing, as a heartbeat, as something that lives as long as its heart beats. The body manifests life; it expresses life. But life's expression in the sense of a leverage moving in its centre of rotation does not really express life. It is only a leverage; the life and the potency are really in the quiet fulcrum – not where it moves – not where it pulsates. Our bodies don't live; they are really only an expression of the source of life."* (Walter Russell in: „Das Erleben der Fulcren in der Osteopathie und das Entstehen der Stille"; Paulus 2006, p. 195)**[44]**.

According to Paulus (2006), Sutherland distinguished three categories of fulcra:

- A *"physical, mechanical fulcrum"*, which is of great importance for *"biomechanical osteopathy"*;
- an *"inert fulcrum of a dysfunction"* (*"inertia"* which is meant here, can be perceived in the tissue *"area of dysfunction")*, and a

- *"spiritual, non material fulcrum"* that is *"always in balance with the universe"* (Ibid. p. 196).

To come back to my subject – the ML – I would like to include another quote by Paulus (2006) here: *"Jim Jealous and Elliott Blackman introduced the term 'midlines', which originates from embryology, to osteopathy. Midlines are fulcra, not only remnants from embryology. Midlines are linear fulcra. Midlines are a function inside a structure. Midlines are perceived as circumscribed neutral lines with a reference to stillness."* (ibid., p. 197)[45]

In the book mentioned above, Liem (2006) describes the fulcrum under the title "Behandlungsprinzipien" ("principles of treatment") like this: *"A fulcrum is a kind of stillpoint or flexible fixed point which makes it possible to lift a weight for example; its inherent potency acts as an organising factor for the orientation of motional and organisational patterns. In nature, a fulcrum may be the eye or the centre of a hurricane, for example. A variety of fulcra exist in the human organism. The pivot-points of the cranial fissures (where the rims of outwardly or inwardly directed joints meet) are fulcra, for example; they function as a stillpoint or a centre of rotation for the motion of the cranial bones. The sternal end of the clavicula represents an osseus fulcrum for the function of the whole upper extremity. Further on, an osseous fulcrum on a level with the SSB, a membranic fulcrum on the level of the Sinus rectus and a neutral fulcrum on the level of the Lamina terminalis are described. [...] Sutherland and Becker also described spiritual fulcra. Examples of this are regularly practicing meditation, a particular religion, a principle of life or a guideline such as 'love your next of kin as much as yourself'. By adjusting one's life to this guideline, the potential force of this guideline may be put into effect in life. Just like regular meditation represents a stillpoint, a point of reflection, a ship on the infinite ocean of life, a fulcrum can be a regular reflection to become empty before and during a therapy and to be open for the patient, as Chila points out."* (Liem 2006, p. 262)[46]

To summarize, we can say that Liem describes a multitude of fulcra; there are anatomical fulcra (osseous, neuronal, membranous fulcra), spiritual fulcra (meditation, religion), psychological fulcra ('guidelines'), fulcra in nature, as well as

fulcra that are relevant in practice (tuning in on a patient). Besides these, there also exist so-called 'dysfunctional' fulcra as mentioned before by Paulus: *"This eye of dysfunction, this area of stillness inside the tension patterns of the tissue is the place that represents the specific potency of a particular dysfunction. In a way it is dysfunction's soul [...] every change in this area causes a change of the tension patterns in their structural-functional interrelations. The osteopath can learn to palpate and localize these areas.* (Liem 2006, p.263)**[47]**

All this may seem a bit too theoretical for the reader and he may find the many fulcra being thrown at him exasperating; he may be helped by the following quote by Rollin E. Becker (2000) which could also be a tip for the laborious osteopath in his every-day practice: "*You cannot describe function. [...] But you don't have to worry about it because it's already taking place anyway. If it needs help you just establish a fulcrum, establish a point from which function can take off and do its thing. This takes a lot of strain off you. You don't have to make the gastric juices dissolve the sandwich eaten today. The body physiology is going to do it - you just encourage the process.*" (Becker 2000, p. 54)

Osteopathy can be as easy as that! Or can it?

3.3.3.3. SUMMARY AND DISCUSSION

Chapter 3.3.3.1 (The terms "function" and "structure") dealt with the famous chicken-egg issue: which comes first, structure or function? The old controversy between the so-called 'structural' and the so-called 'functional' osteopaths was discussed as well as the relevance of this differentiation for ML osteopathy.
An overview of the various MLs discerned by my interview partners was given: structural or anatomical ML, functional ML, embryonic ML, energetic ML, central ML, main ML, final ML, and real ML …

In chapter 3.3.3.2., my attempt to structure and clarify the "functional approach" seems to have failed. The term 'fulcrum' has too many diverse meanings in the

osteopathic use of language. It seems to be impossible here to guide the reader on a clearly discernable path through this jungle of ML definitions.

Hence, my conclusion is that a great Babylonian confusion of tongues exists in osteopathy in relation to the ML and it would be an exciting and ambitious project to find a common vocabulary in the future. It would be easier for osteopaths to talk about such phenomena as the ML or to explain them to a non-osteopath. Osteopathic thinking and acting could gain much more clarity and precision that way.
WEBER hits the marks by saying: "*We would only have to try to sort out the terms*" (3/14).

3.3.4. SPIRITUAL APPROACH

"The discussion is tedious because no developed language is available to describe osteopathic experience, let alone a typical osteopathic spirituality." (Wührl 2005, p. 27)[48]

"*Osteopathy is a spiritual science, and to teach it anything other than that is not teaching osteopathy.*" (SHAVER 2005, p. 2/32)

"The supernatural has to be integrated into this scientific system."
(WEBER 2004, p. 12/31-32)

"Although metaphors are inherently irrational, they have often proved helpful for the construction of working hypotheses to approach a scientific problem."
(McPartland, Skinner 2006, p. 349)[49]

I put these quotes at the beginning of this chapter to tune the reader into the metaphorically-rich language that osteopaths have used since the beginning of osteopathy to describe apparently spiritual phenomena that can show up in the course of their work. I will examine to what extent spirituality is an important issue in osteopathy and in ML osteopathy in particular in the following chapter. I compiled the statements of my interview partners relating to 'spirituality' and supplemented them with correlative articles from reference books and magazines. As before, this chapter – particularly this chapter - will depict a great diversity and vagueness of terms. Wührl (2005) finds very accurate words for it in the quote mentioned above. He addressed the issue of 'osteopathic spirituality' in a detailed article in the magazine "Deutsche Zeitschrift für Osteopathie" with the meaningful title "Erfahrungsprozess oder Bungee-Sprung in den Interzellularraum? Zu den Grundlagen osteopathischer Spiritualität" ("A process of experience or a bungee-jump into intercellular space? About the basics of osteopathic spirituality") (Wührl 2005, p. 27).

Right at the beginning of his essay, he asks about the *"… obstetricians of osteopathy. Did and does it originate from reproducible scientific cognition, as some hope and want to ensure by setting the political agenda? Was it founded out of a humanistic, a Darwinist, a Christian, a stoic or a Buddhist philosophy, depending on how you prefer to see it? Or does osteopathy rest upon the spiritual practice of osteopaths?"* (ibid)[50]. To ask about the significance of spirituality in osteopathy thus seems to be relevant not only for ML osteopathy, but for osteopathy in general.
Before discussing the interrelation of spirituality and my ML-research in detail, I want to give a definition of spirituality here. It also comes from Wührl's (2005) article mentioned above: *"I suggest to visualize spirituality now as a wide horizon of human experiences that encompasses moments of emotion as well as deep contemplation, conditions of emphatic participation and engrossed perception, of quiet entrancement and of ecstasy."* (ibid)[51]. He writes about osteopathic spirituality in particular: *"Osteopathic spirituality is the aspect of our practical work that is yet to be described. In it, the attention we give to ourselves, to the patient and to the reality that surrounds are intertwined. A phenomenology of osteopathic sensitivity would have to try and describe this attention, its sensuous quality, its ritual practice and its historic place of origin; this would be a first attempt at answering the question of a specific osteopathic spirituality."* (ibid., p.28)[52]

The answers that my interview partners gave to the following questions explain why spirituality is discussed as a particular thematic issue at all in my ML study. The questions were:

- How important is a certain mental disposition of both the therapist and the patient when working on the ML? How much knowledge / preparation is necessary?
- How, where and when does the ML begin and end?
- What happens within yourself when you are working on the ML of a patient?
- Do you personally have a certain inner picture (idea) of the ML? How does it feel?

These were the guide questions from which other questions were developed during the conversations. The answers are not only incorporated in this chapter about spirituality, but also in the following chapter (3.3.5. "psychotherapeutic approach").

It can be said in general that a spiritual idea appears in almost every part of this study. For example, SHAVER has been quoted repeatedly, saying that osteopathy is a *"spiritual science"* (2/32) and that a *"central ML"* exists (11/9-19). LIEM's *"final ML"* and *"final fulcrum"* have been mentioned as well in chapter 3.3.3.1. ("the terms function and structure"), Sutherland's explanations on the "Breath of Life" were presented in chapter 3.2.2.. In chapter 3.3.1. ("embryological approach"), the terms "Long Tide" , "Quantum ML" (see Sills, 3.3.1.3), and "Potency" (see Jealous, 3.3.1.3.) were discussed. In the same chapter (3.3.1.3.), I quoted Still who believed in a *"divine plan"*; and WEBER (3.3.1.5) who spoke about the experience of *"stillness as richness"*. In chapter 3.3.3.2. ("the fulcrum"), many references to the spiritual approach can be found.

I chose to explain a few of the many possibles subjects in greater detail here. The decision which subjects should be given the main focus was made according to their occurrence in the interviews. The following ranking resulted:

- **Stillness - Stillpoint**: the perception of stillness (sometimes also "dynamic stillness") and of stillpoints seems to be essential for ML osteopathy and was mentioned by four of the seven interview partners in one context or another.

- **Love**: the term "love" showed up in four interviews in one context or another.

- **Faith - religion – ersatz religion**: The "faith in something" (but not necessarily bound to a particular religion) was important for three interview partners.

- *Death*: death and dying were an issue in three interviews.

- **Long Tide - Potency - Breath of Life**: these terms will briefly be discussed once more.

3.3.4.1. STILLNESS - STILLPOINT

"To be able to perceive the ML, you have to be able to perceive the stillness."
(SHAVER 2005, p. 10/40-47)

"What is stillness? One point of the ML" (Van den Heede 2003-2005)

"There is a main midline, that feels ... that radiates calmness, and you find it in every stillpoint and in every fulcrum, in every point of balance." (WEBER 2004, p. 14/38-53)

"It is the stillness of the Tide, not the stormy waves that bounce upon the shore, that has the potency, the power." (Sutherland 1990, p. 16)

In the following section, I want to elucidate these quotes. Let's go back to the beginnings of osteopathy and to Sutherland. Liem (2006) writes the following about him and stillness: *"Sutherland used to set aside periods of quietness every day to 'listen to the stillness'. By tuning into our own stillness and 'emptying ourselves' we will not only help ourselves but also our interaction with the patient. Because in stillness, the art of 'palpation without prejudice' can develop, where the therapist becomes an 'empty jar' and allows the impression of the patient in."* (Liem 2006, p. 153)[53]

WUTZL puts it like this: *"One needs a place for the perception of stillness to identify stillness; an area for the perception of space and an area for the perception of function without structure. In my opinion, these are the basic conditions."* (4/35-41)
Stillness is inseparable from the ML not only for Wutzl but also for VAN DEN HEEDE, SHAVER and WEBER, as shown by the following statements.

VAN DEN HEEDE thinks that an osteopath who has never experienced the ML function and stillpoints has done something wrong or at least missed something. To quote him directly: *"It doesn't work without meditation. Once in their lives they will [...] reach this stillpoint and will perceive that stillness exists somewhere. But if they only do this*

[and] *[...] still have no idea what a stillpoint or a ML function might be after twenty years, they have been doing* [something] *wrong for twenty years, not wrong, but outside this perception and without being synchronized."* (9/25-33). Van den Heede describes the feeling of *"arriving"* at the ML like this: a change of *"motion, tension and density"* occurs. It is like *"arriving in the stillness"* or in a *"neutral essence; this is a condition that doesn't express subjectivity anymore, only neutrality"*. He also says: *"Stillness is the goal of the treatment [...] this stillness is a point of the ML, a point of balance. It is a memory without images (images appear later, they need a reference). It is 'blueprint memory'. It is a moment of highest probability. The way to stillness is via the Long Tide."* (Van den Heede 2003-2005). And in a different section, he speaks about this *"arriving at the ML"*: *"It is stillness. This stillness can be perceived both by the patient and the therapist."* (8/30-33)

ML osteopathy and stillness are inseparable for SHAVER. One is not possible without the other (see quote above). He gives this advice to a student who asks for help and guidance: *"Look for the stillness, sense for the stillness.*" (14/14). *"Look for the stillness in that motion, the stillness from which all the motion comes. And that's your reference centre.*" (10/40-47)

WEBER has a lot to say about stillness. Here, the patient's perception and experience no longer seem to be clearly separable from the therapist's. In my understanding, the following statements could refer to both of them. Maybe the conditions described can only arise through interaction. WEBER perceives *"stillness as a richness that reaches the limits of the universe"* (5/1-9). *"The ML expresses stillness."* (16/7-10). *"Entering stillness is also a process of qualifying matter. This qualification of matter is also a qualification of one's own being."* (16/39-42). *"If I want to perceive the finest motions, I will have to reach an ultimate stillness."* (16/29-31). *"A mirror opens. And for many this is hard to stand."* (16/52-54, 17/1).
WEBERS statements about the mirror that can open during a ML treatment inspired me to add a separate section called "ML as a mirror function" (3.3.5.3.) to the chapter called "Psychotherapeutic approach" (3.3.5.). WEBER sees this *"reaching an ultimate stillness"* as *"stimulation for relationships"* (17/15-17), and he also calls this stillness *"the only thing that really unites us*" (17/1-6).

The Bulgarian-German author Elias Canetti, a virtuosic master of language command, is said to have made the following statement that could express the same idea from a completely different point of view: *"There is no bigger illusion than the assumption that language is a means of communication between people."* (Elias Canetti, quote from: Wikiquote, free encyclopaedia "http://de.wikiquote.org/wiki/Elias_Canetti", 20.10.2005)

Thus, stillness could not only be a way to the ML, but also an important tool for human communication? A fascinating thought that asks for further contemplation.

3.3.4.2. LOVE

At first sight it may seem unusual to find a chapter titled "love" in a scientific study about the ML in osteopathy. It wasn't planned from the start but rather emerged during the analysis of the interviews. Since four interview partners have spoken of love more or less directly in correlation with ML osteopathy, it shall be included here. Taking into account the statements made by Liem in his article about the "principles of diagnosis" in the book "Morphodynamik in der Osteopathie" (2006), five of my seven interview partners refer to love in association with ML osteopathy. Liem (2006) says: *"And our heart with its love, empathy and understanding is part of every approach to the patient."* (Liem 2006, p. 202)**[54]**

SHAVER puts it like this: "*And the capacity to experience love is probably the most vital nucleus of interest*." (8/42-44). To apply this kind of (ML) osteopathy, it takes "*some willingness to be of service and help, some desire or need or internal knowledge that a person needs to function in a service way*" (8/38-42) in his opinion. It seems that the love meant here equals "charity" in a Christian sense.

I would like to add a few statements by Jealous (2002) here, which are in line with this application area and which he formulated very clearly: *"As a religious person you could have the notion that 'good and bad' exist; but as physicians it isn't our concern. We are*

here to serve the patient. We can't allow ourselves to judge what is good or bad for the patient; we have to remain neutral. To look at a patient as if he was a lesion would disqualify us as nursing staff. The Breath of Life allows us to take a neutral position that corresponds to love itself, which doesn't originate from our own heart, but from the heart of the world." (Jealous 2002, p. 29)[55]. Serving the patient is also Jealous' postulation. To achieve this, the therapist should adopt a neutral position. This neutrality originates from the "Breath of Life" (see also 3.3.4.5.), which he equates with love (a universal love, not a individual love – author's note). In another context, Jealous talks about Still and his own education: *"Aged eighty-six, Dr.Still said: 'I love my patients because I see God in their faces and their bodies'. He saw more than their lesion and their ailment. He saw something supernatural and divine in their shape. In a certain sense he gave me the permission to discover that a divine image is standing or sitting or lying in front of me. The tuition I received allowed such thoughts. When I started to discover the perfection in the patient, I didn't feel like a non-osteopath at all."* (ibid)[56]

Fulford, one of Still's pupils, puts it like this: *"You (the therapist) remain neutral and serve as a conductor for the flow of God's love. Once you learn to integrate love in your therapy, your body vibrations will increase and dealing with the force of love's energy will become easier."* (Fulford in: „Entwicklung der Behandlungsansätze" by McPartland, Skinner 2006, p. 353)[57]

WUTZL experiences ML treatment as an encounter: *" 'I would call it an encounter [...] for me it's an encounter. And I perceive it – if you want to see it spiritually – I feel it in my heart, but not in my physical heart; it is like a centre, about a hand (six inches) in front of my heart. I perceive this centre that opens up naturally. Then I perceive it in myself … this pulse. If it really works well, I immediately receive energy for the next four treatments. And it's different every time. In the moment … it often happens that you have this encounter with the 'Breath of Life' on three consecutive days in a very particular way; and once your own mind has got a picture of it, it will most often disappear eventually, and the 'Breath of Life' will show up in a different shape after some time. It's similar in meditation. Once you have got a picture of some kind of content it is already so limited that it doesn't … that the encounter is already (inherently) prevented. In this sense it is really like meditation for me.' Dunshirn: 'A*

form of meditation with the tissue?' Wutzl: 'Meditation over the tissue, over the patient; and everyone involved benefits from it.' " (Laughter) (10/3-20)

WEBER offers only one short but distinct remark in this context. When asked whether purely structural techniques lead to the ML, he answers: "*If someone has a heart for the patients, then he can transport the midline in this form too" [*by using structural techniques – author's note*]* (11/38-39).

NUSSELEIN talks about love in a different context. She recounts the story of a patient who had great problems with allowing herself deep emotions and with bestowing affection: "*So if you have somebody with really problems with affection, with giving love, very often you come back to the ML; what has happened actually during the pregnancy. Were you welcome, yes or no? You know, lots of children are - may be - quite a surprise, when the mother felt pregnant. But during the pregnancy, they can change that, they can overwhelm it with love, because they feel, this child has a reason why it is there. And you can help them, contribute to that acceptance, but there are … as well … they took it so seriously they can't move out from that. And so, if you come back to that and say 'I have a feeling that...' or: 'Can you ask your Mum about the first stage of her pregnancy, when she really just found it out?' They always come back with something; it was a shock. It was actually difficult to be pregnant, the father was unemployed, … financial problems, marriage problems … and so, if you know that, as the patient, then you feel 'yes, I can understand what it means for an individual'. I never forget a patient who had already for twenty years this problem. She felt, there is something, that isn't good: 'My marriage is alright, but you know, I know, I have to give him a kiss, but it felt a little bit, it is not coming from my heart'. And when that changed, that was an eye-opener and she said, something has switched.*" (11/23-37).

NUSSELEIN establishes a correlation between the love of a mother to her unborn child and the ability of an adult to give and receive love later in life. It would be helpful for an adult to know about the problems that his mother experienced - whatever the reason was - at the beginning of her pregnancy in accepting her child; and maybe it would even help him understand why it was so difficult for his mother. This description leads us over to the "psychotherapeutic approach" (3.3.5.) because

NUSSELEIN's analysis shows the close relation between ML osteopathy and psychotherapy.

3.3.4.3. FAITH – RELIGION - ERSATZ RELIGION

"*God is the Father of Osteopathy, and I am not ashamed of the child of His mind.*"
(Still 1908, p. 254)

The central question of this chapter can be phrased like this: does being a religious person ease the approach to the ML?
Generally, none of the interview partners think that a religious attitude is a pre-condition. But WUTZL, WEBER and NUSSELEIN think that a "belief in something", a certain spiritual attitude is necessary. I will quote the relevant sections from the interviews now.

Contradicting the statements mentioned above, VAN DEN HEEDE doesn't see the necessity of a certain spiritual attitude; he thinks it will *"develop on its own"* (7/21-24).

WUTZL thinks that *"spiritual antennae"* are helpful, but in his opinion that doesn't have anything to do with religion: *" 'He [the osteopath] needs a certain attitude and a certain wealth of experience to gain enough confidence to see that the ML activates processes that can lead to a patient's health – because health is not the opposite of illness.' Dunshirn: 'Is this directed towards spirituality in a way?' Wutzl: 'Undoubtedly , although the word is well worn, in my opinion.' Dunshirn: 'Well, someone who comes from a religious tradition …' Wutzl: 'No, this doesn't have to do with religion. It could be someone who doesn't care for religion at all. What you really need are spiritual antennae; one needs a place for the perception of stillness to identify stillness; an area for the perception of space and an area for the perception of function without structure. In my opinion, these are the basic conditions.' Dunshirn: 'And anyone could have these?' Wutzl: 'Everyone has them.' Dunshirn: 'Everyone has them, but not everyone knows that he has them?' Wutzl: 'Not everyone knows it, and not everyone wants it. But it has nothing to do with religion and religiousness.' "* (4/26-50)

WEBER also considers a certain spiritual attitude important. One would have to give *"room to the incomprehensible"* (8/13-14). *"We have to dare to step into a space that we can't perceive sensorially anymore. And once that happens, we start getting afraid. That means the principle of the midline is that it's bottomless"* (12/15-17)

NUSSELEIN says: *"I don't think that it is necessary, but it will be helpful that you believe in an energy that is watching over us, and that is an energy, where we are coming from, and we were all connected with that energy. And it doesn't matter if you are a Christian or a Muslim or a Buddhist, we are all connected. And I think that energy, if you believe in God or you believe in Allah or in Buddha that is that energy. And so I don't think you need to be religious. The only thing is, you need to believe that you are watched over. And there is some energy that is only wanting the best of us. And that is sending us here to – well, to have a good life. And maybe a life is always for everybody to learn. Because maybe you are here the first time, a lot of others are here for the second or maybe the tenth time. And what is happening in your life here will help you to come over what has happened in other lives. But this is very philosophical, but I think that is the case."* (6/1-11)

I don't want to leave these quotes completely unexplained. Instead, I will include some statements by osteopaths and non-osteopaths that seem relevant to me in connection with "faith – religion – ersatz religion" here. For example, one of the "old osteopathic masters" shall be quoted. Nathalie Trottier (2006) recounts the following scene in her essay "Anfänge der Osteopathie und Stills Einfluss auf Sutherland" ("The beginning of osteopathy and Stills influence on Sutherland"): *"In 1944, Sutherland was asked whether cranial therapy was a religious concept. He gave the following answer: 'If Still's perception of God as the creator of the human body is religious; the whole concept of osteopathic science will be religious. If osteopathic science is religious, this will also apply to the cranial concept'. "* (Trottier 2006, p. 340)[58]

According to this statement, Sutherland seemed to think that the whole concept of osteopathic science is religious.

I would like to ask the reader to bare this statement in mind to be able to understand to following comments. The osteopathic community is still – or once again - concerned with how much religiousness the osteopathic concept contains. For

example, Martin Pöttner and Christian Hartmann wrote an essay for the magazine "Osteopathische Medizin" about "triune osteopathy" that critically discusses terms like spirituality, philosophy and religion in relation to the osteopathic concept. Since I consider it exceptionally important to define terms – also in relation to ML osteopathy - , I would like to cite the definitions as given by Pöttner and Hartmann:

- *"'**Philosophy'** has to be understood as an individually shaped part of the human quest for founded knowledge and founded practice. A philosophical tendency exists to conceive one's own practice and one's own knowledge in a comprehensive context. In this way, every ordinary and experienced farmer can impersonate an extremely competent natural philosopher.*

- ***'Spirituality'** signifies some form of 'spiritual' concentration on the vital interests and the vital motivations of a human being.*

- ***'Religiousness'** signifies a way of perceiving vital interests 'spiritually'. In accordance with the philosopher Wittgenstein, one could say that religious statements can be seen as 'life's rules put into images'. Therefore they must not be confused with scientific statements."* (Pöttner, Hartmann 2005, p. 19)[59]

In their essay, Pöttner and Hartmann assert that philosophical and spiritual aspects are generally excluded from the health-care system. They note that this dynamic of exclusion can also be found in osteopathy. They express their desire to encourage an interdisciplinary exchange with non-osteopaths in this essay. They hope to avoid the *"sightlessness that robbed American osteopathy of its concepts of 'triune man' and its holistic identity in the course of the 20th century"* (ibid)[60]. According to Pöttner and Hartmann, the term "triune man" was shaped by Still and has the following meaning: *"the differentiated triple unity of Man as **mind**, **body** and **spiritual being** (soul as a principle of motion). **Mind**, **body** and **spiritual being** are permanently interacting."* (ibid)[61]
Their conclusion sounds discouraging: *"De facto, osteopathic philosophy according to Still and Sutherland cannot be integrated into our present health-care system. A so-called holistic body therapy that conforms with the system goes against a 'triune osteopathy' that*

can't be integrated into the health-care system at the moment." (Pöttner, Hartmann 2005, p. 23)[62]

In short, one can say that Pöttner and Hartmann make an appeal for a reinforced implementation of spiritual and philosophical aspects in the osteopathic concept.

Statements by Peter Sommerfeld (2005) also fit into this philosophical-spiritual context. In an essay for the magazine "Osteopathische Medizin" entitled "Osteopathie. Eine quasi-medizinische Spielart des unvollständigen Nihilismus? Versuch einer ontologischen Standortbestimmung" ("Osteopathy. A quasi-medical variety of incomplete nihilism? An attempt at ontological position-fixing"), he offers some criticism, although the direction of his criticism is different. Right at the beginning of the essay he asks whether *"osteopathy can claim to be an art and a philosophy and a science"*. He answers this question, among others, like this: *"It is evident that it isn't a science according to the occidental modernistic understanding of science [...]. As a philosophy – and this is my allegation – the reflection of its principles - if it exists at all and if these principles are not approved dogmatically – lacks methodical stringency and clarity."* (Sommerfeld 2005, p. 18)[63]

In Sommerfeld's words, osteopathy is neither a science nor a philosophy. Following up on this, he explains how he reached this conclusion. He quotes Nietzsche and his statements about "nihilism" and "incomplete nihilism" (I will try to give a short, simplified account of these statements here): "Nihilism" is a condition without an aim. No answer is given to the question 'why?' That means that the highest values are devaluated, that no truth exists, that no absolute condition of matter exists. "Incomplete nihilism" is the attempt to avoid nihilism, to avoid reassessing the highest values. Sommerfeld deduces from these statements that Nietzsche saw *"incomplete nihilism as a certain inability to face the nature of nihilism. This weakness leads to an escape, for example to ersatz religions and to ersatz values."* (ibid., p. 19)[64]

What do these statements imply for osteopathy? Sommerfeld continues: *"There is a tendency of incomplete nihilism in modern osteopathy to confront this monistic perception with an 'otherworld' as a common practice (Monism means replacing the wholeness with material aspects. Nothing else exists beyond). [...] In this sense, osteopathy is more complementary than alternative to conventional medicine. The 'otherworld' fills the vacuum that people (both patient and therapist) have to face through their self-perception, which is*

reduced to material aspects. It is the cold wind of machinery that blows around our ears; osteopathy tries to build a warming fire now and then. This fire is partly nurtured by a vitalistic approach (vital forces etc.) and partly by a naïve platonic dualism (what lies behind the material world really is the crucial factor; all other things are only expressions of energies, potencies etc.)." (ibid., p. 19-20)[65]

Once one understands what Sommerfeld is saying in these statements, one can perceive that harsh criticism is applied to many aspects of the osteopathic concept here. To summarize once more, he is speaking of an 'otherworld' that can become an ersatz religion, a substitute for a remaining emptiness and a warming fire against the cold wind. What is this warming fire and how can it be explained? Here, Sommerfeld's criticism really takes off: *"All these explanations about the 'otherworld' explain precisely nothing. They are arbitrary statements that aim at calming things down for the moment. I would even go as far as saying that they are more often used explicitly as an ersatz religion, which drives the character of incomplete nihilism as defined by Nietzsche to the peak."* (ibid., p. 20)[66]

To put it simply, Sommerfeld criticises the fact that there are too many spiritual and religious contents, which are not precisely defined, in the osteopathic concept; whereas Pöttner and Hartmann criticise the fact that too little attention is paid to spiritual and religious contents. Now we are right in the middle of a wonderful osteopathic factional struggle. I will try to present these opposed positions as candidly as possible and to encourage further discussions. I personally see these differing points of view as inspiring and enriching. This diversity explains to a great extent why I found osteopathy so appealing and accounts for much of the joy that I experience in the osteopathic profession.

The last part of this chapter will feature excerpts from a discussion between cardinal Christoph Schönborn – head of the Catholic Church in Austria – and Renée Schröder – a molecular biologist – that was published in the Austrian daily paper "DER STANDARD" on the 24th of December 2005. I want to point out parallels between the dogmatic argumentation of the Catholic Church and the arguments some osteopaths use.

The subject of the discussion was "Creationism and Science" or "Intelligent Design". The discussion was triggered by a guest comment by cardinal Schönborn in the New York Times from the 7th of July 2005. In this comment called "Finding Design in Nature", he wrote: "*Evolution in the sense of common ancestry might be true, but evolution in the neo-Darwinian sense – an unguided process of random variation and natural selection – is not. Any system of thought that denies or seeks to explain away the overwhelming evidence for design in biology is ideology, not science." (Original quotes taken from International Herald Tribune, www.iht.com/articles/2005/07/07/opinion/edschon.php, 25th of Dec. 2005)*[67]

Further on, he also quotes pope John Paul II. As follows: *"To speak of chance for a universe which represents such a complex organization in its elements and such marvellous finality in its life would be equivalent to giving up the search for an explanation of the world as it appears to us. It would be to abdicate human intelligence, which would thus refuse to think and to seek a solution to its problems." [...] "This finality which orientates beings in a direction for which they are not responsible or in charge of, forces one to suppose a Mind is its inventor, its creator."* (ibid)[68].

Miss Schroeder refers to these statements in the STANDARD discussion and says: *"Where is this goal? I don't see this goal at all. What is so amazing about evolution is that it really isn't in balance. If it were in balance it would actually be dead. That means it must be constantly irritated in some way, and then it must re-adjust itself."* (All quotes in this section taken from STANDARD, original edition 24th of Dec. 2005)[69]

"The goal is missing" is one of Sommerfeld's statements in the article mentioned above in which he describes Nietzschean nihilism. The molecular biologist Renée Schroeder also sees "no goal". Further quotes by Schönborn from the STANDARD: *"I attribute the reasonability of reality to the reasonability of the Creator."*[70] Schönborn also quotes pope John Paul II. : *"This goal that leads all creatures in a direction for which they don't bear responsibility obliges us to imply a spirit that was the creator of this goal."*[71] And finally another quote by Schönborn: *"The faith of the believer needs no scientific support."* (ibid)[72].

Since osteopathy uses terms such as "Breath of Life", "Higher Intelligence", "Ancestral Health", "Potency", "Fluid within the Fluid", etc., and statements such as "The Breath of Life makes the decisions", the following questions necessarily come up: is ML osteopathy an ersatz religion in Sommerfeld's sense of the term? Is ML work not a balancing act between structure and spirituality at all, but rather – in the final analysis - a spiritual act?
Whatever the answer to these questions may be, osteopaths need to pay attention to their phraseology and choice of words to possibly avoid dogmatism in connection with osteopathic concepts.

3.3.4.4. DEATH

„Here you lay aside the long words, and use your mind in deep and silent earnestness; drink deep from the eternal fountain of reason, penetrate the forest of that law whose beauties are life and death. To know all of a bone in its entirety would close both ends of an eternity."
(Still 1905, p. 152)

"*And the patient said that this feeling was fantastic, and that if death was like this, it would be wonderful.*" (WEBER 2004, p. 5/32-33)

This last quote is from a patient that underwent a ML treatment by WEBER and which he spoke of during the interview. This patient came to him with massive symptoms of anxiety, insomnia and overall nervousness. After the second or third therapy, a great calm overcame the patient, and she was freed from anxiety. The quote above about dying was a patient's spontaneous reaction to a ML therapy by WEBER (5/24-33). Reviewing this case, he contemplates death. He speaks of a "*higher life*" in this context in which we are "*embedded*", which doesn't "*die*", and inside which we are also "*connected to our deceased next of kin*" (13/34-39). WEBER also calls it a "*superordinate axis*" (13/12) that reaches beyond our individual lives. Further on, he says that we should make it a life-task to be "*healthy at the end of our lives*" (13/48-50) and that "*dying belongs to health*" (14/12). Individual life has to end one day and

leave room for the *"big organism"* (14/29-30). As a consequence, WEBER sees death as a physiological fact (14/12-16) which we have to confront as long as we live (13/40-42).

For SHAVER, there exists a ML which doesn't end with death: " *'You might say the midline interacts and the body disintegrates over time. It withdraws from the body and that kind of thing. But the midline is still present somewhere.' Dunshirn: 'It's somewhere else then. You can feel that?' Shaver: 'Sure.'* " (14/3-9). In a different section, he says: *„It has no beginning, it has no end and it can't be destroyed.*" (5/31)

NUSSELEIN thinks that the ML ends with death:: *„Well you know, then it doesn't have a function, if it is an energetic ML. The soul is out; you pass away. It depends; with some people the soul goes out a day later, some straight away, when they pass away, some a few hours later. [...] The spirit is out and so the ML is not functioning any more, it is gone.*" (9/10-13)

Following this, she describes her work as a carer for the terminally ill and why she places so much importance on not leaving a dying person alone: "*I think it depends a little bit on the life the patient has had or that human being has had. There are people ... they are really burning out. And so, when it is time to leave, immediately they ... take everything ... and you can sense that, when you are there. It is like something is lifting out of the body. And if you feel the body, you don't feel anything anymore. But there are people, who are saying okay, farewell, but they are still a little bit there. And if you feel their body, it is like – it's still a little bit alive. You can't change it. It is settling down. But the soul can't actually leave the body straight away. And one of my very close friends, when she died it was summer and it was really … it was no wind at all … and it was only one window open, the door was closed, and it was like ... there was a woe wind going through the room. What is this? And then her soul said, okay, it's time to go. So there is something ... everybody is doing that in their own time, in their own pace. And that is the reason why I think it is so important when somebody is passing away, not to say, okay, let him take out of the house or whatever. But to stay there because somebody can be still there coming out and helping you, to get over, to grieve.*" (9/22-35)

In a different section, NUSSELEIN speaks of a treatment during which she had an encounter with death in the form of a bright, white figure: "*I think when the time is there ... and I experienced that once with a terminal breast-cancer-patient, who had metastasis everywhere, and she came into my practice, and I never forget that, there came a very white light figure at her feet end and I did realize, that is the death getting her. So it disappeared, she – it was very funny- she blew it away like it is no time yet. So I was very pleased, I said not in my practice here. Her husband was waiting, what would he say? But she was very open for all this. But when she phoned me a few days later; she was in hospital; she could hardly speak. They would like to give her a chemotherapy - and I said, well, what do you think. And then you can help, what to say. It will not make your life longer; it will not make your quality better. Is that what you always wanted, because you fought against it. And she said, no, it is time to go. And in that way you know, you can't change that. Death is there. It has knocked on the door. You know, what I advised her after the treatment is, do whatever you are able to do and you really want to do. Eating something ...* " (10/19-30)

WUTZL says about the end of the ML: *"Well, I believe that the ML is a constant that probably remains inside the body as long as the body exists. But these are questions that don't interest me, because for me it is there at the moment; at the moment when I can perceive it."* (11/32-34)

For LIEM it ends with death: *"It would naturally end with death in any case, because then the tissue slowly disintegrates."* (12/14-15)

To sum up, we could say that the ML ends with death for NUSSELEIN and LIEM. SHAVER and WEBER believe in a ML that continues to exist after death. WUTZL, VAN DEN HEEDE and TOTH refrain from such clear specifications. WEBER and NUSSELEIN have apparently been confronted very directly with death and dying during their work on the ML.

3.3.4.5. LONG TIDE - POTENCY - BREATH OF LIFE

From a variety of possibly terms that we could discuss here, I chose three that were often mentioned by my interview partners in connection with the ML. They seem to have great relevance for the ML topic. All three terms have been mentioned before in this study. Let's start with the term "Long Tide".

3.3.4.5.1. „Long Tide":

WUTZL equates the Long Tide with the ML (5/5-6). I wrote about this in section 3.3.2.1. ("Structural approach – the significance of anatomy") and quoted Wutzl in his own words there. In a different section, he vividly describes what *"coming into the long tide"* feels like for him: *"The feeling is very clear. You go - once you have really contacted the ML or the ML has contacted you – you get into this rhythm that lies behind neurology; so you leave this 'six–to-twelve' rhythm and get into this very slow rhythm, respectively into this big stillpoint. You realize that you are regenerated and that the patient is fully charged. ML osteopathy is the best insurance you will be able to practise osteopathy until you're sixty, because it doesn't exhaust you unlike other osteopathic methods. That means you don't take energy away from the patient, and the patient doesn't take away your own energy. In a manner of speaking this is zero-energy osteopathy. That means what regenerates you doesn't have anything to do with this energy-event-decline from therapist to patient or vice versa. And this is why I work with waves of health, naturally through the lesion, where I might also get lost in the lesion. I perceive best through the ML what the lesion needs at that moment."* (9/24-35)

Since WUTZL talks about different rhythms here, I want to include a short overview of the three main rhythms that are described in the cranio-sacral concept. I refer to statements made by Sills (2001) here. He summarises the three rhythms as three levels of perception:

*"**1.** **CRI** (=Cranial-Rhythmic-Impulse):*

- *8-14 cycles a minute*
- *Hands float on tissues like corks on water.*
- *Perceptual field narrows to tissue, bone, membrane.*
- *Mind is interested in individual structures and relationships of structures/parts.*

2. Mid-Tide

- *2,5 cycles a minute*
- *Hands are immersed/float within fluid.*
- *Perceptual field widens to hold the whole of the person and the biosphere.*
  (The biosphere is the body and the field of potency and environmental exchange around it.)
- *Mind is relatively quiet, has a wider field, and is in relation with the whole person.*

3. Long Tide

- *100-second cycles*
- *Hands are immersed/float within potency (the fluid within the fluid).*
- *Perceptual field widens to the horizon.*
- *Mind is expansive and still, breathes with the Breath of Life."*
  (Sills 2001, p. 423)

Van den Heede (2002) says about the Long Tide: "*Tide can be compared to a big motion of waves in the depth of the ocean in opposition to the many rhythms of the body that can be compared to small motions of waves on the surface of the ocean. You can only perceive the big wave motion out of which everything else evolves once everything has become totally calm. The body always tries to get to the centre metabolically, biomechanically, oxidoreductively etc.; rhythmically, that means in the direction of the Long Tide. I think its origin is not inside the body. Also in embryology the ovum develops inside a sphere. A wave exists outside the body that one can hardly perceive because one doesn't see it as a part of anatomy. 'Long Tide' is like a wave that permeates the body. It meets resistance in the form of tissue, which leads to the formation of new smaller waves."* (Van den Heede 2002, p. 28)[73]

I already spoke about the different MLs according to Sills (2004) in detail in chapter 3.3.1.3. ("Embryological approach – similar theories by other authors"). He calls one of them "Long Tide". To summarize, he says that the Long Tide is a slow, rhythmical motion that reminds him of the tides, permeates everything and is omnipotent. It is closely related to the Breath of Life, and the notochord and the neural tube develop in relation to this Long Tide (Sills 2004, S. 17). Sills describes the Long Tide many times in his books. Another original quote: "*The Long Tide seems to act like a great wind which seemingly arises out of nowhere. It is the Original motion, which is an expression of the creative intentions of the Breath of Life. The Tibetans call this Original motion the 'winds of the vital forces'. It has a vast field of action and manifests locally as the organizing wind of the human bioelectric field. This can be perceived as centrifugal and centripetal spiral-like motions within a large field of action around the human body. These motions express a dynamic equilibrium in space, and a stable bioelectric form is generated. The action of the Long Tide generates this bioelectric field, which grounds the creative intention in form. This is an expression of the creative intentions of the Breath of Life in which its potency is expressed as a local field phenomenon. This is literally a coherent quantum-level field of light. It can be perceived as an energetic field around and within the body. The Breath of Life organizes space in order to organize form.*" (Sills 2001, p. 37)

Sutherland places great value on the terms "Tide", "Breath of Life", and "Potency" and uses them often in his writings and lectures. I quoted him at length in chapter 3.3.1.3. ("Embryo
logical approach – similar theories by other authors") and in chapter 3.2.2. ("Historical development – what was before Still?"). I would like to quote him once more: "*Rely upon the Tide*." (Sutherland 1990, p. 14)

3.3.4.5.2. „Potency":

The term Potency can't be discussed separately from terms like Long Tide and Breath of Life, because they are so often used together in different combinations. I want to summarize the relevant quotes briefly here.

VAN DEN HEEDE speaks of a *"Potency-Level*", which he equates with an *"electrical level"* and a *"ML-level"* (2/22-27). This was already discussed in chapter 3.2.1 ("Historical development"). In a different section, he talks about certain anatomical structures where one can perceive *"… this delicate exchange, the impression of rhythms, or of the 'Potency' particularly well"* (4/2-4). I wrote about it in chapter 3.3.2.2. ("Which structures can be related to the ML?"). In a different context, he equates this *"small, subtle motion of ML-function"* with Potency (9/1-3).

In Sutherland (1990), one can find the following statement: "*The potency of the Tide is what we have to consider - something with more power in the reduction of membranous articular strains of the cranium than any force you can safely apply from the outside. It will function intelligently. Carry this in your mind and along with it carry the mental picture that comes in answer to the question, 'How do these membranous tissues restrict the fluctuation of the Tide'."* (Sutherland 1990, p. 31). According to Sutherland, this Potency is highly intelligent; it is "*more intelligent than your own human mentality*" (same p. 14).
Sills (2001) makes things even "clearer" by saying: "*Remember that the cellular and tissue world is organized by potency and the natural world is organized by the great Breath of Life*." (Sills 2001, p. 439)

3.3.4.5.3. „Breath of Life" (BoL)

„Without the guidance of the Breath of Life, the patient doesn't get treated, the concept of disease does." (Jealous 2003, p. 11)

WUTZL describes the ML treatment as an *"encounter"* which he can perceive in his (non-physical) heart. For him, it is an encounter with the BoL (10/3-15). I already discussed this statement in chapter 3.3.4.2. ("Love").
The BoL was also mentioned in chapter 3.3.2.2. ("Which structures can be related to the ML?") in reference to the connecting line from the coccyx to the ethmoid. McPartland and Skinner (2006) recount how the BoL transforms into a fluid motion

(for them, this is the Long Tide) that ascends from the coccyx to the ethmoid and then descends in an elliptical curve (McPartland, Skinner 2006, p. 320).
Sutherland (1990) defines the BoL as "*a fluid within this fluid, something that does not mix, something that has potency*" (Sutherland 1990, p. 14) and an "*omnipresent force*" that is also the cause of the primary-respiratory-mechanism at the same time, as McPartland and Skinner describe it (McPartland, Skinner 2006, p. 319). They also describe the BoL as a "*Quantum field force*" (ibid.). I already wrote about this in chapter 3.3.1.3. ("Summary - Sills").

Jealous (2003) assigns a whole list of qualities to the BoL:

- *It can be sensed coming into, and through the body without loss of force.*
- *It brings the ‚not yet' from the future into the moment as a therapeutic potency with the ability to transmutate disease into the Divine form, the Original.*
- *It inspires and it humbles one's presence.*
- *It cannot be 'used'.*
- *It brings the Whole to the part.*
- *It moves slowly but at the point of contact with distortion the action is instantaneous, not sequential; it 'arcs' a spark of life into the fulcrum of inertial forces.*
- *It requires cooperation, as that is its Nature.*
- *Sutherland stated that no force is necessary during treatment and that one can follow the intention of the Breath of Life and serve its potency. This is a literal truth.*
- *One will not perceive a single rate, more like an electric wind moving slowly towards its goal, discharging the Whole into the part and moving on, unchanged.*
- *The power of the Breath of Life is not a sterile electric force, it contains a Living voice that creates and Consciously notices the need of each living being. [...]*
- *Your greatest challenge will be to wait during ‚nothingness' without looking for work to do. Maybe God is pondering or changes are occurring in a private sanctuary in the patient. Wait, hold onto the Wind even if it is still, the air stills as well as circulates.*
- *You are on the threshold of no compromise in your relationship with your Divine-self. The Wisdom of who we are is out of sight for most of us."*

  (Jealous 2003, p. 112-113)

3.3.4.6. SUMMARY AND DISCUSSION

A quite harmless-sounding question – to what extent spirituality is an important issue for (ML) osteopathy – was answered with a multitude of elements and in a very extensive style. And even terms like stillness, love, death, faith, and (ersatz) religion that were discussed here only represent a selective extract; more chapters could be created from the interviews.
The controversial approaches to spirituality in osteopathy were depicted in this chapter. Simplistically, one could say that the critics take one side (see Sommerfeld's comments on ersatz religion and also the reference to dogmatic argumentation inside the Catholic Church with cross reference to possible dogmata in osteopathic explanatory models). On the other side there are those who think that what we do in practice every day wouldn't be osteopathy without spirituality (see Hartmann's and Pöttner's comments on "triune osteopathy" or Shaver's statement "*Osteopathy is a spiritual science, and to teach it as anything other than that is not teaching osteopathy*."(2/32)).

No matter which position one may take in this conflict, there is no denying one fact: spirituality is a commonly discussed issue among osteopaths and it therefore seems to have certain relevance and a right to exist in the osteopathic context. Many statements made by osteopaths, beginning with the founding fathers of osteopathy (Still, Sutherland) unto the authors of our time (Sommerfeld, Liem, Wührl, Pöttner, Hartmann), substantiate this assumption.
Many of the terms (Stillness, Breath of Life, Potency, Long Tide, ...) that swirl around in osteopathic lectures, and often leave more than one student (including myself) with a lot of open questions, find their explanation in the "spiritual approach" in my opinion. I spoke about this confusion of terms in the introduction of my study, and it was one of the mainsprings of this master thesis.

Conclusion: The attributions made here could maybe help to clear the secretive character of many terms and show a way out of the "mysterious speechlessness" that may be agreeable and natural for some osteopaths, but may be excluding to others.

3.3.5. PSYCHOTHERAPEUTIC APPROACH

"The psychoanalyst knows that he is working with the most explosive forces and needs to apply the same care and conscientiousness as a chemist."
(Freud 1915, p. 111, see also Freud, GW, p. 306-321)[74]

Some particular statements made by my interview partners, especially WUTZL, WEBER and LIEM, prompted me to devise a separate psychotherapeutic approach. My own experiences as a therapist and patient played a part in convincing me on how important the reflection of psychic processes in an osteopathic (ML) treatment really is. This applies to the psychic processes of both the patient and the therapist.
I divided this topic into four sections:

3.3.5.1. "Working on oneself": this is mainly about the role of the therapist.

3.3.5.2. "Projection, transference, counter transference": the interaction between the therapist and the patient is the issue here.

3.3.5.3. "ML as a mirror function" ("Spiegelfunktion"), "mirror neurons": here, the anxiety that can be triggered by being confronted with a mirror is discussed. As I will explain later, this can happen both to the patient and the therapist. In this sense this section is also about the interaction between the therapist and the patient with greater consideration of the neurobiological component.

3.3.5.4. "Systemic psychotherapy": this section will examine to what extent it is reasonable and necessary to include elements of systemic family therapy in osteopathic work.

3.3.5.1. WORKING ON ONESELF

" 'The first person that's going to have to make a change is you. Anything that you've ever learned before in your life, forget it!' I tell them [the students], *‚I have no answers here. You're not going to learn anything here, but when you get through, you'll be pointed in a direction to go, and you'll have to find it out the hard way yourself. But you're going to have to drop everything - drop your identity, drop your ‚Doctor' - and just start off with a clean slate when you step up to the table to find out.'* "(Becker 2000, p.39)

LIEM would advise a student seeking help in perceiving and understanding the ML to work *"regularly on oneself, because it is a known fact that one imparts to the patient [...] what one is oneself"* (besides studying embryology) (13/4-8). Further on, he says that *"every tissue in its actual condition also has a correlative on the level of consciousness"* (13/34-35). In his opinion, it would be dangerous to work exclusively with the tissue and *"not to give its counterpart, the subjective, enough space , which it needs."* (13/32-34). This would be *"reductionist"* (13/37). *"The more you manage to combine psychology and work on the structure, the more holistic you will be in my opinion."* (13/40-42).

Liem (2006) says similar things in his preface to a book he published called "Morphodynamik in der Osteopathie": *"The degree of consciousness of the osteopath and his awareness of his own and his patient's sensomotorical, vital, emotional, mental, and spiritual conditions determine to what degree he will be able to discern tissue-energy-patterns in the patient, but also to what degree he will be able to interrelate tissue patterns and energetic patterns with inner dimensions and to observe their significance. The more he can achieve this, the higher the probability of avoiding the formation of new dissociative patterns."* (Liem 2006, p. VIII)[75]

In a different section of the same book, in a chapter called "therapist and therapeutic interaction", Liem (2006) makes some specific proposals (in reference to Montgomery) of what this "working-on-oneself" could be like:

- *"care for one's own health,*
- *work on one's own emotional blocks ,*
- *better time management,*
- *longer consultations,*
- *better continuity of patient care, [...]*
- *communication training,*
- *regular feedback from patients [...] "*

(Liem 2006, p. 239)[76]

Liem (2006) also reminds us that *"Still pointed out that osteopathy starts with trusting your own body. The osteopath must develop this trust in his own body first before he can start to make changes in the patient's body. The osteopath experiences the potential of transformation in every expression of an illness within himself; this shouldn't be given away carelessly by an overhasty suppressive elimination of symptoms. The therapist should induce changes in the patient with reserve before having experienced them himself."* (ibid., p. 240)[77]

WUTZL talks of *"wrong MLs": " 'In refined osteopathy in particular one can include a lot of one's ego and belief in which concept to apply. One can induce wrong MLs in the body; they can be very hard to … well, you really have to recognize them.' Dunshirn: 'So this comes from the therapist, not from the patient.' Wutzl: 'This comes from the therapist. And then there is something that comes from the patient, caused by a lesion, a compensation, where he sets up a wrong ML; that could be car accidents, where the ML is partly outside the body, or problems with gravitation where the body tries to establish a new virtual ML over years of compensation. Then one has to recognize this.' Dunshirn: 'And you would perceive that something – let's say an accident of which you just spoke – pulls you to the side, or …?' Wutzl: 'Yes, of course. One can also clearly define a wrong ML. They have only little … they don't have the ability to compensate. It would be very hard to lead such a ML to a transversal expansion.' Dunshirn: 'But for all that, is it possible to imagine that the right ML could be behind or under the wrong ML?' Wutzl: 'Yes, it could be beside it.' Dunshirn: '…or beside it. So everyone has it, but in some people it …' Wutzl: '… it is superposed by compensation.' "*
(7/46-51, 8/1-22)

Further on he warns against projecting one's own problems into the patient (11/1-2). He says: *"ML osteopathy really leaves the body behind. That means one creates big axes. So the worst thing that can happen to a ML is that the therapist 'falls' into the patient. That means the more I can concentrate on the big axes, in a manner of speaking, the higher the sensitivity and the more I can perceive occurring changes."* (10/46-47). This inner attitude can be discerned in the therapist's posture during the work. *"That would be reflected in the posture, so that I straighten my body slightly upright … and slightly backwards."* (11/2-5).

3.3.5.2. PROJECTION, TRANSFERENCE, COUNTER TRANSFERENCE

This chapter will discuss projections between the patient and the therapist and phenomena of transference and counter transference as predominantly described by Freud (1905). To immediately place this topic in a context relevant to osteopathy, I would like to start with a quote by Wührl (2005) from the "Deutsche Zeitschrift für Osteopathie": *"Osteopathy as an experience demands great durability of the therapist. We must be able to endure extreme emotional intensity that the patients may trigger in us without falling for it or losing ourselves in it. This requires a particular awareness. Since we don't want to do without osteopathy as an adventure, a reflection of the therapeutic experience seems more than necessary. The therapist's transference and counter transference processes are unquestioned parts of self-reflection and supervision in other therapy forms; in osteopathy this is rather an exception. The innocence and pretended neutrality with which we project ourselves into the patient's tissue or with which we open up for projection doesn't seem authentic. What if the projection turns into a projectile? It would do our journey through the patient's tissue a lot of good to take critical self-reflection along in our luggage. In this case, it is inevitable that the issue of the osteopath's experiences will be raised."* (Wührl 2005, p. 29)[78]

The dimension of our therapeutic osteopathic work that Wührl addresses here hasn't been picked up as a central theme in this study so far. Until now the reader may have got the impression that ML osteopathy mainly has to do with stillness, harmony,

calming down, and cosmic love. Here, an osteopath talks about the fact that osteopaths have to endure *"extreme emotional intensity"* and high strains for the first time. It seems advisable to discuss counter transference, projections of the therapist and the necessity of self-reflection and supervision (in a psychological, psychotherapeutic sense) here. Wührl criticises the *"innocence and pretended neutrality"* with which osteopaths approach a tissue. He asks: *"Is osteopathy as an event a therapist's dream or his trauma? [...] What would it be like to follow the suction to the centre of the dysfunction by committing oneself to the patient's forces? What happens when imagination and reality are not always discernible, even for the most astute therapists among us? The black hole could devour us; the patient's imaginations of murder and death could become real. Every treatment would become a hazard. What if reality breaks in and we get carried away? What if our projections turn out to be unsecured bungee-jumps into the vastness of intercellular space? What would happen to our awareness? Would we remain present in the actual events even if our language and ourselves dissolved in the process? We reluctantly speak about the therapist's fears of the event called 'patient'. To see osteopathy as an event would create the possibility of developing a specific language for this part of our practice."* (Wührl 2005, p. 29)[79]

Wührl (2005) invites us to admit fears, to acknowledge the dangers of osteopathic work and not to neutralise them by dispensing them to a *"cosmic dimension"*: *"Although osteopathy presents itself as an event, the problem consists of acknowledging the dangers and fears that are part of it. The threatening appearance of the suction is often deflected, or the suction is dispensed to a cosmic dimension and thus neutralised. It may then seem as if the therapist and patient could first meet in infinity. The forces that threaten to tear us apart in the therapeutic process are thinned down in the cosmic. [...] They scatter in a cosmic space that is filled by an abstract deity that wants to do neither good nor bad to anybody. Whether this is real or a successful projection that replaced the awareness of the therapist remains questionable."* (ibid., p. 30)[80]

What makes Wührl talk about *"fears and dangers"*? My study has offered (some) clues what could be meant here. One of them was NUSSLEIN's description of treating a patient with problems in her neck, for example, during which she experienced a medieval execution scene (see chapter 3.3.1.5. "The germ line or: ML as a time machine"). Another one was WEBER's report of a patient with whom he had

problems over a long period of time: *"Each time I had the feeling my stomach was contracting and my breathing got flat."* (6/40-41) (see chapter 3.3.2.3. "Can purely structural techniques lead to the ML?").

Milne (1999) offers an explanation for these "fears and dangers" when talking about "archaic wounds". According to Milne, Upledger calls this phenomenon an *"energetic cyst"*, Woodman calls it a *"psychotic corner"*, and Grof calls it a "*condensed experience*" ("*COEX*"). This phenomenon can be of physical or psychic origin. Milne explains how archaic wounds can form and how they can be healed: *"As a tendency, they are locked away in the body in some kind of time capsule. Once you reach them, the body tends to close down, to freeze, as if it was shocked. But once enough trust has been established, the memories start to unravel and the time capsule reveals its contents. The client finds himself taken back to the ancient events and lives through all the smells, sounds, images and despairs of the time."* (Milne 1999, Volume 1, p. 180)[81]
One could explain the "execution scene" which NUSSELEIN experienced with her patient with this phenomenon.

In my personal opinion, everyone who works with people, and especially someone who works permanently with his hands on somebody else, has experienced negative emotions that can show up in the process. And I further believe that we are not always able to immediately differentiate whether this comes from the patient or from ourselves. Even more so, we don't always know the cause of these negative emotions, let alone how we should react to them. They could be *"negative transferences"*, as Freud (1912) describes them; this will be discussed later (see Freud, GW, p. 364-374).

Until now, we have only discussed negative emotions, negative transferences and archaic wounds in this chapter. But according to Freud (1912), *"positive transferences"* also exist (ibid.). Examples of this would be a therapist falling in love with his patient or the other way round. What osteopath has not experienced this? And where has one learned to cope with such elemental emotions in a constructive way (constructive in this context means for the patient's own good and his/her healing)?

Let us dwell on this example for a moment (a patient falls in love with his female therapist). Liem (2006) describes in the following quotes why this could signify a positive transference (although he doesn't name it, he is talking about the same thing in my opinion). In his article called "Palpation – the art of perception" (Original: "Palpation – die Kunst des Fühlens"): "*A deliberately performed, respectful palpation which is directed towards the wholeness of the patient addresses the oldest parts of our sensory system; 'these react to palpation, to the sensation of pulling and pressure, to the warmness of the hand and its stroking motions. The person who is palpated in the original meaning of the word feels the lessening of the muscle tone, the deepening of his respiration and its regularity, the improved blood circulation in his skin, and is overwhelmed by these sensations. He/she senses his/her most primitive patterns of behaviour – these are evolutionary primal, and forgotten by consciousness – and remembers the sense of well being of a small child', writes Feldenkrais. Through this palpation, a multitude of impressions is imparted and exchanged, the majority of which arrives in the subconscious.*" (Liem 2006, p. 150)[82]

In another section of the same article, Liem (2006) says "*…that osteopathic palpation is consistent with the warm, loving hands of our mother, which we experienced as children to drive away our fears. Methodological approaches to integrate emotional contents in osteopathic practice exist, but they are scarce and partly rudimentary.*" (Liem 2006, p. 156)[83]

These descriptions of emotions that are triggered by palpation are in fact descriptions of transference phenomena. Because of this, I would like to add a short explanation of the terms 'transference' and 'counter transference' here. Freud (1905) says about transferences: "*They are reissues, replica of emotions and imaginations that are supposed to be evoked and brought to consciousness by the advancing analysis. The replacement of a former person by the analyst is characteristic of this category. In other words: a whole chain of earlier events is not perceived as being past, but as a current, lively link with the analyst. There are transferences that are completely congruent in their content with their archetype except for the substitution. Following the analogy, these are simple replica, unchanged reissues. Others are more artistic; they have experienced a dilution of content, a sublimation, as I call it, and may become manifest in allusion to some subtly exploited particularity of the*

analyst's character or his personal circumstances. Thus these are readaptions, not reissues any more." (Freud 1905, p. 92; see also Freud GW, p.161-286)[84]

In a different passage, Freud (1912) describes the phenomenon of transference like this: *"In a manner of speaking, a cliché (or several clichés) evolves, and is regularly repeated – reissued - in the course of life as far as the circumstances and the nature of the available love objects allow; this cliché certainly is not completely unchangeable by recent impressions. Our research has shown that only a part of these emotions that determine one's love life underwent full psychic development; this part is orientated towards reality, is at the disposal of the conscious personality and is an important part of it. Another part of these libidinous emotions has been blocked in its development, it is kept from the conscious personality and from reality, was allowed to unfurl only in imagination or has remained totally subconscious, so that it is unknown to the consciousness of the personality. Those whose longing for love has not been satisfied by reality have to turn towards each newly appearing person with libidinous expectations, and it is most likely that both parts of their libido – the conscious and the subconscious – take part in this attitude.*

Thus it is completely normal and understandable when the partly dissatisfied person's libidinous cathexis, which is kept ready and full of expectations, turns towards the person of the analyst. According to our assumption, this cathexis will follow archetypes, relate to one of the person's characteristic clichés, or, as we could also say, will include the analyst in one of the psychic 'lines' which the sufferer has built so far. The relevance of the father-imago (following Jung's fortunate expression) complies with the real relationship with the analyst. But the transference is not bound to this archetype; it could also follow the mother- or brother-imago etcetera. The particularities of transferences to the analyst that go beyond the explainable and reasonable become understandable once it is taken into consideration that not only conscious expectations, but also those which are repressed and subconscious, established this transference." (Freud 1912, p. 39-41; see also Freud GW, p. 364-374)[85]

Transference is *"the most powerful lever of success"*, but at the same time *"the strongest means of resistance"* in Freud's words (Freud 1912, p. 41; see also Freud, GW, p. 364-374)[86]

Counter transference is the reaction of the analyst to the transferences of the patient, to put it simply. According to Sandler (1973), different forms of counter transference exist. Here is a list of a few examples:

- *"Resistances in the analyst triggered by activated inner conflicts*
- *Transferences of the analyst*
- *Communicative disturbances between patient and analyst*
- *Personal characteristics of the analyst, which are reflected in his work and can possibly lead to complications in the therapy*
- *Specific deficiencies of the analyst that are triggered by a patient's particularities; also specific reactions of the analyst to a patient's transferences*
- *The 'reasonable' or 'normal' emotional reaction of the analyst to his patient"* (Sandler 1973, p. 110)[87]

Little (1951) says that the *"… very subjective counter transference can show the way to the patient's subconscious. For this reason one should stand by it."* (Little 1951, p. 113)[88]
To finish this, I would like to present a few examples of complications that were caused by counter transferences as compiled by Kemper (1954):

- *"Motherly, wholehearted helpfulness: advice given too soon, explanations given too soon, comfort given too soon. Patient as dependant as a small child. Feelings of omnipotence and unsatisfied affective seeking of contact by the therapist. I am in danger of misusing my patient in the way mentioned above, and retrieving from him what I lack so bitterly if my private life offers too little libidinous and narcissistic satisfaction, and my life situation is lacking in sexual and affective fulfilment.*
- *Impersonal, austere contact. Distance, spartanic harshness – expresses fear of too much softness, compliancy, and kindness*
- *Overly soft and kind: defense against one's own aggressive-overwhelming impulses*
- *As a beginner, I tend to make concessions to my patients, because I am economically vulnerable: too friendly, offering explanations too soon and too anxiously, trying to impersonate a faultless, omniscient expert to stop the patient from changing therapists."* (Kemper 1954, p. 84-85)[89]

These quotes taken 'deliberately' from a big thematic complex should make it clear that definitions of phenomena not unknown to osteopaths have existed for a long time in psychoanalytic vocabulary. In my opinion, the osteopathic community has yet to formulate appropriate definitions.

Wührl (2005) ends his article called "Erfahrungsprozess oder Bungee-Sprung in den Interzellularraum" ("Process of experience or bungee-jumps into intercellular space?") on a very critical note: *"The seemingly abandoned necessity of communicating in common terms in this dimension should arouse our suspicions. The typical scepticism of many spiritual traditions towards language becomes a battle for controlling emphatically charged terms, and their mention alone evokes admiring murmur. Here, language has taken leave as a critical companion and reflective option for describing our awareness."* (Wührl 2005, p. 30)[90]

I would like to end this chapter with the following appeal by Liem (2006): *"An interdisciplinary cooperation of osteopathy and psychotherapy seems to make sense; primary psychotherapeutic and primary osteopathic strategies of treatment could learn from each other and complement each other."* (Liem 2006, p. 156)[91]

3.3.5.3. ML AS "SPIEGELFUNKTION" ("MIRROR FUNCTION"), MIRROR NEURONS

"For psychotherapy, the phenomenon of mirroring did not have to be invented anew because it has been known for a long time (mirror phenomena have been noticed and studied in psychotherapy which is based on depth psychology and psychoanalysis for a long time; they are termed 'transference', 'counter transference' and 'identification'. They found their way into behaviour therapy recently and are called 'resonance' there). The same applies to medicine, and generally to every encounter between someone who seeks healing and someone who understands how to heal. It wasn't clear though until now on which neurobiological foundation these mirror processes take place. Their influence on the healing process is underestimated. When someone visits a doctor or therapist, it isn't only a meeting between a medical defect and a medical or psychological expert. In fact two persons meet, their whose

attitudes and expectations produce intuitive processes of perception and mirroring, which have a stronger influence on the outcome of the treatment than some therapeutic measures." (Bauer 2005, p. 129)[92]

"The ML is possibly a 'Spiegelfunktion' ." (WEBER 2004, p.7/30-31)

WEBER answers the question whether a certain spiritual attitude of the therapist and the patient play a part in ML osteopathy like this: *"Opening this gap can have a healing effect. [...] This attitude is important both for the patient and the therapist. And if [...] I thought I had to produce some kind of scientifically relevant result in my treatment that has to be to perceivable at any cost, and if I were closing this circle between body and soul and would exclude the mind, I probably wouldn't get there.* (7/9-15). Furthermore, Weber says that the patient's fear of opening this gap – not knowing what might happen - can become a hindrance for the effectiveness of ML osteopathy. According to WEBER, this is because *"many remnants may flow into this gap"* (7/15-17). He also calls these remnants *"mirror image"*. He says: *"And once I open the gap after not having opened it for a long time I will get a mirror image of everything I did without the gap until then. [...] One is afraid of that. Because when you look into the mirror ... the midline is possibly a 'Spiegelfunktion'."* (7/24-31). Once this gap is opened, *"the mirror reflects things for which you have to take responsiblity. Some people are afraid of that. That's why they don't open this gap."* (7/35-39)
WEBER says two things in these quotes: firstly, an osteopath who tries to produce scientifically relevant results in his treatments is in danger of ignoring mental aspects. Such a therapist probably is unable to use ML osteopathy. Secondly, a patient's fear of looking into a mirror could be a hindrance for ML osteopathy.

Liem (2006) says that *"… most people are unaware of tensions, frustrations and suppressed emotions that are incorporated in their body"* (Liem 2006, p. 156)[93].

A statement by WUTZL in reference to the question whether the ML could be treated successfully by exclusively structural techniques also fits into this context. He talks of thrusts (these are manipulation techniques applied with high speed – author's note)

and mentions in this context that *"if a thrust is applied here at the right moment, I often experience the phenomenon where people return to themselves, in other words, the ML gets 'medialised'. I sometimes experience it with thrusts, with DOG-techniques in the area of the thoracic spine, when an emotional event is in the background, and this agglutination or [...] this lesion on a structural level is the last tie that holds this emotional lesion inside the body. It often happens that these people start to cry or undergo strong emotional upheavals when they get home. For me, this is a sign that they got out of this physical condition of shock and that their ML has taken over functionality again."* (6/32-40)

These statements have one thing in common: different forms of tension and suppressed, often subconscious emotions exist in a patient, and whenever an osteopath touches a patient, he may get in contact with these elements. What was hidden and stored away in the subconscious can be reawakened in the process of a (ML) treatment, or, to speak in WEBER's words, emerge from the depth of a "gap" (that was opened by a ML treatment), and this can cause diverse reactions within the patient.

Jealous (2002) speaks of a different mirror and a different fear: *"To sit down and look into a patient's eyes - a patient that reflects us – causes fear. Sometimes, it is pretty awkward to recognize that the suffering person is stuck in the same way as oneself. If one allows his mind to remain humble, one can do more for other people and let God's mercy work."* (Jealous 2002, p. 30-31)[94]. The therapist's fear of what he may see in the mirror held by the patient is the issue here.

It is interesting in this context to contemplate the function of so called "mirror neurons". In his book called "Warum ich fühle, was Du fühlst. Intuitive Kommunikation und das Geheimnis der Spiegelneurone" (Translation: "Why I feel what you feel. Intuitive communication and the secret of mirror neurons"), Bauer (2005) says: *"Nerve cells, which can implement a certain programme in the body but also become active when one is observing or perceiving a given individual executing this programme, are called mirror neurons."* (Bauer 2005, p. 23)[95]. *"Mirror phenomena can be scientifically proven by methods like functional magnet resonance imaging."* (ibid. p. 25)[96]

Mirror neurons function as simulators for things that other individuals do. Bauer (2005) describes it like this: *"Actions perceived in other individuals inevitably activate the observer's mirror neurons. They activate a particular motoric scheme in his brain, which is identical to the one that would control the perceived action if he had performed it himself. The process of mirroring happens simultaneously, involuntarily and without any cogitation. An internal neuronal copy of the perceived action is produced, as if the observer was performing the action himself. Whether he really performs it remains his choice. But he can't prevent his resonating mirror neurons from delivering the programme of action that they saved to his inner perception. Whatever he observes will be replayed on his own neuro-biological keyboard in real time. Thus, an outside observation triggers a simulation inside the human being. This is similar to a flight simulator. Everything feels like real flying, even the giddiness experienced in nose-diving; only one isn't really flying. By experiencing the observed action as an inner simulation programme, the observer understands spontaneously and without thinking about it what the other person is doing. This understanding comprises another dimension of analysing the observed action than merely doing it intellectually or mathematically, because it encompasses the inner perspective of the acting person. What the mirror neurons produce in the observer is a mirror of what the other person does. Naturally, perceiving another human being is not limited to inner simulation, but it incorporates this important aspect."* (ibid., p. 26-27)[97]

Mirror neurons are also responsible for a phenomenon we call intuition, according to Bauer (2005): *"Mirror neurons make situations – good or bad – predictable. They generate a feeling we call intuition, which helps us anticipate what is going to happen."* (ibid., p. 28-29)[98]. *"Mirror neurons can complete parts of an observed scene so that it becomes an anticipated complete sequence based on probability. The programmes which are stored by mirror neurons are not devised at random but are typical sequences based on all experiences the individual has undergone."* (ibid., p. 31)[99]. *"Intuitive anticipations can develop in a person even without entering consciousness. For example, one has a bad feeling, but doesn't know why. Subliminal – that means not consciously perceived – cognitions that activate mirror neurons inside of us can be the reason for this. But the ability to develop a feeling for what other people do is different to a certain degree in every person."* (ibid., p. 32)[100]. *"The ability to understand intuitively, which is a gift of our mirror neurons, doesn't protect us from misapprehensions. Perceiving certain scenes can cause the neurobiological mirror*

system to activate programmes that may seem to be an appropriate continuation of the observed action for the brain, but turn out to be erroneous later. The reason for this is the ambiguity of many everyday scenes that could match different serial stories. Past individual experiences will play a significant role in differing interpretations." (ibid., p. 33)[101]

The next statements are of particular significance for osteopaths in my opinion. They want to prevent us from making overhasty opinions and "diagnoses": *"In fact, intuition isn't everything. Reason needs to help where intuition fails. A critical reflection of things we experience with and in other persons retains its indispensable value. [...] One of the weaknesses of our intellectual-analytical apparatus is its slowness. Reflecting on someone else takes longer than intuitive assessment. Mirror neurons work spontaneously and quickly. What they call up is immediately available.*

Conclusion: intuition and rational analysis cannot replace each other. Both play an important role and should be used. The probability of having assessed a situation correctly is highest once intuition and critical reflection reach similar results and complement each other." (ibid., p. 33-34)[102]

Let me sum up: "reflections/mirror functions", "remnants that were locked away inside us", "having to take over responsibility", "experiencing fear", "intuition and rational analysis", … many catch phrases were discussed in this chapter. What do they have to do with ML osteopathy? WEBER thinks that the ML might be a "Spiegelfunktion", as was mentioned at the beginning of this chapter. WUTZL talks about lesions that are locked away in the body and can equal a state of shock. He believes that patients can be freed from this state of shock by ML osteopathy.

Thus both the therapist and the patient can come across these phenomena in the course of a ML treatment. We should be aware of this as osteopaths and be extremely careful and thoughtful in our interaction with the patient (when perceiving, watching, listening, palpating, diagnosing, manipulating, prognosing, discussing …). Self-analysis, self-reflection and supervision should be given highest priority by us therapists.

3.3.5.4. SYSTEMIC PSYCHOTHERAPY

"ML experiences can include helping the patient in a process of cognition and comparing how the ML feels before and after. One surely can teach these things. It takes a lot of instinct which you only develop by doing these things."
(WUTZL 2005, p. 12/30-34)

WUTZL used the term "family constellation" in our interview when speaking of treating twins, triplets and quadruplets. I will quote him here directly one more time (I used the same quote in chapter 3.3.1.4.): *"Dunshirn: 'So they had a common ... ' Wutzl: '- a common ML.' Dunshirn: 'And so it could feel as if one child wasn't inside the body, but displaced?' Wutzl: 'Correct. And if you don't incorporate the other one, you will not reach a therapeutic result. Dunshirn: 'So you have to treat them together because they have a common ML?' Wutzl: 'Right. In the majority of cases, they become autonomous over the course of time – several years - to a degree that they can each incorporate themselves, in a manner of speaking. But this process of incorporation must not happen too fast, because their interlinking connection can often be very important. Even more so if a third child died in the womb, for example. Then you also have to incorporate that one.' Dunshirn: 'Then it gets even more complicated.' Wutzl: 'This is similar to a 'family constellation', and you simply have to work with the ML here as well. This is another particular phenomenon of the ML."*(8/29-51)

The term 'family constellation' is inseparable from the name Bert Hellinger. Let me give you a brief overview of him and his therapy system here. Bert Hellinger studied philosophy, theology and pedagogy and became a Catholic priest. In the 1980s, he developed the so-called systemic family therapy (Hellinger 2002, see cover text "author" in: "Zweierlei Glück. Konzept und Praxis der systemischen Psychotherapie").
Thomas Schäfer, an alternative practitioner and psychotherapist in Germany, wrote a book (2000) called "Was die Seele krank macht und was sie heilt" ("What makes the soul ill and what heals it"). He is a personal acquaintance of Hellinger's, who supplied him with material for this book. Schäfer also included personal conversations with Hellinger (Schäfer 2000, p. 12). He writes about Hellinger's

systemic psychotherapy: *"According to Hellinger, we are not as free as we would like to believe. If we act without acknowledging our bounds, these actions are not free but blind. Acting freely can only result from belonging to a system (family). A system is defined by a multitude of elements, which are interrelated in a particular way. Each change in one element will automatically affect the other elements. Every human being is part of a family system, which also is a system of relations. Because of this, he takes part in his family members' problems, either knowingly or unknowingly."* (Schäfer 2000, p. 20)[103]. In a different section, Schäfer (2000) describes this in more detail: *"In Hellinger's work, the family is seen as a system; no one is able to withdraw from it easily. Our parents have parents themselves, and come from families with particular fates. All this has an effect on the present family. Something terrible that happened in the past has consequences over generations. The aim of family constellations according to Hellinger's design is to bring these subconscious interrelations to the fore and allow the original love to flow again."* (ibid., p. 24)[104]

According to Schäfer (2000), a family constellation reflects the subconscious of a family system like a dream reflecting the subconscious of a dreamer. A classical family constellation will look like this: clients and therapists sit in a circle, and a client positions his original family, for example. He then asks individual participants to play the part of a family member. *"In this way, father, mother, siblings and a person who represents the client are selected. The therapist makes sure that no unloved or unspoken-of family members like illegitimate children, stillborn children, and inmates of psychiatric institutions or former fiancés are overlooked. For all of this, the therapist needs only little information. [...] Once all family members are named and selected, the client concentrates, takes the representatives by the hand and positions them in the room according to his inner image. Through this, representatives establish a relation. Following this, the client can sit down. The visible layout of the family constellation alone can already shed light in some cases. [...] Once everyone established a relation, the therapist asks the representative how they feel physically and emotionally and what they feel towards the other family members. Time and again it is amazing in how much detail the representatives can represent the family's history even though they are total strangers. The representatives feel as if they were real family members. [...] After all family members, meaning their representatives have reported how they feel, the therapist adjusts the position of the family members until an arrangement is found in*

which everyone feels comfortable. Looking for a solution helps the whole family, not just the client." (Schäfer 2000, p. 26-28)[105]

Schäfer (2000) quotes an answer given by Hellinger to a journalist's question (Gabriele ten Höve, 1996). She asked him how strangers could possibly feel like real family members in such a constellation. His answer was that he didn't care for theories; he was working with what worked. He said: *"There is a depth where everything flows together. It is outside of time. I see life as a pyramid. On top of it happens what we call progress. Deep down, future and past are identical. There, only space exists; without time. It happens in some situations that one gets in contact with this depth. Then, one recognises regularities for example, regularities that are hidden, and then one can touch something bigger in the soul."* (Schäfer 2000, p. 36)[106]

In the line of Hellinger's argumentation, certain parallels to the current ML discussion can be detected. Sentences like 'I work with what functions, I don't care for theories' or statements about the depths that exist outside of time and have secret regularities could be taken from an interview about the osteopathic ML as well.

Conclusion: after all these comments, it is obvious that an osteopath who works on the ML can also get in contact with the patient's whole family system. According to WUTZL, it is even imperative in paediatric osteopathy to take these phenomena into account and include them in the therapeutic situation when treating twins, triplets etcetera; this means treating these children together for example because they can have a common ML.

The question could be whether an osteopath lets himself be drawn into a system or whether he can create new orders here. But how can he do it? And where does he learn it?

I quoted Freud at the beginning of the chapter "psychotherapeutic approach", and I would like to end this chapter with the same quote and a question that follows it:

"The psychoanalyst knows that he is working with the most explosive forces and needs to apply the same care and conscientiousness as a chemist." (Freud 1915, p. 111, see also Freud, GW, p. 306-321)[107]

Does the osteopath know this as well?

3.3.5.5. SUMMARY

Starting with my interview partners' statements (WEBER's reference to the mirror function of the ML and WUTZL's reference to family constellations as a special phenomenon of the ML), this chapter was dedicated to phenomena that have long been defined and scientifically discussed in psychotherapy, whereas a definition of terms and a detailed discussion of these phenomena have not yet been achieved in the osteopathic context.

A discussion followed about 'working on oneself', the necessity of critical self-reflection and supervision, the ability to work under pressure (which osteopathic work demands from the therapist), the dangers inherent to any treatment, *"the suction to the centre of the dysfunction"* (Wührl), *"wrong MLs"* (WUTZL), *"archaic wounds"* (Milne), and *"the worst that can happen to a ML"*, which is a therapist *"falling into a patient"* (WUTZL).

The topics of transference and counter transference were mentioned. I have to say though that the presentation of these terms was only fragmentary and part of a vast complex. The main intention here was to point out the relevance that these terms could have for osteopaths.

The ML as a mirror function (WEBER) as well as a neurobiological explanatory model (Bauer) for this phenomenon was discussed. Another issue was the relation of intuition and rational analysis; "faster" intuition was set in contrast to "slower" critical reflection. The osteopath should think about the significance of intuition and critical reflection in his daily therapeutic work.

At the end of this chapter, family constellation (Wutzl) and systemic psychotherapy (Hellinger) and their relevance for osteopathic work were discussed.

3.4. THE ML IN OSTEOPATHIC PRACTICE

"Treating someone is actually the simplest thing. All techniques can help, all techniques are useful!" (VAN DEN HEEDE 2005, p. 6/44-50)[108]

"We are not treating lesions. We are supporting health and its manifestation. Health already knows how to treat the lesions. Any idiot can find the lesions!"
(SHAVER 2005, p. 5/35-38)

"The necessary basic setting is relaxed curiosity. Not a curiosity that pokes around and tries to dig out the onions to see whether they grow or not; rather a receptive curiosity."
(WUTZL 2005, p. 12/40-43)

This chapter's aim is to find out how much practical relevance the previous ML discussion has and how the insights derived from it could be applied in practice. From a multitude of topics, I chose some key issues. Other areas that have already been discussed in detail will only be alluded to shortly. The thematic focus will be on topics that haven't been specifically discussed until now.

I have created five subchapters:

- Section 3.4.1. "How to administer a ML therapy?" will discuss the possible handholds that can be applied to a patient. Further on, general guidelines for an osteopathic (ML) treatment will be summarized.
- Section 3.4.2. will explain the so-called "écoute". This is a special osteopathic 'listening' technique used in diagnosis. Since it is my assumption that the écoute has a strong significance for assessing the actual condition of a patient's ML, this topic will be mentioned here.
- In section 3.4.3., "meditation – concentration – awareness" will be the issue, including their relevance for preparing a ML treatment. Six out of seven interview partners mentioned these terms as a topic.

- Section 3.4.4. is about "visualisation" and its significance for ML osteopathy. Five interview partners referred to this subject.
- Section 3.4.5., "the ML in horse osteopathy" can be seen rather as a kind of postscript. Since I found out that a ML technique exists in horse osteopathy, I wanted to add it here.

3.4.1. HOW TO ADMINISTER A ML THERAPY?

"Dunshirn: What would you suggest to a student that wants to understand and perceive the ML better? Wutzl: 5000 patients! (Laughter)" (WUTZL 2005, p. 12/7-12)

Liem (2006) describes "three therapy steps" in his chapter about treatment principles. He considers them to be relevant for every osteopathic treatment. I want to reproduce this description here because it seems to me to be consistent with ML treatment.

"Three therapy steps:

- *The first therapeutic step is to get in contact with the patient's inherent stillness and with the homodynamic forces in the organism.*
- *Step two diagnoses the abnormal tension patterns and the subtler energetic patterns and investigates the fulcra around which these patterns are organised or are being organised. In the process, tissue tensions are correlated to the dynamics and interdependencies of the objective and subjective factors of the patient's inner (physical, emotional, mental and spiritual levels of consciousness) and outer world (socio-cultural environment, environmental influences etcetera).*
- *Step three encompasses the establishment of some kind of therapeutic fulcrum, around which motion/energy can organise itself in a way that allows the development of a higher-ranking integration by dissolving the abnormal patterns of tension and energy."*

  (Liem 2006, p. 264)[109]

The importance of perceiving stillness and understanding the fulcrum and the physical, mental, spiritual and emotional levels of consciousness is stressed in this description once more.
The following quotes refer to a special kind of intelligence and an indestructible primary healthiness that principally exist in human beings and can be used as a guide through a therapeutic session, according to some interview partners.

WUTZL says *"I gather best what the lesion needs at the very moment through the ML"* (9/35). He explains what he means with an example of a patient with a "frozen-shoulder" problem. One tries to find out *"where health is in the lesion, where the range of movement is in the lesion. One can only heal a frozen shoulder in this way, well, and sometimes it works and sometimes it doesn't. One has to put this into perspective of course, but it has happened more than once. Simply put on your hand, and where is the minimal motion in this blockade? And the whole tissue can release via this minimal motion then."* (9/40-44).
WEBER experiences a ML treatment similarly. He describes it like this: *"I am looking for health. I don't have to protect myself. There are patients with whom it is a bit harder to find this health, but in theory it is always about finding the part which is perfect."* (15/9-11).
I want to include another quote by Liem (2006) here that tries to express the same thing in other words in my opinion: *"It can become necessary to focus a part of one's awareness on the centre of the dysfunction in the course of a treatment. Despite of this, the treatment has to be deeply rooted in health – that means in the patient's available resources – and always has to remain in contact with these resources while synchronising with the centres of dysfunction."* (Liem 2006, p. 264)[110]
Another aspect of this chapter is dedicated to a question that will probably be on the tip of the practitioner's tongue: how do I concretely administer a ML treatment and where exactly should the hands be placed?
NUSSELEIN says, *"It is not necessary for you to have the ML between your hands!"* (7/31). In VAN DEN HEEDE's words, it is more about *"being able to receive the tissue information"* and a *"synchronisation of patient and therapist"* (7/38, 28-29).
Those who still find all this too vague and want to get more concrete "clues" can be helped. Liem (2006) describes twelve ML techniques in the book "Morphodynamik

in der Osteopathie" in a chapter called "Midline - Entstehung und Einführung" (Midline – formation and introduction"), including concrete specificities of their application. Short and simple, these techniques can be summarized as follows: in reference to Van den Heede's "theory of the tripartition ML" (see chapter 3.3.1.1.), the hands are placed upon different anatomical reference points (as described by Van den Heede) in different combinations, for example on the coccyx, the sacrum, the sternum, the inion, the SSB, the navel, etcetera. A notochord – technique according to Jealous is also described (Liem 2006, p. 306-311).

In the second volume of his book "Aus der Mitte des Herzens lauschen. Eine visionäre Annäherung an die Craniosacralarbeit" ("The Heart of Listening: A Visionary Approach to Craniosacral Work"), Milne (1999) describes an exercise called "human centre": *" 'human centre' is an acupuncture point (governing vessel 26) situated at the low mark of the anterior spina nasalis curve. You get into contact by using a middle finger's nail. You encompass the great wings of the sphenoidale with the thumb and middle finger of the other hand; meanwhile, the metacarpophalangeal joint rests upon the glabella with a significant physical and energetic touch. From the "human centre", you direct energy inwardly to the hypothalamus, which is the cerebral centre of identity and the central indicator of alertness. You let this energetic line impinge on a cross line, which stretches medial between the wings. Finally, you direct an energy vector from your glabella contact to the hypothalamus. This technique helps people to center their consciousness, to 'come home' to the place where a deeper level of identity exists. It has a deeply stabilizing function."* (Milne 1999, p. 288 & 303)[111]

There seems to be no limit to the imagination of handholds.

I deliberately kept this chapter a bit shorter, because specific techniques and handholds may be very helpful for a beginner in this field, but were not given much importance by my interview partners. It really seems that the different approaches and phenomena already discussed in this study (in other words, what's behind the techniques and handholds) embrace the essence or character of the ML more completely than specific handholds.

3.4.2. "ÉCOUTES"

"Écouter" is originally French and means "to listen to, to hark, to hear" (online dictionary: http://www.wordreference.com/fren/%E8couter, 29.11.2006). In English osteopathic literature, it is generally translated as "listening" (author's note).

This chapter can be seen as an insertion since it bears no direct reference to the interviews, but is in line with the context in my opinion.

Écoute tests, which are important for making diagnoses, are taught in osteopathic training in varying forms. According to Paoletti (2001) it is assumed that *"... fasciae have a 'memory' that is used to store the various traumata (in the broadest sense) that the individual experienced in his life inside the connective tissue. It is the therapist's job to reveal the traces of these memories and, if possible, to remove them or at least tone them down."* (Paoletti 2001, p. 194)[112].

In his book called "Faszien. Anatomie - Strukturen - Techniken. Spezielle Osteopathie"(2001), he describes the procedure in this test very accurately: *"In the écoute test, a hand is put on an arbitrary body area to perceive possible changes underneath. The hand remains totally passive and receptive to be able to sense even the smallest changes. [...]*

Some basic conditions for carrying out an écoute test have to be provided. Naturally you can't carry out an écoute test spontaneously. Extensive training is necessary to refine the sensitivity of the hands. At the same time, you have to admit the idea of being able to sense the most delicate motions with your hands. A good test process depends on a variety of factors:

- *manual contact*
- *tuning in on the patient*
- *your neutrality as a therapist [...]*

Your hand has to be placed flat on the examined area and the contact of the hand should be as widespread as possible. [...] The hand rests upon the tissue in a relaxed way with its own

weight, but has to cling to it as firmly as a vacuum cup at the same time. It is 'glued' to the tissue and can easily follow every motion this way. The écoute test is the most refined form of palpation. Since the tissue stores the past in its memory, it is your job to read the patient's history that is recorded in the tissue. A passive dialogue develops, in which the patient is no longer in command of the information that comes from the fasciae, but starts to communicate with you on a subconscious level. [...] One has to approach the patient and his tissue very respectfully and act as if asking to be allowed to get in contact with them. Deciphering the information that is stored in the tissue requires absolute neutrality. You should therefore approach the tissue without preconceived idea and remain in a neutral condition that solely serves to listen to the body, serves the écoute…. [...] The test can localise certain problematic areas, but it isn't sufficient for a full diagnosis, of course. Carrying out the écoute test in standing position displays the fascial dynamics in the overall body mechanics. Interestingly, the fasciae are generally affected as well in depressed persons. The patient has to be treated with care, because they are in danger of falling backwards. You should always be prepared for this to be able to catch the patient if necessary." (Paoletti 2001, p. 195-198)[113]

This quiet listening to the patient's body, which is a precondition for carrying out an écoute test, seems to be particularly appropriate for an experienced osteopath to gain a first impression of the patient's ML relatively fast. In my experience, the écoute in standing position - with the therapist's hand resting on the highest point of the patient's head (vertex) -, and the écoute applied at the patient's feet in dorsal position, are particularly significant.

3.4.3. MEDITATION – CONCENTRATION - AWARENESS

"I really think that people are unable to learn to deal with awareness without spending time alone, in pure, untouched nature. I don't think it is possible otherwise."
(Jealous 2006, p. 8)[114]

"Alternate forms of consciousness that can be found in dreams, poetry, music, painting, or in cultures outside the western world (e.g. meditation or trance) are underdeveloped in our society. By limiting our knowledge to what can be proved in reductionist experiments, the human mind has been kept out of western medicine successfully."
(McPartland, Skinner 2006, p. 349)[115]

For WUTZL, who started meditating long before getting in contact with osteopathy, ML osteopathy is *"a synthesis, in a manner of speaking, where meditation congregates with osteopathy"* (4/10-11). In a different context, he says that ML osteopathy is *"also really like meditation for me. [...] A meditation over the tissue, over the patient; and everyone involved benefits from it." (Laughter)* (10/15-20)
WUTZL shares experiences in meditation outside osteopathy with LIEM. LIEM says that he had his *"… deeper experiences outside osteopathy, not within it. Experiences that touched me happened more in meditation or in psychotherapeutic training, and less so in osteopathy"* (4/40-42). He personally practises *"… two hours of yoga and one hour of mediation, six days a week."* (6/34-35). He instructs his students to focus and to earth themselves before placing their hands on a training partner to *"… restore oneself in a certain kind of neutrality, in a manner of speaking."* (6/44-51). For LIEM, it is essential to orientate on a *"dimension of infinity"*. *"But this doesn't take long, about a quarter of a minute. [...] The more often you do it, the quicker you will become."* (7/18-21)

TOTH also practises a short meditation every day before commencing treatment: *"I connect my ML with the ML of the earth and the ML of the solar system and [...] try to sense it and to integrate myself in nature."* (4/13-15)

WEBER also describes a certain, short ritual prior to treating patients: *"Before I start a treatment, I always get in contact with the stillness outside of the patient, in space; I synchronize with that and search for the stillness inside the organism. The midline expresses stillness, I can find this stillness everywhere."* (16/7-10). This doesn't take him long: *"It is only a moment. I sit down and take in the stillness."* (16/23-27)

NUSSELEIN agrees with her male colleagues that preparation before starting a treatment is important: *"It's important that you centre yourself; so coming back in your own ML, to be as receptive as possible. And if you are not in your ML, you will see that you don't recognize that in your patient." (5/41-43). "It is easier to be in your own ML. Otherwise you give problems over and you start to get frustrated." (12/34-35). "You have to sit very much grounded, because otherwise you take it in or you give far too much out. So it is enormous important that you know, okay, this is mine. I have enough energy. I can pick things up; I can give things back to support. I have an understanding what is happening, but it can't touch me that much." (13/13-16).*

VAN DEN HEEDE calls this condition – a special kind of awareness that is indispensable for him – *"devotion". "It doesn't work without it".* One should *"synchronise oneself"* to be able to *"reach a Stillpoint"* (9/25-33).

A few osteopaths have made clear appeals to *"awaken and train awareness"* (McPartland, Skinner 2006). McPartland and Skinner (2006) created an independent chapter about this topic. In it, they describe intuitive and instinctive skills that are *"… part of an embedded natural system of communication and relation with the earth. These skills are in danger of atrophying like an unused muscle when they are not applied. Intuition and instinct are available from birth. But they wither from lack of use caused by social and pedagogical demands. Intuition, instinct and perceptive forces are dulled by stress and the strains of urban life and professional careers. The places where BOFC training sessions (Biodynamic Osteopathy in the Cranial Field - author's note) take place are chosen very carefully. Nature must be accessible to be able to learn from it. Jealous personally experienced in the wilderness of Canada and New England how the deeper self, the human mind, surfaces through the encounter with nature. The 'enchantment of the senses' in nature calms down the*

central nervous system and leads to a dissolving of the boundaries between the individual and the wholeness." (McPartland, Skinner 2006, p. 358)[116]

Jealous (2006) tries to accurately describe how one can reach this particular awareness and which obstacles appear: *"Basically, osteopathic training creates something very limiting: we tell our students to place their hands on the body and be aware, as if they knew what that means. One can't simply fetch someone who is used to sitting in front of a computer or a TV [...]. We have to teach the students to allow their awareness to remain natural. Most people have no idea how they should use their inner perceptions. They simply have no awareness of it."* (Jealous 2006, p. 7-8)[117]
This particular awareness Jealous talks about seems to be very hard to access for people in our day and age, who are so dependent on computers and television. According to Jealous, it is a very difficult task to *"place the hands on the body and be aware"*. How can one make students use their inner perceptions? Here, Jealous says: "*The first principle of learning to work with awareness therefore is learning to divide one's awareness between the therapeutic forces and the lesion area in the patient. We teach them to concentrate not only on the lesion, but also on the presence of the primary respiration as a whole. Therefore, we start to divide the awareness between the local processes and the systemic processes. . [...] So we have to educate people to open and widen their awareness."* (ibid.)[118]
Jealous also wants to point out the way people in the western world use their eyes, the way we look at things: *"We have to get rid of all the bad habits. People stare: they are used to staring at a television, to staring at a computer. Additionally, a lot of eye contact exists in the western world. Therefore, no one is used to looking at a person he is talking to as if he were sitting in an ocean. [...] So we teach the students to see the background and the foreground - both together, until we are able to bring the background to the foreground. Once we have brought the background to the fore, we can create a new background for it. In the end, everyone is able to observe the therapeutic process as well as the lesion area at the same time. So awareness is really an important thing."* (ibid.)[119].

Let me summarize the last paragraph: Jealous prompts us to look not only at the *"foreground"* and remain there with our awareness, but to bring the background to

the fore by blurring the focus; then our awareness, our consciousness can widen. (A small insertion by the author: could it be that Freud had similar reasons when he invented his famous couch and placed himself behind it during an analysis, to remain invisible to the client and to avoid looking permanently into his eyes, possibly because this would make "free associations" easier?)

Jealous warns us that we should not believe that this process of widening the awareness and opening up to inner perceptions can be carried out quickly and easily: *"If one wants to attend to one's awareness, one has to spend a lot of time on reacting to information that reaches the senses. [...] We must learn to let our mind be quiet – let it be quiet, not keep it quiet – and how to let it perceive a completely different aspect of information. [...] In addition, no supporting system exists for this. If you decide to work on your awareness and to care for it, you won't be getting much support. You really have to let yourself fall into it. It is absolutely necessary."* (ibid.)[120]

If one takes the risk of working with patients in this way – and ML osteopathy complies with this approach in my opinion – one's efforts and endeavours will be rewarded: *"We know that blood pressure is reduced and the pulse and respiration slow down in the process. We know that it enhances your patience. And it gives one a feeling of being a part of life in a magnificent way instead of only identifying oneself with the 'humble profession'."* (Jealous 2006, p. 7-8)[121]

Fulford (1996) seems to have had similar experiences to Jealous' in the course of his many years in the profession. He describes them in other words, but with a similar quintessence. He dedicates a whole chapter to meditation in his book "Dr. Fulford's Touch of Life". In it, he praises the amenities of regularly practised meditation: *"When people ask me if I know any other secrets to obtaining good health, I tell them I do: a quiet mind. A quiet mind leads to a more thorough understanding of your body, and with that understanding comes the knowledge of health. Those still interested then ask how to help the mind become quiet. The answer to that is meditation. Not that prayer can't be useful, too, but prayer has a drawback: too many of us have been taught that prayer should be directed toward a God who exists outside of us, rather than within us. The advantage of meditation is that it can draw you inward, which is the state necessary to improve your health."* (Fulford 1996,

p. 125-130). Fulford speaks about a "*quiet mind*", which not only bestows one with long lasting health, but also with an understanding of one's own body and a knowledge of its inherent self-healing forces. Meditation is the path to this *"quiet mind"*. The advantages of regular meditation are manifold: "*Meditation can also help you become more radiant, because you're not burning up your vital force on a condition that's tearing you apart inside. And it helps you overcome the stress of today's chaotic environment. In the long run, meditation can also help you progress toward spiritual evolvement, because by helping eliminate negative thought patterns, it will guide you toward a better appreciation of the world's magnificence.*" (ibid.)

To end this, I would like to add his relatively concrete advice for learning meditation: "*There are many varieties of meditation. To discover which one works for you, simply sit and try out different methods. It's best to start without a guru or a mantra or a religion or a list of what's right or wrong. Just sit down, close your eyes, and try to stop thinking about your daily life and clear your mind. [...] Stopping your thought processes takes discipline, but it isn't impossible. As thoughts appear, don't pay any attention to them. When you first start to meditate - and maybe for a long time afterward - you won't be able to keep hundreds of thoughts from popping into your mind. Don't hang on to them. Just listen to them, say hello, and then let them go. Another thought may appear right afterward. Repeat the procedure - acknowledge the thought's presence, and then let it go. [...] Be patient, and your patience will be rewarded.*" (Fulford 1996, p. 125-130)

What Fulford promises here – similarly to Jealous – is a reward for our patient efforts to reach a *"quiet mind"* or to train the *"perception of our inner awareness"*. I want to end this chapter with this comforting and animating prospect.

3.4.4. VISUALISATION

"*Anatomy is taught in our school more thoroughly than in any other school, because we want the student to carry a living picture of all or any part of the body in his mind, as an artist carries the mental picture of the face, scenery, beast, or anything that he wishes to represent by his brush. I constantly urge my students to keep their minds full of pictures of the normal body.*" (Still 1902, p.9)

"*It will be necessary to stretch your imagination many times in order to understand the normal for your patient. The perfect anatomical picture is a necessary background for understanding what you see in many living heads. It is a process, and it is simple if you look and feel with an understanding of what adaptations are possible. The goal with your patients is to find the way to healthy function within the mechanism that they bring to you. You need the perfect mental picture to guide you, but it is not beneficial to undertake to impose the ideal upon the head as you find it.*" (Sutherland 1990, p. 6-7)

Two different meanings are attributed to the term 'visualisation' in this chapter. Firstly, it represents a concrete image of anatomical structures that one should create internally during osteopathic work, as described in the quotes above. Secondly, it means images that can help to understand, diagnose and treat the ML, visual impressions that can form in the course of ML work.

Still's and Sutherland's plea is that an osteopath should visualise the anatomy and physiology of a normally functioning, healthy body in mental images, and that theses images should be available all the time.

Becker (1997) also fully agrees with this by saying: "*You, as the physician-student, create techniques based on understanding the mechanism, visualizing what you think should be for that area, and then developing techniques as you understand the mechanism for each individual case and each individual patient. In other words, you are given lots of room for experimentation, as long as you obey the laws of the science of osteopathy. You will get results in proportion to your knowledge and your developing sense of touch.*" (Becker 1997, p. 9)

It is easier to discern the aberrances of a norm - a patient's dysfunctions - if one can visualise the "ideal" anatomical image.

Abehsera (2002) describes this process like this: *"Where bonesetters mainly used force and healers mainly used the mind, Still used both force and the mind. His hands and his awareness federated, and they massaged the surface and the depth together. Nowadays, osteopaths call this ability 'visualisation'. Still was exceptionally talented in this. He believed that he was able to 'see' organs underneath the skin, which enabled him to 'move' the ureter, the bladder or the intestine with an identical handhold or motion of the hand. One should realize what 'visualisation' means in the osteopathic tradition. Visualisation implies a belief in the direct connection between the therapist's awareness and the patient's living matter. The therapist's thoughts are fulfilled inside the patient. It is true that Still took this 'vision' from the 'healers', but he fundamentally transformed his teachers' ideas. [...] His hands stopped working on the patient like hammers and became concrete extensions of his thoughts. His hands could sense as deeply as his awareness could visualise."* (Abehsera 2002, p. 26-27)**[122]**

The importance and significance of anatomy for the osteopath have already been discussed in chapter 3.3.2.1. ("Significance of Anatomy"). The specific structures that are relevant for ML osteopathy were presented in chapter 3.3.2.2. ("Which structures can be related to the ML?") in detail. Because of this, I don't want to go further into these issues here.

Besides anatomical pictures, many other images that can be helpful for the perception of the ML have been mentioned in this study. Examples for this are embryologic structures and development processes (3.3.1.), the fulcrum (3.3.3.2.), and the ML as a mirror (3.3.5.3.). All these can be helpful concepts for a person with a visual disposition in context with the ML.

I would like to present some new images now that were mentioned by my interview partners. Especially SHAVER made several suggestions in this respect. There are special handholds, for example, the so-called "Becker holds". SHAVER describes

them like this: "*Becker holds are basically as though you were holding a bowl of water, and holding that bowl of water ... seeing if you can sense the point of stillness in that bowl of water. And whatever hold it takes for an individual to do that. It's a hold that looks like you're holding a bowl of water, and that may apply anywhere on the body. So you can [...] feeling motion, looking for the stillness in that motion. The stillness from which all the motion comes. And that's your reference centre, and that will be the ML in that particular bowl of water. So, to be able to perceive the ML, you have to be able to perceive the stillness.*" (10/40-47)
One could also visualise a tube: "*The most literal picture would be that it is a tube of some diameter, highly variable diameter*" (12/33-34) "*and water running down the drain in the tube*" (14/38). Another picture that SHAVER offers is a hurricane: "*It's just the same as looking at a hurricane. Where is the power of the hurricane? It's in the stillness of the eye. You can pick any arm of the hurricane or any place in this world and track it back to its origin, which is in the stillness in the eye.*" (14/35-37). Or a galaxy: "*So you can look at the galaxy.*" (14/37)

Interestingly, NUSSELEIN and LIEM have different visual impressions depending on whether they encounter a powerful, energetically charged, "healthy" ML or a weak, "unhealthy" ML.

NUSSELEIN describes a "positive" ML like this: "*I see that more as an energetic beam of light. And when the light is switched on, then it is like - that's great. And if you see the light, it radiates, and that is what I see with the anterior and posterior ML. The radiation is a kind of flow around that ML. When you have treated somebody [...] you see that very light. It's really – it's not black, it is very light. It depends a little bit, how spiritual a patient is. If you have a really spiritual person, maybe, they don't know, maybe they don't know themselves, but then you can see a different kind of light. You see a little bit of blue light, or pink light, or purple light.*" (9/44-51, 10/1-3). She describes the „negative" ML like this: "*Very low and dark. It is really like the light has gone. And sometimes that is the case. You feel like the ML is burnt out. It is like a little candle you have … and the candle is just, just on.*" (10/12-14).

LIEM also describes the "positive" ML as *"rather bright"* (10/45) and the "negative" ML as a feeling of *"little energy in the middle; it feels as if it was interrupted, as if it wasn't upright and not directed towards this notochord level, and it feels dark"* (10/39-41).

But my interview partners don't even agree on the visual perception of the ML.
TOTH breaks ranks by saying that he sees a *"clear, distinct, strong ML, like a magnetic, black thread"* (1/42-44). In another passage, he says: *"The ML is dark in my vision, full of the universe's power. It is bound, intact, dense, and it vibrates."* (5/23-25). *"Vibrating; that means energy is present. The transmutation has taken place, and the ML must vibrate. It's a delicate vibration, it's agile. An agile ML vibrates."* (5/41-43)

I want to end this chapter with a quote by Van den Heede:
"The most important osteopathic treatment principle is visualisation; to have a mental image" (Van den Heede 2003-2005)

3.4.5. THE ML IN HORSE OSTEOPATHY

A special ML technique exists in horse osteopathy. It is called "tail-pull" ("Schweifzug") according to Langen and Schulte (2004). The therapist stands behind the horse, grabs the tail and structurally affects the sacrum, occiput and the Dura mater by pulling.

"The pulling on the tail has to build up slowly to adjust to the horse's perceptible motion tendencies. The pulling has to last for a while [...] as a result, the horse will relax. This becomes apparent in the lowering of the head and the neck [...] the meningeals are being 'stretched'." (Langen, Schulte Wien 2004, p. 137,141)[123]

The idea for this chapter came from Dr.Astrid Schwarz, a veterinary and osteopath in Villach, Carinthia. She also kindly supplied me with the photograph below.

Picture: Dr. Astrid Schwarz administers a "tail-pull" technique.

3.4.6. SUMMARY

There seem to be no limits to the imagination when it comes to a practical execution of ML treatment: it is possible to actually palpate structures or to work on them via visualisation. No rules seem to exist on where to place the hands in the sense of localisation. Also temporal limitations seem non-existent. A ML osteopath seems to have the ability to enter different levels of time, according to some interview partners' statements. He not only works in the present, but can also "engage" in embryologic processes (VAN DEN HEEDE, Jealous), or even reach an ancient past – for example a former life (NUSSELEIN) – if "archaic wounds" (Milne) exist that have to be treated.

What does seem to be a precondition though, is

- the ability to perceive stillness (see also chapter 3.3.4.1. about stillness – "Spiritual approach")
- the ability to perceive function without structure (WUTZL)
- synchronisation with the patient (VAN DEN HEEDE)
- a state of "devotion" (VAN DEN HEEDE)
- a widened, open awareness (Jealous).
- training in the ability to visualise and
- regularly practised meditation seems to be helpful

A "simple" DOG – technique (manipulation of the thoracic spine) can represent a successful ML treatment in this context, according to WUTZL.

Two additional insertions about the "écoute" and a ML technique in horse osteopathy round off this chapter.

4. SUMMARY OF THE WHOLE STUDY AND OUTLOOK

This work has investigated the following questions by means of a qualitative approach: "Is the ML in osteopathy a balancing act between structure and spirituality? What exactly do osteopaths mean when they say they work with the ML?"

We can summarise by saying that several different approaches are possible to answer these questions. The analysis of the interviews was structured into five categories: the "embryological approach", the "structural approach", the "functional approach", the "spiritual approach", and the "psychotherapeutic approach". The interview partners' statements were assigned to the according approaches in each case.
Summaries and sometimes also discussions of the text are included at the end of each chapter; because of this, I will abstain from summarizing each chapter in detail here.

If one wanted to draw conclusions about the significance of content from the size (number of pages) of each chapter, the "embryological approach" would be most prominent. Such a course of action could not do justice to this complex topic, though.

It is therefore advisable to maintain a simultaneousness and parity of approaches and phenomena here. One of the main conclusions that can be drawn from the interview analysis is that the ML in osteopathy encompasses a multitude of contents.

One osteopath may explain the ML rather in context with embryologic development processes or allocate it to anatomical structures; another may describe it as a function, and yet another may see ML osteopathy as a spiritual or mental process, or even as an expression of a religious experience. ML could also be a codeword for a therapeutic relation or for a very specific process of developing awareness. The term ML could signify all these contents, and the list could be continued. Another option to represent this variety would be to speak of different midlines. It would then be necessary however to note or ask which ML is currently spoken of.

In any case, this study was not able to deduct a distinct ML definition that would be valid for all interview partners. The ways of looking at it were too manifold.

The analysis was complicated by another factor: many terms that are in common use among osteopaths are not clearly defined so far. One encounters different phrasings that sometimes mean exactly the same thing; on the other hand, one sometimes encounters a particular term that has different meanings for several osteopaths. It could be a worthwhile objective in the near future to structure the terms and to find a common language for osteopaths, as has already been done in psychotherapy to a higher degree.

Although this conclusion may seem unsatisfactory for some readers at first, I personally discern a great opportunity and challenge in it. The complexity of this topic demands a lot of open-mindedness and impartiality towards different concepts from an osteopath who wants to approach the ML. If clear, limited guidelines and regulations existed, the ML would already be too confined and robbed of its most beautiful, exciting, secretive and beneficial elements in my opinion.

Therefore, it can be concluded that the idea of a confined concept should be abandoned. The willingness to expose oneself - as a therapist and human being - to the insecurities, dangers and anxieties that an encounter with the ML can trigger seems to be another precondition. After analysing and interpreting all the interviews, it seems that encountering the ML can eventually become an encounter with the deepest layers of a human life and often touches mental, spiritual and, if we want to call them so, religious aspects, which are not accessible with a traditional scientific approach.

However, that doesn't mean that an osteopath can do this without critical reflection of himself, of the patient-therapist relation and of his "techniques". On the contrary, this study points out in many passages that critical reflection is an indispensable requirement. Besides this, a majority of interview partners called for a solid rooting

of osteopathy - and especially ML osteopathy - in anatomy, physiology, neurology, and embryology as an important tool for the osteopathic craft.

In this sense, ML osteopathy really is a balancing act, not so much between structure and spirituality, but more between a scientifically explainable and a non-scientifically explainable method, which nevertheless apparently functions and heals.

5. LIST OF ABBREVIATIONS

BoL = Breath of Life
IM = Involuntary Mechanism
ML = Midline, Midlines, Mittellinie, Mittellinien
PRM = Primary-Respiratory-Mechanism (Primär-Respiratorischer Mechanismus)
SSB = Synchondrosis-Spheno-Basilaris
WHO = World Health Organisation
WSO = Wiener Schule für Osteopathie (Vienna School of Osteopathy)

6. BIBLIOGRAPHY

Arlot J. 1998. Kranialosteopathie. Kursskriptum. Übers.: G Meddeb. Wien. Wiener Schule für Osteopathie.

Abehsera A. 2002. Die Geschichte des Heilens. Eine Medizin ohne Werkzeug. In: Leitfaden Osteopathie. Liem T, Dobler TK. München. Jena. Urban & Fischer Verlag.

Abehsera A. 2002. Strukturelle und funktionelle Osteopathie. In: Leitfaden Osteopathie. Liem T, Dobler TK. München. Jena. Urban & Fischer Verlag.

Bauer J. 2005. Warum ich fühle, was Du fühlst. Intuitive Kommunikation und das Geheimnis der Spiegelneurone. 7. Aufl. 2005. Hamburg. Hoffmann und Campe Verlag.

Becker RE. 2000. The Stillness of Life. Edited by RE Brooks. Portland, Oregon. Stillness Press.

Becker RE. 1997. Life in Motion. The Osteopathic Vision of Rollin E. Becker, D.O. Edited by RE Brooks. Portland, Oregon. Stillness Press.

Blechschmidt E. 1982. Sein und Werden. Die menschliche Frühentwicklung. Stuttgart. Verlag Urachhaus Johannes M. Mayer GmbH & C.KG.

Blechschmidt E. 2002. Wie beginnt das menschliche Leben. Vom Ei zum Embryo. 7. erw. Aufl. Stein am Rhein. Christiana Verlag.

Delaunois P. 2002. Familiäre Einflüsse. In: Leitfaden Osteopathie. Liem T, Dobler TK. München. Jena. Urban & Fischer Verlag.

Delaunois P. 2002. Osteopathische Prinzipien. In: Leitfaden Osteopathie. Liem T, Dobler TK. München. Jena. Urban & Fischer Verlag.

Eichberger G. 2001. Imaginative Psychotherapie. Theorie I. Kursskriptum. (Vom Verfasser freundlicherweise zur Verfügung gestellt).

Flick U, Kardorff E, Steinke I (Hg.). 2003. Qualitative Forschung. Ein Handbuch. 2. Aufl. Hamburg. Rowohlt.

Freud, S. Gesammelte Werke (18 Bände und ein Nachtragsband), Imago Publishing Co., Ltd., London 1940-1952, und S.Fischer Verlag, Frankfurt am Main 1968, 1987.

Freud S. 1905. Was sind Übertragungen? In: Imaginative Psychotherapie. Theorie I. Eichberger G. 2001. Kursskriptum. (Vom Verfasser freundlicherweise zur Verfügung gestellt). (see also Freud GW, p.161-286)

Freud S. 1912. Zur Dynamik der Übertragung. In: Zur Dynamik der Übertragung. Behandlungstechnische Schriften. 2. Aufl. 2000. Frankfurt am Main. Fischer Taschenbuch Verlag. (see also Freud GW, p.364-374)

Freud S. 1915. Bemerkungen über die Übertragungsliebe. In: Zur Dynamik der Übertragung. Behandlungstechnische Schriften. 2. Aufl. 2000. Frankfurt am Main. Fischer Taschenbuch Verlag. (see also Freud GW, p.306-321)

Froschauer U, Lueger M. 2003. Das qualitative Interview. Wien. Facultas Verlags- und Buchhandels AG.

Fulford R. 1996. Dr. Fulford's Touch of Life. The Healing Power of the Natural Life Force. New York. Pocket Books.

Hellinger B. 2002. Zweierlei Glück. Konzept und Praxis der systemischen Psychotherapie. Weber G. (Hg.). Heidelberg. Carl-Auer-Systeme Verlag.

Hermanns H. 2003. Interviewen als Tätigkeit. In: Flick U, Kardorff E, Steinke I (Hg.). 2003. Qualitative Forschung. Ein Handbuch. 2. Aufl. Hamburg. Rowohlt.

Hopf C. 2003. Qualitative Interviews - ein Überblick. In: Flick U, Kardorff E, Steinke I. (Hg.). 2003. Qualitative Forschung. Ein Handbuch. 2. Aufl. Hamburg. Rowohlt.

Jealous J. 2001. The Biodynamic of Osteopathy. The Midline. Audio CD-series. Marnee Jealous Long, 6501 Blackfin Way, Apollo Beach, FL 33572: USA.

Jealous J. 2002. Interview mit Jim Jealous. Osteopathische Medizin. 3(2): 26-31.

Jealous J. 2003. Emergence of Originality. A Biodynamic View of Osteopathy in the Cranial Field. Course transcript.

Jealous J. 2006. Interview mit Jim Jealous. Osteopathische Medizin. 7(3): 4-8.

Kemper W. 1954. Gegenübertragungskomplikationen. In: Imaginative Psychotherapie. Theorie I. Eichberger G. 2001. Kursskriptum. (Vom Verfasser freundlicherweise zur Verfügung gestellt).

Klein P. 2002. Geleitwort. In: Leitfaden Osteopathie. Liem T, Dobler TK. München. Jena. Urban & Fischer Verlag.

Kowal S, O'Connell DC. 2003. Zur Transkription von Gesprächen. In: Flick U, Kardorff E, Steinke I. (Hg.). 2003. Qualitative Forschung. Ein Handbuch. 2. Aufl. Hamburg. Rowohlt.

Langen B, Schulte Wien B. 2004. Osteopathie für Pferde. Grundlagen und Praxis. Stuttgart. Sonntag Verlag in Medizinverlag Stuttgart.

Liem T. 1998. Kraniosakrale Osteopathie. Ein praktisches Lehrbuch. Stuttgart. Hippokrates Verlag.

Liem T, Dobler TK. 2002. Leitfaden Osteopathie. Parietale Techniken.München. Jena. Urban & Fischer Verlag.

Liem T. 2004 Cranial Osteopathy. Principles and Practice. 2nd edn. Edinburgh. London. New York...Elsevier.

Liem T. 2005. Interview mit Monika Dunshirn. Aufgenommen am 18.8.2005 in Hamburg.

Liem T. (Hg.) 2006. Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. Stuttgart. Hippokrates Verlag.

Liem T. 2006. Behandlungsprinzipien. Fulcrum. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. Stuttgart. Hippokrates Verlag.

Liem T. 2006. Diagnoseprinzipien. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. Stuttgart. Hippokrates Verlag.

Liem T. 2006. Midline - Entstehung und Einführung. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. Stuttgart. Hippokrates Verlag.

Liem T. 2006. Palpation - die Kunst des Fühlens. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. Stuttgart. Hippokrates Verlag.

Liem T. 2006. Therapeut und therapeutische Interaktion. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. Stuttgart. Hippokrates Verlag.

Ligner B, Van Assche R. 1993. Gelenke der unteren Extremität. Mobilisation und Korrektur. Bildatlas der Osteopathie. Band 1. Kötzingen/Bayer. Wald. Verlag für Osteopathie Dr. Erich Wühr.

Little M. 1951. Zitate zur Gegenübertragung. In: Imaginative Psychotherapie. Eichberger G. 2001. Theorie I. Kursskriptum. (Vom Verfasser freundlicherweise zur Verfügung gestellt).

Mayring P. 2003. Qualitative Inhaltsanalyse. In: Flick U, Kardorff E, Steinke I. (Hg.). 2003. Qualitative Forschung. Ein Handbuch. 2. Aufl. Hamburg. Rowohlt.

McPartland JM, Skinner E. 2006. Die Bedeutung der Midline in der Osteopathie. Die Midline bei metabolischen Bewegungen. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

McPartland JM, Skinner E. 2006. Das biodynamische Modell der kranialen Osteopathie. Einleitung. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

McPartland JM, Skinner E. 2006. Das biodynamische Modell der kranialen Osteopathie. Metapher und Archetyp: Die Schlüsselhüter. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

McPartland JM, Skinner E. 2006. Das biodynamische Modell der kranialen Osteopathie. Die funktionelle ML. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

McPartland JM, Skinner E. 2006. Das biodynamische Modell der kranialen Osteopathie. Entwicklung der Behandlungsansätze. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

McPartland JM, Skinner E. 2006. Das biodynamische Modell der kranialen Osteopathie. Erwecken und Trainieren der Aufmerksamkeit. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

Milne H. 1999. Aus der Mitte des Herzens lauschen. Eine visionäre Annäherung an die Craniosacralarbeit. Band 1 u. 2. Petersberg. Verlag Via Nova.

Nusselein H. 2005. Interview mit Monika Dunshirn. Aufgenommen am 20.2.2005 in Wien.

Nietzsche F. 2000. Die fröhliche Wissenschaft. Frankfurt am Main und Leipzig. Insel Verlag.

Paoletti S. 2001. Faszien. Anatomie - Strukturen - Techniken - Spezielle Osteopathie. München, Jena. Urban & Fischer Verlag.

Paulus S. 2006. Das Erleben der Fulcren in der Osteopathie und das Entstehen der Stille. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

Pons. 2002. Großwörterbuch für Experten und Universität. Englisch-Deutsch, Deutsch-Englisch. Vollständige Neuentwicklung. Stuttgart. Ernst Klett Sprachen GmbH.

Pons. 1978. Französisch - Deutsches Schulwörterbuch. Stuttgart. Ernst Klett Verlag.

Pöttner M, Hartmann C. 2005. Triune osteopathy. Osteopathische Medizin. 6(2): 19-23.

Rohen JW. 2002. Morphologie des menschlichen Organismus. 2. Aufl. Stuttgart. Verlag Freies Geistesleben.

Rohen JW, Lütjen-Drecoll E. 2002. Funktionelle Embryologie. Die Entwicklung der Funktionssysteme des menschlichen Organismus. Stuttgart. Schattauer GmbH. Verlag für Medizin und Naturwissenschaften.

Sadler TW. 1998. Medizinische Embryologie. Die normale menschliche Entwicklung und ihre Fehlbildungen. Übers.: U Drews. 9. Aufl. Stuttgart. New York. Thieme Verlag.

Sandler. 1973. Sichtweisen der Gegenübertragung. In: Imaginative Psychotherapie. Theorie I. Eichberger G. 2001. Kursskriptum. (Vom Verfasser freundlicherweise zur Verfügung gestellt).

Schäfer T. 2000. Was die Seele krank macht und was sie heilt. Die psycho-therapeutische Arbeit Bert Hellingers. München. Droemersche Verlagsanstalt Th. Knaur Nachf..

Shaver T. 2005. Interview mit Monika Dunshirn. Aufgenommen am 6.4.2005 in Wien.

Sills F. 2001. Craniosacral Biodynamics. Vol 1. Revised edition. Berkeley, California. North Atlantic Books.

Sills F. 2004. Craniosacral Biodynamics. Vol 2. Berkeley, California. North Atlantic Books.

Sommerfeld P. 2005. Osteopathie. Eine quasi-medizinische Spielart des unvoll-ständigen Nihilismus? Versuch einer ontologischen Standortbestimmung. Osteopathische Medizin. 6(4):17-21.

Springer Großwörterbuch Medizin. 2005. Deutsch-Englisch/English-German. 2. Aufl. Berlin. Heidelberg. Springer-Verlag.

Stark J. 2005. Vorwort. In: Das große Still-Kompendium. C Hartmann (Hg.). Übers.: M Pöttner. 2. Aufl. Pähl. Jolandos.

Still AT. 1902.The Philosophy and Mechanical Principles of Osteopathy. Kansas City, Mo. Hudson-Kimberly. Reprint 1986. Kirksville, Mo. Osteopathic Enterprise.

Still AT. 1908. Autobiography of A.T.Still. Revised ed. Kirksville, Mo. Published by the author. Fifth Reprint 2000. Indianapolis. The American Academy of Osteopathy.

Still AT. 2002. Das große Still-Kompendium. C Hartmann (Hg.). Übers.: M Pöttner. 2. Aufl. Pähl. Jolandos.

Sutherland WG. 1939. The Cranial Bowl. Mankato, Minnesota. Free Press Company. Reprint 1994.

Sutherland WG. 1990. Teachings in the Science of Osteopathy. Lectures given by the author in 1949-1950. Edited by AL Wales. Fort Worth, Texas. Sutherland Cranial Teaching Foundation.

Toth A. 2004. Interview mit Monika Dunshirn. Aufgenommen am 8.12.2004 in Wien.

Trottier N. 2006. Anfänge der Osteopathie und Stills Einfluss auf Sutherland. In: Morphodynamik in der Osteopathie. Grundlagen und Anwendungen am Beispiel der kranialen Sphäre. T Liem (Hg.). Stuttgart. Hippokrates Verlag.

Van den Heede P. 2002. Interview mit Patrick Van den Heede. Osteopathische Medizin. 3(3): 26-28.

Van den Heede P. 2003-2005. Kursunterlagen. Wien. Wiener Schule für Osteopathie.

Van den Heede P. 2005. Interview mit Monika Dunshirn. Aufgenommen am 5.3.2005 in Wien.

Weber KH. 2004. Interview mit Monika Dunshirn. Aufgenommen am 1.12.2004 in Wien.

Wehr G. 2003. Die großen Psychoanalytiker. Profile-Ideen-Schicksale. Düsseldorf. Patmos Verlag.

Wutzl C. 2005. Interview mit Monika Dunshirn. Aufgenommen am 12.3.2005 in Wien.

Wührl P. 2005. Erfahrungsprozess oder Bungee-Sprung in den Interzellularraum? Zu den Grundlagen osteopathischer Spiritualität. Deutsche Zeitschrift für Osteopathie. 3(3): 27-30.

Zweig S. 1931. Die Heilung durch den Geist. Mesmer/Mary Baker-Eddy/ Freud. 3. Aufl. 2003. Frankfurt am Main. S. Fischer Verlag.

7. APPENDIX: ORIGINAL QUOTES

---

[1] *„Vom Ziele der Wissenschaft. -*
Wie? Das letzte Ziel der Wissenschaft sei, dem Menschen möglichst viel Lust und möglichst wenig Unlust zu schaffen? Wie, wenn nun Lust und Unlust so mit einem Stricke zusammengeknüpft wären, dass, wer möglichst viel von der einen haben will, auch möglichst viel von der andern haben muss - dass, wer das ‚Himmelhoch-Jauchzen 'lernen will, sich auch für das ‚Zum-Tode-betrübt' bereit halten muss? [...] Die Stoiker glaubten wenigstens, dass es so stehe, und waren konsequent, als sie nach möglichst wenig Lust begehrten, um möglichst wenig Unlust vom Leben zu haben. [...] Auch heute noch habt ihr die Wahl: entweder möglichst wenig Unlust, kurz Schmerzlosigkeit oder möglichst viel Unlust als Preis für das Wachstum einer Fülle von feinen und bisher selten gekosteten Lüsten und Freuden! Entschließt ihr euch für das erstere, wollt ihr also die Schmerzhaftigkeit der Menschen herabdrücken und vermindern, nun, so müsst ihr auch ihre Fähigkeit zur Freude herabdrücken und vermindern. In der Tat kann man mit der Wissenschaft das eine wie das andre Ziel fördern! Vielleicht ist sie jetzt noch bekannter wegen ihrer Kraft, den Menschen um seine Freuden zu bringen und ihn kälter, statuenhafter, stoischer zu machen. Aber sie könnte auch noch als die große Schmerzbringerin entdeckt werden - und dann würde vielleicht zugleich ihre Gegenkraft entdeckt sein, ihr ungeheures Vermögen, neue Sternenwelten der Freude aufleuchten zu lassen!"(Nietzsche 2000, p. 48-49)

[2] *„Ich glaube, dass die Zeit reif ist, auch im wissenschaftlichen Bereich andere Denkrichtungen zu Worte kommen zu lassen. Das soll nicht heißen, dass die analytisch-quantitative Denkweise falsch ist und durch eine synthetisch-qualitative ersetzt werden müsste; es soll lediglich zum Ausdruck gebracht werden, dass das heute vorherrschende quantitative Denken einseitig ist und durch ein Denken ergänzt werden muss, das die funktionellen Zusammenhänge, die lebendigen Ganzheiten und Qualitäten zu verstehen sucht, um wieder Sinnzusammenhänge in das menschliche Handeln bringen zu können. Qualitative Begriffe sind aber oft nicht so scharf zu definieren wie solche aus den physikalischen Maßsystemen, man muss sie mehr umschreiben und versuchen, sie intuitiv zu erfassen, so wie man ja auch das Wesen eines Menschen nie ganz exakt beschreiben kann, sondern es eher umschreibend und erfühlend zu verstehen suchen muss." (Rohen 2002, p. 11)*

[3] *„Was macht allgemein die besondere Attraktivität und Aktualität qualitativer Forschung aus? Sie ist in ihren Zugangsweisen zu den untersuchten Phänomenen häufig offener und dadurch ‚näher dran' als andere Forschungsstrategien, die eher mit großen Zahlen und stark standardisierten, daduch auch stärker objektivistischen Methoden […] arbeiten. […] Standardisierte Methoden benötigen für die Konzipierung ihrer Erhebungsinstrumente (z. B. ein Fragebogen) eine feste Vorstellung über den untersuchten Gegenstand, wo-gegen qualitative Forschung für das Neue im Untersuchten, das Unbekannte im scheinbar Bekannten offen sein kann." (Flick, Kardorff, Steinke 2003, p. 17)*

[4] *„Der Aufwand, den die Arbeit mit qualitativen Interviews mit sich bringt, wird oft unterschätzt. Dahinter steckt meist die irrige Annahme, es genüge für qualitative Analysen, mit Menschen zu sprechen und deren Aussagen zusammenzufassen. Dies trägt vielleicht zum Alltagsverständnis bei, lässt jedoch das analytische Potential qualitativer Analyseverfahren brachliegen. Meist sind es nicht die vordergründigen Aussagen, die ein Verständnis ermöglichen, sondern die sorgfältige Analyse von Struktur und Entstehungsbedingungen von Gesprächsaussagen. Und dafür benötigt es ausgefeilte Strategien der Erhebung und der Analyse." (Froschauer, Lueger 2003, p. 8)*

[5] *„ … ob man sich bei der Interviewführung an ausformulierten Fragen orientiert, deren Abfolge im Interview gegebenenfalls auch festgelegt ist, oder ob das Interview sehr offen auf der Grundlage einiger weniger, vorab festgelegter Fragen oder Fragerichtungen geführt wird. Die in der Forschung besonders häufig eingesetzten Varianten qualitativer Interviews stehen zwischen diesen Extremen und sind als relativ flexibel eingesetzte teilstandardisierte Interviews zu beschreiben: Die Forscher orientieren sich an einem Interview-Leitfaden, der jedoch viele Spielräume in den Frageformulierungen, Nachfragestrategien und in der Abfolge der Fragen eröffnet." (Hopf 2003, p. 351)*

[6] *„Im Interview müssen spezifische Aufgaben bewältigt werden. Zunächst müssen Gesprächspartner gewonnen und Gespräche räumlich, zeitlich und thematisch verabredet werden; es muss eine fruchtbare Gesprächsatmosphäre geschaffen und über die Verwendung eines Recorders Einverständnis erzielt werden; der*

Interviewpartnerin muss verdeutlicht werden, in welcher Eigenschaft sie angesprochen wird, es muss ihr die im Interview gestellte Aufgabe und die Erwartung des Interviewers verdeutlicht werden. Schließlich muss das Interview methodisch durchgeführt und die Begegnung irgendwann einem Ende zugeführt werden. Die Anforderungen an die Gestaltung des ‚interpersonellen Dramas' eines Interviews sind also vielfältig und die möglichen Fallen zahlreich." (Hermanns 2003, p. 361)

[7] *„ … erstens mit dem Dilemma der Vagheit zu tun: Auf der einen Seite sind die Vorgaben für die Interviewdurchführung meist äußerst vage, auf der anderen Seite besteht die Anforderung, durch das Interview einen wesentlichen Beitrag zur Forschungsfragestellung zu leisten. Eine zweite Schwierigkeit kann man als das Fairness-Dilemma bezeichnen: Der Aufgabe und dem inhaltlichen Interesse des Interviewers, möglichst viel und Persönliches von der Interviewpartnerin zu erfahren, steht der Anspruch nach respektvollem Umgang mit der Gesprächspartnerin gegenüber. Schließlich kann für den Interviewer ein Dilemma der Selbstpräsentation auftauchen: Um sein Interview gut zu führen, kann er sich nicht so wissend und kenntnisreich zeigen, wie er zu sein glaubt." (Hermanns 2003, p. 361)*

[8] *„Auf der einen Seite zeichnet er sich durch Empathie aus, indem er versucht, sich in die Darstellung der Interviewpartnerin zu versetzen, um zu verstehen, wie sie die Welt erlebt und deutet. Zugleich muss er jedoch eine andere Haltung zur Interviewpartnerin aufbauen, nämlich, dass er die Worte wohl hört, aber nicht sicher ist, welchen Bedeutungshorizont die Begriffe für die Interviewpartnerin haben. Er kennt nicht die selbstverständlichen Voraussetzungen, die die Interviewpartnerin mit ihren Begriffen verbindet, und der Interviewer muss sich der Fremdheit ihrer Darstellung bewusst sein. Er muss sich in eine Haltung absichtlicher Naivität begeben und die Interviewpartnerin danach fragen, was ihre Sicht von Dingen ist, die ihm als solche ‚eigentlich' bekannt sind. Und er muss dabei gleichzeitig im Gespräch den Eindruck vermitteln, interessiert und entspannt zuzuhören." (Hermanns 2003, p. 364)*

[9] *„Es ist wichtig, sich im Rahmen der Forschungstätigkeit auf Unbekanntes und Neues einzulassen. […] Ein vorschnelles Schubladieren von Themen, Personen oder Wertungen steigert die Gefahr von Vereinfachungen und verengt den Wahrnehmungsspielraum. […] Zuhören ist deshalb ein aktiver Prozess des Mitdenkens." (Froschauer, Lueger 2003, p. 59-60).*

[10] *„Offene Forschungsgespräche beginnen nicht mit der ersten Frage, sondern bereits im Vorfeld der Planung und Kontaktaufnahme; sie reichen auch nicht bloß bis zum Gesprächsende, sondern bis zur abschließenden Dokumentation der Gesprächssituation." (Froschauer and Lueger 2003, p. 63)*

[11] *„Die Transkription eines Interviews sollte möglichst exakt unter Beibehaltung des Dialektes oder sprachlicher Besonderheiten ohne Annäherung an die Schriftsprache erfolgen."(Froschauer, Lueger 2003, p. 223).*

[12] *„Diese methodische Vorkehrung ist nötig, um die fraglose Anwendung von Vorwissen zu unterbinden. Diese Zerteilung trennt die jeweils zu analysierende Texteinheit systematisch vom Kontext ab und schafft dadurch die Notwendigkeit, im Zuge der Interpretation ohne weitreichende Vorkenntnisse die fallspezifischen Besonderheiten und die allgemeine Dynamik der dahinter stehenden [...] Welt zu erkunden und damit zu rekontextualisieren." (Froschauer, Lueger 2003, p.106)*

[13] *„Moderne Inhaltsanalyse zielt dabei nicht mehr nur auf den Inhalt des verbalen Materials ab. Formale Aspekte ebenso wie latente Sinngehalte kann sie zu ihrem Gegenstand machen. Der Grundgedanke einer qualitativen Inhaltsanalyse besteht nun darin, die Systematik [...] der Inhaltsanalyse für qualitative Analyseschritte beizubehalten, ohne vorschnelle Quantifizierungen vorzunehmen." (Mayring 2003, p. 468-469)*

[14] *„Angesichts der Misserfolge der traditionellen Medizin seiner Zeit und unter dem starken Einfluss der iatromechanischen Bewegung, die in Frankreich durch Descartes und in England durch William Harvey und seine Arbeiten über die Blutzirkulation vertreten wurde, entwickelte Dr. Still die Auffassung, dass jene Gesetze, die das Universum lenken und von Galilei, Newton und Kepler beschrieben wurden, auch auf den Menschen und das Tier anwendbar sind. Ebenso wie diese vertritt er die Meinung, dass Lebewesen aus verschiedenen ‚Teilen' zusammengefügt sind, die miteinander harmonisch funktionieren müssen und deren Vitalität von der Blutzirkulation abhängt. Jegliche Behinderung dieser Zirkulation beeinträchtigt die Versorgung dieser ‚Teile' oder Strukturen und führt zu Krankheit." (Arlot 1998, p. 4)*

[15] *„Die Analyse soll vielmehr dazu anregen, uns trotz aller pragmatischen Theorieskepsis Fragen zu stellen. Sie soll einen Diskurs in Gang bringen, der sich Fragen aussetzt, die den Grund des Wie und Was unseres klinischen Handelns klarer machen können. [...] Ich schlage daher vor, die Grundbegriffe unseres osteopathischen Denkens und Handelns auf den Prüfstein zu stellen. Damit ist gemeint, eben diese Grundbegriffe auf deren Grund hin wieder zu befragen. Was heißt Leben? Was heißt Gesundheit? Was heißt Krankheit? Was heißt Heilung? Was heißt Schmerz? All diese Fragen laufen auf einen Fokus zu: Was heißt Mensch-sein? [...] Bei all diesem Fragen aber heißt es, geduldig zu sein, die Frage überlegt zu stellen und keine schnellen Antworten zu erwarten." (Sommerfeld 2005, p.17-21)*

[16] *„Von einem philosophischen Standpunkt aus gesehen kann es zu Widersprüchen im Inneren eines Paradigma, wie das der Osteopathie, führen. Stehen zudem wissenschaftliche experimentelle Untersuchungen im Gegensatz zur althergebrachten Lehrmeinung, ist die Fragestellung und sogar die Infragestellung unausweichlich und notwendig. So eine Entwicklung spricht schlussendlich für die Gesundheit der Osteopathie." (Klein 2002,VIII-IX)*

[17] *„Die Bedeutung der Darstellung der geschichtlichen Entwicklung besteht u. a. darin, [...] aus dem geschichtlichen Verständnis dogmatische oder schon fast sektenähnliche Einstellungen und nicht Zeitgemäßes in der Osteopathie aufzudecken und in Frage stellen zu können." (Klein 2002, VIII.)*

[18] *„Geschichtlich betrachtet war Stills Osteopathie in Bezug auf Technik oder Prinzipien kaum neu. Zu seiner Zeit existierten bereits die grundlegenden Prinzipien und Techniken, die wir unter ‚kranial' oder ‚strukturell' verstehen. Für uns ist es einfach wichtig herauszufinden, was ihn inspiriert hat."(Abehsera 2002, p. 25)*

[19] *„Das Studium der Prinzipien und Praktiken von Mesmer entspricht daher auch dem Studium der Techniken und Überzeugungen von Still zu Beginn seiner Karriere" (Abehsera 2002, p. 19-20)*

[20] *„Erschüttert vom Tod seiner Kinder versucht Still 1865 auf fragwürdige Weise, mit ihnen Kontakt aufzunehmen. Er beginnt, sich mit Spiritismus [...] zu beschäftigen." (Delaunois 2002, p. 15).*

[21] *„...der Mesmerismus, der vor der Jahrhundertmitte in den USA auftauchende Spiritismus und die in medizinischen Zusammenhängen durchgeführten hypnotischen Praktiken im Laufe des 19. Jahrhunderts als Zugangswege zu den Dunkelbereichen der Psyche benützt wurden. Insbesondere der Einsatz der Hypnose, von einem Großteil der Medizin ebenso abgelehnt wie der Magnetismus, sollte namentlich in Frankreich, an der berühmten Salpêtrière in Paris, Einsichten vermitteln, die sich die Gründerväter der Psychoanalyse zunutze zu machen wussten. Sowohl Freud als auch Jung gingen für kurze Zeit bei [...] Charcot (1825-1893) in die Schule." (Wehr, 1996, p. 24)*

[22] *„Die Embryologie vermittelte mir die Erklärung der Konstruktion und Funktion der Mittellinie. Seitdem versuche ich Muster zu ‚re-harmonisieren', und mich jedem Balancepunkt so nah wie möglich in Richtung der Mittellinie der aktuellen Körperfunktion zu nähern." (Patrick van den Heede 2002, p. 26)*

[23] *„...nicht Körpertiefe, sondern Tiefe in Form von Zeit. Das heißt, dass bestimmte Läsionen den Eindruck vermitteln, dass sie nicht kurzfristig entstanden sind. Diese Läsionen lassen sich nicht lösen, wenn nur ein mechanischer Balancepunkt aufgebaut wird, sondern nur, wenn das anatomische Wissen in Form von einer Entwicklung, die sich innerhalb des Körpers befindet, mit in die Behandlung integriert wird" (Van den Heede 2002, p. 26-28)*

[24] *„Die dreidimensionale Information reicht nicht aus, sondern die Dimension der Zeit muss in die Behandlung integriert werden, um eventuelle embryologische Informationen zu erkennen. Funktion ist eigentlich nur eine verbesserte Wiederholung von Embryologie, die auch Bewegung ist." (Van den Heede 2002, p. 26-28)*

[25] *„Das Störfeld, das vielleicht bis ins embryonale Stadium zurückreicht, ist eine Art Wissen, das als neurosensorielles Wissen oder im Unterbewusstsein gespeichert sein kann. Wenn man als Osteopath in diese Bewegung oder Spannungen eintritt und einen Balancepunkt findet, kann es sein, dass sich das Bewusstsein ändert und dass durch diese Bewusstseinsebene auch das Gewebe eine andere Ausrichtung, eine Freiheit erhält, die es vorher noch nicht erfahren hat, weil es schon zu einem bestimmten Zeitpunkt in seiner früheren*

Entwicklung gehemmt wurde. Es ist ähnlich wie in einem Computer, in dem man einen Punkt anklickt und sich ein ganzes Bild öffnet. Und das Bild ermöglicht eine Weiterentwicklung." (Van den Heede 2002, p. 26-28)

[26] *„Um das Gleichgewicht der Membranbewegung und -spannung in allen Richtungen zu gewährleisten, müssen die Membranen von einem Fulcrum, einem Ruhepunkt aus operieren. Dieser Ruhepunkt muss schwebend aufgehängt sein, um sich automatisch bewegen zu können, damit eine gleichmäßige physiologische Bewegung der Schädelknochen gesichert ist, wenn Veränderungen auftreten [...]. Das Zentrum dieses intrakranialen Membransystems ist ein fiktiver Punkt, der sich an einer Stelle im Verlauf des Sinus rectus befindet, der durch die Vereinigung der Falx cerebri mit dem Tentorium cerebelli und der Falx cerebelli gebildet wird. Dieser Ruhepunkt wird auch als ‚Sutherland-Fulcrum' oder als ‚automatic shifting suspended fulcrum' bezeichnet. An diesem Punkt werden die dynamischen Kräfte, die auf die Membranen wirken, ins Gleichgewicht gebracht." (Liem 1998, p. 186)*

[27] *„Damit sind im Prinzip für alle elementaren Funktionsbereiche des embryonalen Organismus Anlagen entstanden. Die Gliederung in drei Keimblätter ist also nicht zufällig, sondern spiegelt die elementare Funktionsgliederung des späteren Organismus wieder. Das Ektoderm liefert die Anlagen für alles, was später mit Informationsprozessen zu tun hat (Nervensystem, Sinnesorgane, usw.), das Entoderm stellt das Material für die Stoffwechselorgane, das Mesoderm für die inneren und äußeren Bewegungsprozesse (Zirkulation, Muskulatur, Bewegungsorgane, usw.) zur Verfügung. Dies sind Elementarfunktionen, die schon im Trophoblasten vorhanden waren, sich jetzt aber in den Embryonalkörper verlagert und in drei große Bereiche getrennt haben, die auch im späteren Organismus als die großen Funktionsbereiche auftreten (Informationswechsel, Stoffwechsel und zirkulatorische, rhythmische Prozesse) (sog. funktionelle Dreigliederung). Die Bedeutung der Keimblätter und der aus ihnen hervorgehenden Organsysteme wird erst deutlich, wenn man sie von einer höheren Ebene aus betrachtet. Die Entwicklung vollzieht sich also vom Ganzen in die Teile, nicht umgekehrt." (Rohen , Lütjen-Drecoll 2002, p. 28)*

[28] *„Ganz allgemein kann man sagen, dass aus dem Ektoderm die Organe und Strukturen entstehen, die den Kontakt zur Umwelt herstellen." (Sadler 1998, p. 77)*

[29] *„...das Neuralrohr die Anlage des gesamten Informationssystems" (Rohen 2002, p. 64)*

[30] *„Der größte Teil der Osteopathie ist immer ein Geheimnis geblieben, da wir nicht wissen, wie die einzelnen Osteopathen dorthin gelangt sind. Sie sprechen nicht darüber, aber sie haben ihr eigenes Modell. Alles was ich tue, ist eine Sache offen zu legen, die schon immer da war." (Jealous 2002, p. 30)*

[31] *„... der zur Zeit innovativste, begehrteste, aber auch umstrittenste Vertreter im kranialen Bereich der Osteopathie bezeichnet." (Introduction to the interview with Jealous 2002, p. 26)*

[32] *„Der Embryo ist die perfekte Antwort auf den Breath of Life. Er umfasst Weisheit, Geometrie, Transzendenz, ist dazu geschaffen, zu heilen, mit einer Fülle an Liebe für alle Mitreisenden." (Jealous 2002, p. 29)*

[33] *„Sutherland sah die Ursache des PRM (Primär Respiratorischer Mechanismus) in einer allgegenwärtigen Kraft, die er „Breath of Life" (BoL) nannte. Seine Konzepte schienen Newtons Physik zu widersprechen, sodass viele Osteopathen sie nicht beachteten. Heute steht uns die Quantenphysik zur Erklärung seiner Konzepte zur Verfügung. Der BoL verhält sich wie eine Quantum-Feldkraft (Quantum field force). Wenn er durch den Körper strömt, erzeugt er räumlich geordnete Bewegungen, die sich auf der physikalischen Ebene durch fluide Kräfte äußern (elektromagnetische Wasserstoffbindungen). Die resultierende bioelektrische Matrix lenkt die biologischen Strukturen, die bei Kompression oder Dekompression auf das elektrische Feld reagieren (z. B. piezoelektrische kristalline Materialien, wie die Phospholipide in den Zellmembranen oder das Kollagen im Bindegewebe). Somit folgt die Struktur der Funktion." (McPartland, Skinner 2006, p. 319).*

[34] *„Das Keimplasma wird von Generation zu Generation weitergegeben, während der daraus hervorgehende Körper am Lebensende abstirbt." (Rohen 2002, p. 172)*

[35] *„Die Urgeschlechtszellen werden von den frühesten embryologischen Entwicklungsstadien (Morula) gewissermaßen beiseite genommen, nehmen an der gesamten Embryonalentwicklung nicht teil und siedeln sich erst relativ spät in den Keimdrüsenanlagen an. Da der Organismus selbst stirbt, das Keimmaterial aber nicht zugrunde geht, sondern von Generation zu Generation weitergegeben wird, spricht man von der Keimbahn.*

Hier liegt also eine funktionelle und - in gewisser Hinsicht - auch materielle Kontinuität vor, die bis in Urzeiten der menschlichen Stammesgeschichte zurückreicht." (Rohen, Lütjen-Drecoll 2002, p. 2)

[36] „Die osteopathische therapeutische Interaktion kann nur schrittweise erlernt werden. Dabei sind fundierte Kenntnisse über jedes Gewebe, seine strukturell-funktionelle Einheit und die vielfältigen Wechselwirkungen der Gewebe und Organsysteme untereinander, sowie die palpatorische Annäherung an das jeweilige Gewebe und an die Globalität der Gewebedynamiken unabdingbare Voraussetzungen. Diese Lernschritte können nicht übersprungen werden. Eine intuitive Herangehensweise ohne diese Grundlagen mündet in einem prärationalen undifferenzierten Berühren. Zu versuchen, intuitive Einsichten der Organisation im Organismus zu gewinnen, ohne in der Lage zu sein, eine Dysfunktion des Omentum minus oder des M. palmaris longus zu befunden [...], ist sicherlich keine Osteopathie. " (Liem 2006, p. IX)

[37] „… dass die rhythmischen Inspirations- und Exspirationsphasen zu einer phasenweisen Steigerung und Verminderung der Gewebspermeabilität und Viskosität der Grundsubstanz im Bindegewebe führt. Das bedeutet, dass im rhythmischen Wechsel während der Inspirationsphase vermehrt Flüssigkeit und Elektrolyte in die Zellen und ins Lymphsystem einströmen und in der Exspirationsphase Flüssigkeit und gelöste Stoffe die Zellen wieder verlassen." (Liem 1998, p. 354)

[38] „Die Lamina terminalis [das ist eine Art vordere Begrenzung des dritten Ventrikels - Anmerkung der Verfasserin] markiert den Abschluss des Kopfendes der Röhre. Die Midline-Struktur besteht beim Erwachsenen am Dach des dritten Ventrikels fort. Sie ist der Drehpunkt jeder neuralen Bewegung. In der Inhalations- bzw. Inspirationsphase des PRM konvergiert das ganze zentrale Nervensystem spiralig auf der Lamina terminalis. In der Ausatemphase bewegen sich alle Gewebe von der Lamina terminalis fort." (McPartland, Skinner 2006, p. 357)

[39] „Der ‚Breath of Life' (BoL) verwandelt sich in Flüssigkeitsbewegung (d.h. in die ‚Long Tide', der longitudinalen Fluktuation des Liquor cerebrospinalis), die am Os coccygis zu Beginn der Einatmung einsetzt, über die zentrale Verbindung (Core-link) aufsteigt und das Foramen magnum in der Einatmungs-mitte durchläuft. Von dort fließt er weiter, um die posteriore, mittlere und anteriore Schädelgrube mit seiner Kraft auszufüllen. Während der Ausatmung steigt er vom Gebiet des Os ethmoidale zum Os coccygis ab und vervollständigt damit am Ende der Ausatmungsphase seine elliptische Bahn." (McPartland, Skinner 2006, p. 320)

[40] „Seit ungefähr hundert Jahren wird der osteopathische Berufsstand immer wieder heimgesucht von Auseinandersetzungen zwischen den ‚Strukturellen' und ‚Funktionellen', wie die beiden Lager sich selbst und gegenseitig bezeichnen. Als funktionell werden hierbei indirekte Techniken bezeichnet, die zum Beispiel eine Dysfunktion verstärken oder übertreiben, strukturell wird mit direkten Techniken gleichgestellt, mit denen zum Beispiel eine Dysfunktion durch Manipulation ‚durchbrochen' wird. [...] Der Beginn des Konflikts kann symbolisch auf den Tag datiert werden, an dem Still Littlejohn, den ersten Dekan der American School of Osteopathy, aus Kirksville herauswarf. Der Gründer der amerikanischen Osteopathie, Still, glaubte, dass die Struktur die Funktion regiere, der Gründer der europäischen Osteopathie, Littlejohn, hielt diese Idee für absurd und behauptete, die Funktion regiere die Struktur. Mit solch gegensätzlichen Paradigmen konnten Still und Littlejohn nicht mehr unter dem selben Dach lehren und mussten auseinander gehen." (Abehsera 2002, p. 17)

[41] „Eine Grundlage in der Osteopathie ist die Wechselwirkung zwischen Struktur und Funktion. Eine gesunde Struktur erfüllt alle Funktionen, für die sie bestimmt wurde. Die von einem Organismus ausgeführten Funktionen werden nur dann gut sein, wenn die Struktur sich in einem guten Zustand befindet. Durch dieses Zusammenwirken gehen Struktur und Funktion Hand in Hand. Beiden gemeinsam ist die Bewegung. Man kann es sich so vorstellen, dass die Struktur eine fest gewordene Bewegung darstellt und die Funktion die Energie der Bewegung ist." (Delaunois 2002, p. 35)

[42] „Midlines sind lineare Fulcren." (Paulus 2006, p. 197)

[43] „Russell war Architekt, Bildhauer, Schriftsteller und autodidaktischer Wissenschaftler. Vor allem war er Mystiker mit einer direkten spirituellen Ausbildung. [...] Er war ein amerikanischer spiritueller Meister und Mitbegründer der Universität für Wissenschaft und Philosophie in Virginia. Sowohl William Sutherland als auch seine Frau Adah waren von der spirituellen Lehre Russells stark beeinflusst. Es ist erstaunlich, wie viel von der Osteopathie im kranialen Bereich der Lehre Walter Russells entspringt." (Paulus 2006, p. 195)

[44] *„Was bedeutet Leben? Wir stellen uns Leben pulsierend vor, als Herzschlag, als etwas das lebt, wenn sein Herz schlägt. Der Körper offenbart Leben; er drückt Leben aus. Aber die Lebensäußerung im Sinn eines Hebels, der sich in seinem Drehpunkt bewegt, drückt nicht wirklich Leben aus. Es ist nur ein Hebel, das Leben und die Kraft jedoch sind im stillen Fulcrum - nicht dort, wo sich etwas bewegt - nicht dort, wo es pulsiert. Unsere Körper leben nicht; sie sind lediglich ein Ausdruck unserer Lebensquelle." (Walter Russell in: „Das Erleben der Fulcren in der Osteopathie und das Entstehen der Stille" Steve Paulus 2006, p. 195)*

[45] *„Jim Jealous und Elliottt Blackman führten den Begriff der Mittellinien (midlines) in die Osteopathie ein, der ursprünglich aus der Embryologie stammt. Midlines sind nicht nur energetische Überbleibsel aus der Embryologie, sondern Fulcren. Midlines sind lineare Fulcren. Midlines sind eine Funktion innerhalb einer Struktur. Midlines werden wahrgenommen als umschriebene Ruhelinien mit Bezug zur Stille." (Walter Russell in: „Das Erleben der Fulcren in der Osteopathie und das Entstehen der Stille" Steve Paulus 2006, p. 197)*

[46] *„Ein Fulcrum ist eine Art Ruhepunkt oder beweglicher Fixpunkt, durch den es zum Beispiel möglich wird, ein Gewicht zu heben und dessen inhärente Potenz als orientierender Organisationsfaktor für Bewegungs- und Organisationsmuster agiert. Ein Fulcrum in der Natur stellt zum Beispiel das Auge oder der Mittelpunkt eines Wirbelsturmes dar. Im menschlichen Organismus sind eine Vielzahl von Fulcren vorhanden. Zum Beispiel sind die Pivot-Punkte der Schädelnähte (Stellen, an denen sich nach innen und nach außen gerichtete Gelenkränder treffen) Fulcren, die als Ruhe- bzw. Drehpunkt für die Bewegung der Schädelknochen dienen. Das sternale Ende der Klavikula stellt ein knöchernes Fulcrum für die Funktion der gesamten oberen Extremität dar. Im Weiteren wird auch ein knöchernes Fulcrum in Höhe der SSB, ein membranöses Fulcrum in Höhe des Sinus rectus und ein neurales Fulcrum in Höhe der Lamina terminales beschrieben. [...] Sutherland und Becker haben auch spirituelle Fulcren beschrieben. Ein Beispiel ist eine regelmäßig ausgeübte Meditation, eine bestimmte Religion, ein Lebensprinzip oder ein Leitsatz, wie ‚liebe Deinen nächsten wie Dich selbst.' Indem man sein Leben in Richtung dieses Leitsatzes ausrichtet, wird sich die potenzielle Kraft dieses Satzes im Leben verwirklichen können. Ebenso wie eine regelmäßig ausgeführte Meditation, einen Ruhepunkt, Besinnungspunkt, ein Schiff auf dem unendlichen Ozean Leben darstellt, kann ein Fulcrum auch eine regelmäßig ausgeführte Besinnung sein, um wie Chila betont, vor und während einer Behandlung leer zu werden und offen zu sein für die Ganzheit des Patienten." (Liem 2006, p. 262)*

[47] *„Dieses Auge der Dysfunktion, dieser Bereich der Ruhe in den Spannungsmustern der Gewebe, ist die Stelle, die die spezifische Potenz der jeweiligen Dysfunktion darstellt. Es ist sozusagen die Seele der Dysfunktion [...] Jede Veränderung in dieser Stelle hat eine Veränderung der Spannungsmuster in ihren strukturell funktionellen Zusammenhängen zur Folge. Der Osteopath kann lernen, diese Stellen zu palpieren und zu lokalisieren." (Liem 2006, p.263)*

[48] *„Die Diskussion ist mühsam, da uns keine entwickelte Sprache zur Verfügung steht, das osteopathische Erleben oder gar eine typisch osteopathische Spiritualität zu beschreiben."(Wührl 2005, p. 27)*

[49] *„Obwohl Metaphern inhärent irrationel sind, haben sie sich stets bei der Bildung von Arbeitshypothesen zur Annäherung an ein wissenschaftliches Problem bewährt." (McPartland, Skinner 2006, p. 349)*

[50] *„ … Geburtshelfern der Osteopathie. Entstand und entsteht sie, wie manche hoffen und über politische Weichenstellung sicherstellen wollen, durch wissenschaftlich reproduzierbare Erkenntnis? Ist sie geboren aus einer, je nach Vorliebe humanistischen, darwinistischen, christlichen, stoischen oder buddhistischen Philosophie? Oder ruht Osteopathie in der spirituellen Praxis der Osteopathen?") (McPartland, Skinner 2006, p. 349)*

[51] *„Ich schlage vor, sich Spiritualität für einen Moment als einen breiten Horizont an menschlichen Erfahrungen vorzustellen, der Momente des Ergriffenseins wie der tiefen Versenkung, Zustände emphatischer Teilnahme und entrückter Wahrnehmung, der stillen Verzückung und der Ekstase umfasst." (McPartland, Skinner 2006, p. 349)*

[52] *„Osteopathische Spiritualität ist jener noch zu beschreibende Aspekt unserer praktischen Arbeit, in dem sich die Aufmerksamkeit gegenüber uns selbst, dem Patienten und der uns umfassenden Wirklichkeit vermischt. Diese Aufmerksamkeit zu beschreiben, ihre sinnliche Qualität, ihre rituelle Einübung und ihren historischen Entstehungsort, wäre die Aufgabe einer Phänomenologie der osteopathischen Sensibilität und ein erster*

Versuch, die Frage nach der spezifisch osteopathischen Spiritualität zu beantworten." (McPartland, Skinner 2006, p. 28)

[53] *„Sutherland pflegte jeden Tag Perioden der Ruhe einzurichten, um der ‚Stille zuzuhören'. Die Hinwendung zur eigenen Stille und des sich ‚Leermachens' kommen dabei nicht nur uns selbst zugute, sondern auch der Interaktion mit unserem Patienten. Denn in der Stille kann sich die Kunst einer ‚Palpation ohne vorgefasste Meinung' entwickeln, indem sich der Therapeut wie ein ‚leeres Gefäß' von den Eindrücken des Patienten berühren lässt." (Liem 2006, p. 153)*

[54] *„Und unser Herz, mit seiner Liebe, Einfühlungsgabe und seinem Verständnis, ist bei jeder Annäherung an den Patienten beteiligt." (Liem 2006, p. 202)*

[55] *„Als religiöser Mensch könnte die Vorstellung entstehen, dass ‚Gut und Böse' existieren, aber als Arzt ist das nicht unsere Angelegenheit. Wir sind da, um dem Patienten zu dienen. Wir können uns nicht erlauben, darüber zu urteilen, was für den Patienten gut oder schlecht ist, wir müssen uns neutral verhalten. Die Tatsache, einen Patienten wie eine Läsion zu betrachten, disqualifiziert uns als Pflegepersonal. Der Breath of Life erlaubt uns eine neutrale Position einzunehmen, die der Liebe selbst entspricht, die nicht aus unserem eigenen Herzen entspringt, sondern dem Herzen der Welt." (Jealous 2002, p. 29)*

[56] *„Dr. Still sagte mit 86 Jahren: ‚Ich liebe meine Patienten, da ich in ihren Gesichtern und Körpern Gott erkenne'. Er sah mehr als ihre Läsion, ihr Leiden. Er sah in ihren Formen etwas Göttliches, Überirdisches. Im gewissen Sinne gab er mir dadurch die Erlaubnis zu erkennen, dass vielleicht ein göttliches Ebenbild vor mir steht, liegt oder sitzt. Der Unterricht, den ich empfangen habe, gab mir die Erlaubnis zu solchen Gedanken. Ich habe mich daraufhin keinesfalls als Nicht-Osteopath empfunden, als ich begann die Vollkommenheit und Perfektion im Patienten zu erkennen." (Jealous 2002, p. 29)*

[57] *„Sie (der Behandler) bleiben neutral und dienen als Leitung für den Fluss der göttlichen Liebe. Wenn Sie die Liebe richtig in Ihre Behandlung zu integrieren lernen, nehmen Ihre Körpervibrationen zu, und der Umgang mit der Kraft der Liebesenergie wird einfacher." (Fulford in: „Entwicklung der Behandlungsansätze" by McPartland, Skinner 2006, p. 353)*

[58] *„Im Jahre 1944 wird Sutherland gefragt, ob die Kranialbehandlung ein religiöses Konzept sei. Er gibt folgende Antwort: ‚Wenn Stills Erkenntnis von Gott als Schöpfer des menschlichen Körpers religiös ist, dann ist das ganze Konzept der osteopathischen Wissenschaft religiös. Wenn die osteopathische Wissenschaft religiös ist, dann ist es auch das kraniale Konzept.' " (Trottier 2006, p. 340)*

[59]

„•‚Philosophie' ist als ein individuell ausgeprägter Bestandteil des menschlichen Strebens nach begründetem Wissen und begründeter Praxis zu verstehen. Dabei besteht die philosophische Tendenz, die eigene Praxis und das eigene Wissen im umfassenden Kontext zu erfassen. So kann jeder einfache und erfahrene Bauer in seinem Lebensplan und seiner Umgebung einen überaus kompetenten Naturphilosophen darstellen.

•‚Spiritualität' bezeichnet irgendeine ‚geistige' Konzentration auf das Lebensinteresse bzw. die Lebensmotivation eines Menschen.

•‚Religiös' bezeichnet eine Form, dieses Lebensinteresse ‚geistig' wahrzunehmen. Dabei kann man mit dem Philosophen Ludwig Wittgenstein sagen, dass religiöse Äußerungen als ‚Lebensregeln in Bilder' gefasst gelten können. Daher darf man sie nicht mit wissenschaftlichen Äußerungen verwechseln." (Pöttner, Hartmann 2005, p. 19)

[60] *„... Betriebsblindheit, welche die amerikanische Osteopathie im Laufe des 20. Jahrhunderts ihres Kernkonzeptes des ‚triune man' und damit ihrer ganzheitlichen Identität beraubt hat." (Pöttner, Hartmann 2005, p. 19)*

[61] *„... die dreifach differenzierte Einheit des Menschen als mind (Verstand), body (Körper) und spiritual being (Seele als Bewegungsprinzip). Mind, body und spiritual being interagieren ständig." (Pöttner, Hartmann 2005, p. 19)*

[62]*„Die osteopathische Philosophie nach Still und Sutherland ist de facto nicht in unser bestehendes Gesundheitssystem zu integrieren. Einer nur scheinbar ganzheitlichen, dafür aber systemkonformen*

Körpertherapie steht eine tatsächlich ganzheitliche, aber gegenwärtig nicht in das Gesundheitssystem integrierbare ‚triune osteopathy' gegenüber." (Pöttner, Hartmann 2005, p. 23)

[63] *„... ob denn Osteopathie für sich in Anspruch nehmen kann, eine Kunst und eine Philosophie und eine Wissenschaft zu sein. [...] Dass sie keine Wissenschaft im Sinn der abendländisch-modernen Auffassung von Wissenschaft ist, liegt auf der Hand. [...] Als Philosophie, dies ist nun mein Vorwurf, fehlt es der Reflexion ihrer Prinzipien, sofern sie überhaupt vorhanden ist und diese nicht dogmatisch übernommen werden, an methodischer Stringenz und Klarheit." (Sommerfeld 2005, p. 18)*

[64] *„... im unvollständigen Nihilismus eine gewisse Schwäche [sah], sich mit dem Wesen des Nihilismus auseinanderzusetzen. Diese Schwäche führt z.B. in eine Fluchtbewegung zu Ersatzreligionen bzw. Ersatzwerten. Die vom Nihilismus hinterlassene Leere wird mit einem Platzhalter besetzt." (Sommerfeld 2005, p. 19)*

[65] *„Der Zug des unvollständigen Nihilismus in der heutigen Osteopathie besteht in der gängigen Praxis, dieser monistischen (Der Monismus besteht darin, dass der materielle Aspekt für das Ganze genommen wird. Darüber hinaus gibt es nichts mehr.) Auffassung eine Hinterwelt gegenüberzustellen. [...] In diesem Sinne ist die Osteopathie eher komplementär als alternativ zur Schul-Medizin. Die Hinterwelt füllt die Leere, die sich den Menschen (den Behandlern und Behandelten) von den auf den materiellen Aspekt reduzierten Sichtweisen ihrer Selbst her entgegenwirft. Es ist der kalte Wind der Maschinen, der uns da um die Ohren bläst - und die Osteopathie versucht hier bisweilen ein wärmendes Feuer zu installieren. Dieses Feuer wird teils von einem vitalistischen Ansatz (Lebenskräfte etc.) her genährt, teils von einem naiven platonischen Dualismus (das hinter dem Materiellen stehende ist das eigentlich Ausschlag Gebende, alles sei z.B. nur irgendeine Manifestation von Energien, Potenzialen etc.)." (Sommerfeld 2005, p. 19-20)*

[66] *„All diese Erklärungen über die Hinterwelt erklären dabei aber gar nichts. Sie sind willkürliche Setzungen, die einer momentanen Beruhigung dienen. Vielmehr noch werden sie manchmal als dezidierte Ersatzreligion betrieben, was den Charakter eines unvollständigen Nihilismus aus Nietzscheanischer Sicht zum Höhepunkt treibt." (Sommerfeld 2005, p. 20)*

[67] *„Die Evolution im Sinne einer gemeinsamen Abstammung aller Lebewesen kann wahr sein, aber die Evolution im neodarwinistischen Sinn - ein zielloser, ungeplanter Vorgang zufälliger Veränderung und natürlicher Selektion - ist es nicht. Jedes Denksystem, das die überwältigende Evidenz für einen Plan in der Biologie leugnet oder wegzuerklären versucht, ist Ideologie, nicht Wissenschaft." (Original quotes taken from International Herald Tribune, www.iht.com/articles/2005/07/07/opinion/edschon.php, 25th of Dec. 2005, german Version documented by KATH.NET, www.kath.net/detail.php?id=10972, 25.12.2005)*

[68] *„Aber angesichts eines Universums, in dem eine solch komplexe Organisation seiner Elemente und eine so wunderbare Zielgerichtetheit in seinem Leben vorhanden ist, von Zufall zu sprechen, würde gleich bedeutend damit sein, die Suche nach einer Erklärung der Welt [...] aufzugeben. In der Tat würde dies gleich bedeutend sein damit, Wirkungen ohne Ursache anzunehmen. Es würde die Abdankung des menschlichen Verstandes bedeuten." [...] „Dieses Ziel, das die Lebewesen in eine Richtung führt, für die sie nicht Verantwortung tragen, zwingt einen Geist vorauszusetzen, der Schöpfer dieses Ziels ist." (Original quotes taken from International Herald Tribune, www.iht.com/articles/2005/07/07/opinion/edschon.php, 25th of Dec. 2005, german Version documented by KATH.NET, www.kath.net/detail.php?id=10972, 25.12.2005)*

[69] *„Wo ist dieses Ziel? Ich sehe dieses Ziel überhaupt nicht. Das Tolle an der Evolution, am biologischen System ist, dass es eben nicht im Gleichgewicht ist. Wäre es im Gleichgewicht, dann wäre es ja eigentlich tot. Das heißt, es muss ständig irgendwie gereizt werden, und dann muss es sich anpassen." (All quotes in this section taken from STANDARD, original edition 24th of Dec. 2005).*

[70] *„Die Vernünftigkeit der Wirklichkeit führe ich auf die Vernünftigkeit des Schöpfers zurück." (STANDARD, original edition 24th of Dec. 2005)*

[71] *„Dieses Ziel, das die Lebewesen in eine Richtung führt, für die sie nicht Verantwortung tragen, zwingt einen Geist vorauszusetzen, der Schöpfer dieses Ziels ist." (STANDARD, original edition 24th of Dec. 2005)*

[72] *„Der Glaube der Glaubenden braucht keine wissenschaftlichen Stützen." (STANDARD, original edition 24th of Dec. 2005)*

[73] *„Tide ist vergleichbar mit einer großen Wellenbewegung in der Tiefe des Meeres, gegenüber den vielen Rhythmizitäten im Körper, die mit kleinen Wellenbewegungen vergleichbar sind, die eher an der Oberfläche des Meeres zu spüren sind. Die große Wellenbewegung, womit alles andere entsteht, spürt man erst, wenn alles still wird. Der Körper versucht immer zur Mitte zu kommen, metabolisch, biomechanisch, oxidoreduktiv etc., rhythmisch heißt das in Richtung der ‚Long Tide'. Ihr Ursprung ist, denke ich, nicht innerhalb des Körpers. Auch in der Embryologie entwickelt sich das Ei innerhalb einer Sphäre. Auch um den Körper herum gibt es eine Welle, die man kaum spürt, weil man sie nicht zur Anatomie zählt. ‚Long Tide' ist wie eine Welle, die in den Körper eindringt. Durch den Widerstand, dem diese in Form der Gewebe begegnet, entstehen neue, kleinere Wellen. " (Van den Heede 2002, p. 28)*

[74] *„Der Psychoanalytiker weiß, dass er mit den explosivsten Kräften arbeitet und derselben Vorsicht und Gewissenhaftigkeit bedarf wie der Chemiker." (Freud 1915, p. 111, see also Freud, GW, p. 306-321)*

[75] *„Der Bewusstseinsgrad bzw. das Gewahrsein des Osteopathen gegenüber seinen eigenen sensomotorischen, vitalen, emotionalen, mentalen und spirituellen Innerlichkeiten und denen seiner Patienten bestimmt, inwieweit er in der Lage ist, Gewebe-Energie-Bewusstseinsmuster im Patienten zu erkennen bzw. Gewebemuster und energetische Muster mit den inneren Dimensionen in Verbindung zu setzen und zu berücksichtigen. Je stärker er dazu in der Lage ist, desto größer ist zudem die Wahrscheinlichkeit, dass durch die Behandlung keine neuen dissoziativen Muster hervorgerufen werden." (Liem 2006, p. VIII)*

[76]

„•auf unsere eigene Gesundheit achten,
•Arbeiten an unseren eigenen emotionalen Blockaden,
•besseres Zeitmanagement,
•längere Konsultationszeiten,
•bessere Kontinuität der Patientenbetreuung, [...]
•Kommunikationstraining,
•reguläres Feedback von Patienten. [...]" (Liem 2006, p. 239)

[77] *„Still betonte, dass Osteopathie mit Vertrauen in den eigenen Körper beginnt. Dieses Vertrauen muss der Osteopath zunächst zu seinem eigenen Körper entwickeln, bevor er im Körper des Patienten Veränderungen veranlassen möchte. Der Osteopath erfährt an sich selbst, wie in jeder Krankheitsäußerung immer auch das Potenzial zur Wandlung liegt, die nicht leichtfertig durch vorschnelles suppressives ‚Wegmachen' von Symptomen verschenkt werden sollte. Veränderungen im Patienten sollten zurückhaltend induziert werden, wenn sie zuvor nicht als Therapeut selbst vollzogen wurden." (Liem 2006, p. 239)*

[78] *„Osteopathie als Erlebnis erfordert eine große Belastbarkeit der Therapeuten. Wir müssen die extreme Gefühlsintensität, die Patienten in uns auslösen können, aushalten, ohne ihr zu verfallen und uns darin zu verlieren. Das erfordert eine besondere Art der Aufmerksamkeit. Da wir uns das Abenteuer Osteopathie nicht nehmen lassen, wäre eine Reflexion des therapeutischen Erlebens nötig. Was in vielen Therapien selbstverständlich ist, dass Gegenübertragung und Projektion des Therapeuten Teil der Selbstreflexion und Supervision sein muss, ist in der Osteopathie eher die Ausnahme. Die Unschuld und vorgebliche Neutralität, mit der wir uns in das Gewebe des Patienten projizieren, oder uns für Projektion öffnen, ist unglaubwürdig. Was, wenn die Projektion zum Projektil wird? Unserer Erlebnisreise durch das Gewebe des Patienten täte es gut, eine kritische Selbstreflexion im Gepäck mit zu führen. Das Erleben des Osteopathen zu thematisieren ist dabei unumgänglich." (Wührl 2005, p. 29)*

[79] *„Ist Osteopathie als Ereignis Traum oder Trauma des Therapeuten? [...] Wie ist es, sich den Kräften der Patienten zu überlassen, dem Sog ins Zentrum der Dysfunktion zu folgen? Was geschieht, wenn Phantasie und Realität auch für die ausgefuchstesten Therapeuten unter uns nicht immer zu trennen sind? Das schwarze Loch mag uns verschlingen, die Todes- oder Mordphantasien des Patienten könnten real werden. Jede Behandlung wird zum Wagnis: Was, wenn es zum Einbruch der Realität kommt und wir mitgerissen werden? Was, wenn unsere Projektion sich als ungesicherter Bungee-Sprung in die Weiten des Interzellularraumes erweist? Was passiert dann mit unserer Aufmerksamkeit: bleiben wir im Geschehen präsent, auch wenn wir uns selbst (und unsere Sprache) sich dabei auflösen? Ungern reden wir über die Angst des Therapeuten vor dem Ereignis*

‚Patient'. Osteopathie als Ereignis zu sehen, würde die Möglichkeit offerieren, eine Sprache für diesen Teil unserer Praxis zu entwickeln." (Wührl 2005, p. 29)

[80] *„Obwohl Osteopathie sich als Ereignis präsentiert, besteht das Problem darin, die dazugehörigen Gefahren und Ängste anzuerkennen. Schnell wird von der Bedrohlichkeit des Soges abgelenkt, oder er wird auf eine kosmische Dimension verteilt und damit neutralisiert. Dann scheint es, als würden sich Therapeut und Patient erst im Unendlichen treffen. Jene Kräfte, die uns im therapeutischen Prozess zu zerreißen drohen, werden im kosmischen verdünnt. [...] Sie zerstäuben in einem kosmischen Raum, der von abstrakter Göttlichkeit erfüllt ist, die niemand Böses oder Gutes will. Ob das realistisch ist, oder ob eine gelungene Projektion hier die Aufmerksamkeit des Therapeuten ersetzt hat, bleibt die Frage." (Wührl 2005, p. 29)*

[81] *„Sie werden tendenziell im Körper weggeschlossen, in einer Art Zeitkapsel gespeichert. Wenn du sie erreichst, neigt der Körper dazu, sich zu verschließen - einzufrieren, als ob er erschrocken wäre. Wenn jedoch genügend Vertrauen vorhanden ist, beginnen die Erinnerungen sich zu entwirren, und die Zeitkapsel gibt ihren Inhalt preis. Der Klient findet sich im damaligen Geschehen wieder und durchlebt alle Gerüche, Töne, Bilder und Verzweiflung." (Milne 1999, Volume 1, p. 180)*

[82] *„Eine bewusst ausgeführte, respektvolle und an die Ganzheit des Patienten gerichtete Berührung wendet sich an die ältesten Teile unseres sensorischen Systems, an die, ‚die auf Berührung reagieren, auf die Empfindungen von Zug und Druck, auf die Wärme der Hand und ihre Streichelbewegung. Die im wörtlichen Sinn behandelte Person spürt zunehmend den sich verringernden Muskeltonus, das Vertiefen der Atmung und ihre Regelmäßigkeit, Wohlbehagen im Unterleib, den besseren Kreislauf in den sich weitenden Hautgefäßen, und sie wird von diesem Empfinden eingenommen. Sie empfindet ihre primitivsten, d. h. entwicklungsgeschichtlich ursprünglichen, vom Bewusstsein vergessenen Verhaltensschemata und erinnert sich des Wohlgefühls eines heranwachsenden kleinen Kindes', schreibt Feldenkrais. Durch die Berührung wird eine Unmenge von Eindrücken vermittelt und ausgetauscht, wovon eine Vielzahl auf unbewusster Ebene ankommt." (Liem 2006, p. 150)*

[83] *„... dass sich die osteopathische Berührung in Kontinuität mit den warmen, liebenden Händen befindet, die wir als Kinder von unserer Mutter erfahren haben, um Ängste zu vertreiben. Methodologische Ansätze zur Integration emotionaler Inhalte in der osteopathischen Praxis sind vorhanden, allerdings noch spärlich und zum Teil rudimentär." (Liem 2006, p. 156)*

[84] *„Es sind Neuauflagen, Nachbildungen von den Regungen und Phantasien, die während des Vordringens der Analyse erweckt und bewusst gemacht werden sollen, mit einer für die Gattung charakteristischen Ersetzung einer früheren Person durch die Person des Arztes. Um es anders zu sagen: eine ganze Reihe früherer Erlebnisse wird als nicht vergangen, sondern als aktuelle Beziehung zur Person des Arztes wieder lebendig. Es gibt solche Übertragungen, die sich im Inhalt von ihrem Vorbilde in gar nichts bis auf die Ersetzung unterscheiden. Das sind also, um in dem Gleichnisse zu bleiben, einfache Neudrucke, unveränderte Neuauflagen. Andere sind kunstvoller gemacht, sie haben eine Milderung ihres Inhaltes, eine Sublimierung, wie ich sage, erfahren und vermögen selbst bewusst zu werden, indem sie sich an irgend eine geschickt verwertete reale Besonderheit an der Person oder in den Verhältnissen des Arztes anlehnen. Das sind also Neubearbeitungen, nicht mehr Neudrucke." (Freud 1905, p. 92; see also Freud GW, p. 161-286).*

[85] *„Das ergibt sozusagen ein Klischee (oder auch mehrere), welches im Laufe des Lebens regelmäßig wiederholt, neu abgedruckt wird, insoweit die äußeren Umstände und die Natur der zugänglichen Liebesobjekte es gestatten, welches gewiss auch gegen rezente Eindrücke nicht völlig unveränderlich ist. Unsere Erfahrungen haben nun ergeben, dass von diesen das Liebesleben bestimmenden Regungen nur ein Teil die volle psychische Entwicklung durchgemacht hat; dieser Anteil ist der Realität zugewendet, steht der bewussten Persönlichkeit zur Verfügung und macht ein Stück von ihr aus. Ein anderer Teil dieser libidinösen Regungen ist in der Entwicklung aufgehalten worden, er ist von der bewussten Persönlichkeit wie von der Realität abgehalten, durfte sich entweder nur in der Phantasie ausbreiten oder ist gänzlich im Unbewussten verblieben, so dass er dem Bewusstsein der Persönlichkeit unbekannt ist. Wessen Liebesbedürftigkeit nun von der Realität nicht restlos befriedigt wird, der muss sich mit libidinösen Erwartungsvorstellungen jeder neu auftretenden Person zuwenden, und es ist durchaus wahrscheinlich, dass beide Portionen seiner Libido, die bewusstseinsfähige wie die unbewusste, an dieser Einstellung Anteil haben.*

Es ist also völlig normal und verständlich, wenn die erwartungsvoll bereitgehaltene Libidobesetzung des teilweise Unbefriedigten sich auch der Person des Arztes zuwendet. Unserer Voraussetzung gemäß wird sich diese Besetzung an Vorbilder halten, an eines der Klischees anknüpfen, die bei der betreffenden Person vorhanden sind, oder, wie wir auch sagen können, sie wird den Arzt in eine der psychischen ‚Reihen' einfügen, die der Leidende bisher gebildet hat. Es entspricht den realen Beziehungen zum Arzte, wenn für diese Einreihung die Vater-Imago (nach Jungs glücklichem Ausdruck) maßgebend wird. Aber die Übertragung ist an dieses Vorbild nicht gebunden, sie kann auch nach der Mutter- oder Bruder-Imago usw. erfolgen. Die Besonderheiten der Übertragung auf den Arzt, durch welche sie über Maß und Art dessen hinausgeht, was sich nüchtern und rationell rechtfertigen lässt, werden durch die Erwägung verständlich, dass eben nicht nur die bewussten Erwartungsvorstellungen, sondern auch die zurückgehaltenen oder unbewussten diese Übertragung hergestellt haben." (Freud 1912, p. 39-41; see also Freud GW, p. 364-374)

[86] *„... der mächtigste Hebel des Erfolges", (aber auch gleichzeitig) „das stärkste Mittel des Widerstandes"(Freud 1912, p.41; see also Freud GW, p.364-374)*

[87]

„• Widerstände im Analytiker aufgrund einer Aktivierung innerer Konflikte
• Übertragungen des Analytikers
• Störungen der Kommunikation zwischen Analytiker und Patient
• Persönlichkeitsmerkmale des Analytikers, die sich in seiner Arbeit widerspiegeln und möglicherweise zu Schwierigkeiten in der Therapie führen
• Spezifische Beeinträchtigungen des Analytikers, die durch besonders geartete Patienten hervorgerufen werden; auch die spezifische Reaktion des Analytikers auf die Übertragung seines Patienten
• Die ‚angemessene' oder ‚normale' Gefühlsreaktion des Analytikers auf seinen Patienten. Diese kann ein wichtiges therapeutisches Instrument und eine Grundlage für Empathie und Verstehen sein." (Sandler 1973, p. 110)

[88] *„… die ganz subjektive Gegenübertragung den Weg öffnet ins Unbewusste des Patienten. Man sollte daher unbedingt zu ihr stehen" (Little 1951, p. 113)*

[89]

„• Mütterlich-warmherzige Hilfsbereitschaft: Ratschläge zu früh, Deutungen zu früh, Tröstung zu früh. Patient so abhängig wie ein kleines Kind. Allmachtsgefühle und ungestilltes affektives Kontaktverlangen des Therapeuten. Vor allem dann, wenn mir mein Privatleben zu wenig an libidinösen wie auch an narzisstischen Befriedigungen bietet, wenn meine eigene Lebenssituation sexuell und affektiv ungenügend gesättigt ist, stehe ich in Gefahr, meinen Patienten auf die geschilderte Weise zu missbrauchen und mir bei ihm das zu holen, was ich sonst so bitter entbehren muss
• Unpersönlicher, strenger Umgang, Distanz, spartanische Härte - Ausdruck der Furcht vor allzu großer Weichheit, Nachgiebigkeit und Güte
• Überweich und gütig: Abwehr gegen eigene aggressiv-überwältigende Impulse
• Wenn ich als Anfänger um meine wirtschaftliche Existenz fürchten muss, neige ich dazu, Konzessionen bei meinen Analysanden zu machen: zu freundlich, deute zu früh oder ängstlich, glaube, ein fehlerloser, allwissender Fachmann sein zu müssen, damit nur ja der Patient nicht den Therapeuten wechsle" (Kemper 1954, p. 84-85)

[90] *„Misstrauisch sollte uns jedenfalls stimmen, dass diese Dimension scheinbar nicht mehr der Notwendigkeit unterliegt, sich begrifflich zu verständigen. Die typische Sprachskepsis vieler spiritueller Traditionen wird hier zum Kampf um die Kontrolle über emphatisch aufgeladene Begriffe, deren Erwähnung schon ein Raunen hervorruft. Damit hat sich die Sprache als kritische Begleiterin und reflektive Beschreibungsmöglichkeit unserer Aufmerksamkeit verabschiedet." (Wührl 2005, p. 30)*

[91] *„Eine interdisziplinäre Zusammenarbeit zwischen Osteopathie und Psychotherapie erscheint sinnvoll, sodass primär psychotherapeutisch und primär osteopathische Behandlungs-strategien voneinander lernen und sich ergänzen." (Liem 2006, p. 156)*

[92] *„Das Phänomen der Spiegelung musste für die Psychotherapie nicht neu erfunden werden, denn es ist hier seit langem bekannt (Spiegelungsphänomene werden in der tiefenpsychologischen und psychoanalytischen Psychotherapie seit langem als ‚Übertragung', ‚Gegenübertragung' und ‚Identifizierung' beachtet und erforscht.*

In die Verhaltenstherapie haben sie neuerdings unter der Bezeichnung ‚Resonanz' Eingang gefunden.). Das Gleiche gilt für die Medizin - ganz allgemein für jede Begegnung zwischen jemandem, der Heilung sucht, und jemandem, der zu heilen versteht. Unklar war jedoch bisher, auf welcher neurobiologischen Grundlage sich Spiegelungsvorgänge abspielen. Der Einfluss, den sie in Heilungsprozessen haben, wird unterschätzt. Wenn jemand einen Arzt oder Therapeuten aufsucht, dann stehen sich nicht nur eine Gesundheitsstörung und ein medizinischer oder psychologischer Experte gegenüber. Es begegnen sich vielmehr zwei Personen, deren Einstellungen und Erwartungen zu intuitiven Wahrnehmungs- und Spiegelungsabläufen führen, die den Behandlungserfolg stärker beeinflussen als manche therapeutische Maßnahme." (Bauer 2005, p. 129)

[93] *„… die meisten Menschen der Spannungen, Frustrationen und unterdrückten Gefühle, die sie in ihrem Körper eingelagert haben, nicht bewusst sind" (Liem 2006, p. 156)*

[94] *„Es löst Angst aus, sich hinzusetzen und einem Patienten ins Gesicht zu schauen, ein Patient, der uns spiegelt. Es ist manchmal unangenehm, zu erkennen, dass diese leidende Person genauso feststeckt wie man selbst. Ist es möglich, seinen Geist demütig sein zu lassen, kann man mehr für die Menschen tun und Gottes Gnade geschehen lassen." (Jealous 2002, p. 30-31).*

[95] *„Nervenzellen, die im eigenen Körper ein bestimmtes Programm realisieren können, die aber auch dann aktiv werden, wenn man beobachtet oder auf andere Weise miterlebt, wie ein anderes Individuum dieses Programm in die Tat umsetzt, werden als Spiegelneurone bezeichnet." (Bauer 2005, p. 23)*

[96] *„Mit Methoden wie der funktionellen Kernspintomographie lassen sich auch Spiegelphänomene nachweisen." (Bauer 2005, p. 25)*

[97] *„Bei anderen wahrgenommene Handlungen rufen unweigerlich die Spiegelneurone des Beobachters auf den Plan. Sie aktivieren in seinem Gehirn ein eigenes motorisches Schema, und zwar genau dasselbe, welches zuständig wäre, wenn er die beobachtete Handlung selbst ausgeführt hätte. Der Vorgang der Spiegelung passiert simultan, unwillkürlich und ohne jedes Nachdenken. Von der wahrgenommenen Handlung wird eine interne neuronale Kopie hergestellt, so, als vollzöge der Beobachter die Handlung selbst. Ob er sie wirklich vollzieht, bleibt ihm freigestellt. Wogegen er sich aber gar nicht wehren kann, ist, dass seine in Resonanz versetzten Spiegelneurone das in ihnen gespeicherte Handlungsprogramm in seine innere Vorstellung heben. Was er beobachtet, wird auf der eigenen neurobiologischen Tastatur in Echtzeit nachgespielt. Eine Beobachtung löst also in einem Menschen eine Art innere Simulation aus. Es ist ähnlich wie im Flugsimulator: Alles ist wie beim Fliegen, sogar das Schwindelgefühl beim Sturzflug stellt sich ein, nur, man fliegt eben nicht wirklich. Indem ein 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 Handlungsablaufs leisten könnte. Was die Spiegelnervenzellen im Beobachter ablaufen lassen, ist das Spiegelbild dessen, was der andere tut. Natürlich beschränkt sich die Wahrnehmung eines anderen Menschen nicht allein auf innere Simulation, aber sie bezieht diesen wichtigen Aspekt mit ein." (Bauer 2005, p. 26-27)*

[98] *„Spiegelphänomene machen Situationen - ob im Guten oder im Schlechten - vorhersehbar. Sie erzeugen ein Gefühl, das wir Intuition nennen und das uns ahnen lässt, was kommen könnte." (ibid., p. 28-29)*

[99] *„Spiegelneurone können beobachtete Teile einer Szene zu einer wahrscheinlich zu erwartenden Gesamtsequenz ergänzen. Die Programme, die Handlungsneurone gespeichert haben, sind nicht frei erfunden, sondern typische Sequenzen, die auf der Gesamtheit aller bisher vom jeweiligen Individuum gemachten Erfahrungen basieren." (Bauer 2005, p. 31)*

[100] *„Intuitive Ahnungen können in einem Menschen entstehen, auch ohne das Bewusstsein zu erreichen. Man hat zum Beispiel nur ein ungutes Gefühl, weiß aber nicht, warum. Dies liegt unter anderem daran, dass es subliminale, also nicht bewusst registrierte Wahrnehmungen sein können, die in uns Spiegelneurone aktivieren. Die Fähigkeit, ein Gefühl dafür zu entwickeln, was andere tun, ist bei Menschen allerdings unterschiedlich ausgeprägt." (Bauer 2005, p. 32)*

[101] *„Die Fähigkeit zum intuitiven Verstehen, dieses Geschenk unserer Spiegelnervenzellen, schützt uns keineswegs vor Irrtümern. Wahrnehmungen von Szenen können über das neurobiologische Spiegelsystem zur*

Aktivierung von Programmen führen, die für das Gehirn zwar zunächst wie eine passende Fortsetzung des beobachteten Geschehens aussehen, sich dann aber als Irrtum erweisen. Dies liegt daran, dass viele Alltagsszenen mehrdeutig sind und zu verschiedenen Fortsetzungsgeschichten passen könnten. Bei der unterschiedlichen Interpretation spielen individuelle Vorerfahrungen eine nicht unwesentliche Rolle." (Bauer 2005, p. 33)

[102] *„Intuition ist eben nicht alles. Wo sie versagt, kann und muss der Verstand helfen. Das kritische Nachdenken darüber, was wir bei und mit anderen erleben, behält seinen unentbehrlichen Stellenwert. [...] Ein Nachteil unseres intellektuell-analytischen Apparates ist seine Langsamkeit. Über jemanden nachzudenken dauert länger als eine intuitive Einschätzung. Spiegelneurone arbeiten spontan und schnell. Was sie abrufen, ist online verfügbar.*
Fazit: Intuition und rationale Analyse können sich nicht gegenseitig ersetzen. Beide spielen eine wichtige Rolle und sollten gemeinsam zum Einsatz kommen. Die Wahrscheinlichkeit, dass wir eine Situation richtig bewertet haben, ist am größten, wenn Intuition und kritische Reflexion zu ähnlichen Ergebnissen kommen und einander ergänzen." (Bauer 2005, p. 33-34)

[103] *„Hellinger zufolge sind wir nicht so frei wie wir gerne glauben. Wenn wir ohne die Anerkennung unserer Bindungen handeln, ist das kein freies, sondern ein blindes Handeln. Ein Handeln in Freiheit ergibt sich erst durch die Zugehörigkeit zu einem System (Familie). Ein System definiert sich durch eine Menge von Elementen, zwischen denen bestimmte Beziehungen bestehen. Jede Veränderung eines Elements hat automatisch auch eine Wirkung auf die anderen Elemente. Jeder Mensch ist Teil eines Familiensystems und damit eines Beziehungszusammenhanges. Dadurch hat er Anteil an den Problemen der anderen Familienmitglieder, gleichgültig, ob ihm das bewusst ist oder nicht." (Schäfer 2000, p. 20)*

[104] *„In Hellingers Arbeit wird die Familie als ein System gesehen, aus dem man sich nicht einfach ausklinken kann. Unsere Eltern haben wiederum Eltern und kommen aus Familien mit bestimmten Schicksalen. All das wirkt sich in der jetzigen Familie aus. Wenn in der Vergangenheit etwas Schlimmes passiert ist, hat das über Generationen hinweg Folgen. Diese unbewussten Verstrickungen bewusstzumachen und die ursprüngliche Liebe wieder zum Fließen zu bringen ist die Aufgabe von Hellingers Form der Familienaufstellungen." (Schäfer 2000, p. 24)*

[105] *„Auf diese Weise werden Vater, Mutter, Geschwister und ein Stellvertreter für den Aufstellenden ausgewählt. Der Therapeut achtet darauf, dass missliebige oder totgeschwiegene Familienmitglieder, wie uneheliche Kinder, Totgeborene, Psychiatrieinsassen oder frühere Verlobte, nicht übergangen werden. Bei alldem braucht der Therapeut nur wenige Informationen. [...] Wenn alle Familienmitglieder benannt und ausgesucht sind, nimmt der Klient in gesammelter Haltung die Stellvertreter am Arm und stellt sie nach seinem inneren Bild im Raum auf. Dadurch treten die Stellvertreter untereinander in Beziehung. Anschließend kann sich der Klient wieder auf seinen Platz setzen. Schon allein das äußere Bild der Familienaufstellungen kann in manchen Fällen Aufschlüsse geben. [...] Wenn alle zueinander in Beziehung stehen, fragt der Therapeut die Stellvertreter, wie sie sich körperlich und emotional fühlen und was sie den anderen Familienmitgliedern gegenüber empfinden. Obwohl es sich bei den Stellvertretern um völlig fremde Menschen handelt, ist es immer wieder verblüffend, wie detailliert diese die Geschichte der Familie darstellen können. Die Stellvertreter fühlen wie die wirklichen Familienmitglieder. [...] Nachdem alle Familienmitglieder bzw. Stellvertreter gesagt haben, wie sie sich fühlen, verändert der Therapeut die Positionen der Familienmitglieder, bis eine Ordnung gefunden wird, bei der jeder sich wohl fühlt. Die Suche nach der Lösung dient nicht nur dem Klienten, sondern der ganzen Familie." (Schäfer 2000, p. 26-28)*

[106] *„Es gibt eine Tiefe, in der alles zusammenfließt. Sie liegt außerhalb der Zeit. Ich sehe das Leben wie eine Pyramide. Oben auf der ganz kleinen Spitze läuft das ab, was wir Fortschritt nennen. In der Tiefe sind Zukunft und Vergangenheit identisch. Dort gibt es nur Raum, ohne Zeit. Manchmal gibt es Situationen, in denen man mit dieser Tiefe in Verbindung kommt. Dann erkennt man zum Beispiel Ordnungen, verborgene Ordnungen, und kann in der Seele an Größeres rühren." (Schäfer 2000, p. 36)*

[107] *„Der Psychoanalytiker weiß, dass er mit den explosivsten Kräften arbeitet und derselben Vorsicht und Gewissenhaftigkeit bedarf wie der Chemiker." (Freud 1915, p. 111)*

[108] *„Behandeln ist eigentlich das Einfachste. Alle Techniken können helfen, alle Techniken sind nützlich!" (Van den Heede 2005, p. 6/44-50)*

[109] *„Drei Behandlungsschritte:*

- *Der erste Schritt in der Behandlung besteht darin, Kontakt mit der inhärenten Stille im Patienten und den homöodynamischen Kräften im Organismus aufzunehmen.*
- *Im zweiten Schritt werden die anormalen Spannungsmuster und feineren Energiemuster befundet und die Fulcren ermittelt, um die sich diese organisieren oder organisiert werden. Gewebespannungen werden dabei in Beziehung zu den Dynamiken und Wechselwirkungen objektiver und subjektiver Faktoren der Innenwelt des Patienten (physische, emotionale, mentale und spirituelle Bewusstseinsebenen) wie auch der Außenwelt des Patienten (soziokulturelles Umfeld, Umwelteinflüsse usw.) gesetzt.*
- *Der dritte Schritt besteht darin, eine Art therapeutisches Fulcrum zu etablieren, um das sich die Bewegung/Energie so organisieren kann, dass eine Integration höherer Ordnung entsteht, indem sich die anormalen Spannungs- und Energiemuster auflösen.“ (Liem 2006, p. 264)*

[110] *„Es kann im Verlauf einer Behandlung nötig werden, einen Teil der Aufmerksamkeit auf das Zentrum der Dysfunktion zu richten. Dennoch ist zuallererst die Behandlung tief in der Gesundheit, d. h. in den verfügbaren Ressourcen des Patienten zu verwurzeln und auch während der Synchronisierung mit Zentren der Dysfunktion stets der Kontakt zu diesen Ressourcen aufrechtzuhalten.“ (Liem 2006, p. 264)*

[111] *„ ‚Mitte des Menschen‘ ist ein Akupunkturpunkt (Gouverneursgefäß 26), der an der tiefsten Stelle der Kurve der anterioren Spina nasalis liegt. Den Kontakt nimmst du mit dem Nagel eines Mittelfingers auf. Mit Daumen und Mittelfinger deiner anderen Hand umspannst du die großen Flügel des Sphenoidale, wobei das Metacarpophalangealgelenk mit einer bedeutsamen physischen und energetischen Berührung auf der Glabella ruht. Von ‚Mitte des Menschen‘ aus richtest du Energie nach innen zum Hypothalamus, dem cerebralen Zentrum von Identität und dem zentralen Initiator von Wachheit. Diese Energielinie lässt du auf eine Querlinie treffen, die zwischen den großen Flügeln medial verläuft. Schließlich richtest du von deinem Glabellakontakt aus einen Energievektor zum Hypothalamus. Diese Technik hilft Menschen ihr Bewusstsein zu ihrer Mitte zu bringen, ‚nach Hause zu kommen‘, an jenen Ort, an dem eine tiefere Identitätsebene wohnt. Sie wirkt tief stabilisierend.“ (Milne 1999, p. 288 & 303)*

[112] *„… Faszien ein ‚Gedächtnis‘ haben, mit dem die verschiedenen Traumata (im weitesten Sinn), die ein Individuum im Laufe seines Lebens erlitten hat, im Inneren des Bindegewebes gespeichert werden. Die Aufgabe des Therapeuten besteht darin, diese Erinnerungsspuren aufzudecken und, wenn möglich, zu entfernen oder zumindest abzuschwächen.“ (Paoletti 2001, p. 194)*

[113] *„Beim Écoute-Test wird die Hand auf eine beliebige Stelle des Körpers gelegt, um eventuell darunter liegende Veränderungen aufzuspüren. Die Hand bleibt dabei völlig passiv und aufnahmebereit, um kleinste Veränderungen spüren zu können. [...]*
Bei der Durchführung des Écoute-Tests müssen einige grundlegende Voraussetzungen gegeben sein. Selbstversändlich können Sie einen Écoute-Test nicht spontan durchführen. Ein langes Training ist erforderlich, um die Sensibilität Ihrer Hände zu verfeinern. Gleichzeitig müssen Sie sich auch auf den Gedanken einlassen, dass Ihre Hand feinste Bewegungen spüren kann. Der gute Testverlauf hängt von mehreren Faktoren ab:

- *vom manuellen Kontakt*
- *von der Einstimmung auf den Patienten*
- *von Ihrer Neutralität als Therapeut [...]*

Ihre Hand muss ganz flach auf die zu untersuchende Zone gelegt werden und der Handkontakt mit den Geweben sollte so groß wie möglich sein. [...] Die Hand ruht ganz locker mit ihrem Eigengewicht auf den Geweben, muss aber zugleich fest wie ein Saugnapf daran haften. Sie ‚klebt‘ an den Geweben und kann dadurch den Bewegungen leicht folgen. Der Écoute-Test ist die feinste Variante der Palpation. Da die Gewebe die Vergangenheit in ihrem Gedächtnis speichern, besteht Ihre Aufgabe darin, die im Gewebe des Patienten aufgezeichnete Geschichte zu lesen. Es entwickelt sich ein passiver Dialog, bei dem der Patient nicht Herr über die Informationen ist, die uns die Faszien mitteilen, sondern auf der Ebene des Unbewussten mit Ihnen kommuniziert. [...] Man muss dem Patienten und seinen Geweben mit viel Respekt entgegentreten und so handeln, als bitte man die Gewebe um Erlaubnis, mit ihnen Kontakt aufnehmen zu dürfen. Das Entschlüsseln der in den Geweben enthaltenen Informationen erfordert absolute Neutralität. Sie sollten daher ohne vorgefasste Meinung an die Gewebe herantreten und sich in einem passiven Zustand befinden, der ausschließlich dem Hineinhören in den Körper, dem ‚Écoute‘ dient. [...] Mit Hilfe der Tests können mögliche Problemzonen lokalisiert werden, er alleine reicht aber natürlich nicht aus, um eine Diagnose zu erstellen. Der Écoute-Test im Stehen zeigt die Dynamik der Faszien in der allgemeinen Mechanik des Körpers. Interessant ist, dass bei

deprimierten Personen die Faszien im Allgemeinen mitbetroffen sind. Bei diesen Patienten ist besondere Vorsicht geboten, da sie leicht nach rückwärts fallen. Sie sollten jederzeit darauf vorbereitet sein, um den Patienten gegebenenfalls auffangen zu können." (Paoletti 2001, p. 195-198)

[114] *„Ich bin wirklich der Meinung, dass Menschen den Umgang mit Bewusstsein nicht lernen können, ohne Zeit alleine zu verbringen, in der unberührten Natur. Ich denke nicht, dass es anders möglich ist." (Jealous 2006, p.8)*

[115] *„Alternative Bewusstseinsformen, wie sie in Träumen, Poesie, Musik, Malerei, oder in Kulturen außerhalb des Westens vorkommen (z. B. Meditation oder Trance), sind in unserer Gesellschaft unterentwickelt. Unser Wissen auf das zu begrenzen, was in reduktionistischen Experimenten bewiesen werden kann, hat den menschlichen Geist durchwegs effektiv aus der westlichen Medizin herausgehalten." (McPartland, Skinner 2006, p. 349)*

[116] *„… Teil eines natürlich eingebauten Systems zur Kommunikation und Beziehungspflege mit der Erde"[...] „Diese Fähigkeit droht wie ein ungenutzter Muskel zu verkümmern, wenn man sie nicht nutzt. Intuition und Instinkt sind also von Geburt an vorhanden, verdorren jedoch durch mangelnden Gebrauch aufgrund der gesellschaftlichen und erzieherischen Anforderungen. Intuition, Instinkt und Wahrnehmungskraft stumpfen auch durch den Stress und die Belastung ab, die das urbane Leben und die Belastungen im Berufsleben mit sich bringen. Mit großer Sorgfalt werden die Orte ausgewählt, wo BOCF-Trainings [=Biodynamic Osteopathy in the Cranial Field, Anm. d. Verfasserin] abgehalten werden. Die Natur muss zugänglich sein, um von ihr lernen zu können. Jealous erfuhr in der Wildnis New Englands und Kanadas selbst, wie das tiefere Selbst, der menschliche Geist bei der Begegnung mit der Natur zum Vorschein kommt. Die ‚Verzauberung der Sinne' in der Natur beruhigt das ZNS [zentrales Nervensystem, Anm.der Verfasserin] und führt zur Auflösung der Grenzen zwischen dem Individuum und dem Ganzen." (McPartland, Skinner 2006, p. 358)*

[117] *„Im Grunde passiert in einer osteopathischen Ausbildung etwas sehr Limitierendes: Wir sagen unseren Schülern, sie sollen die Hände auf den Körper legen und aufmerksam sein. Als ob sie wüssten, wie man so etwas macht. Man kann nicht einfach eine Person vom Computer oder vom Fernseher wegrufen [...]. Man muss den Schülern beibringen, wie sie ihr Bewusstsein natürlich sein lassen können. Die meisten Menschen wissen zunächst überhaupt nicht, wie sie ihre inneren Wahrnehmungen einsetzen können. Sie haben einfach kein Bewusstsein dafür." (Jealous 2006, p. 7-8)*

[118] *„Das erste Prinzip, wie man lernt mit dem Bewusstsein zu arbeiten, ist also, zu lernen, wie man die Aufmerksamkeit zwischen den therapeutischen Kräften und dem Läsionsfeld im Patienten aufteilt. So bringen wir den Schülern bei, die Läsion zu fühlen. Wir bringen ihnen bei, anstatt sich nur auf die Läsion zu konzentrieren, sich auch auf die Anwesenheit der primären Respiration im Ganzen zu konzentrieren. Wir fangen also an, die Aufmerksamkeit zu teilen: zwischen dem, was lokal passiert und dem, was systemisch passiert. [...] Wir müssen also Menschen darin ausbilden, ihr Bewusstsein zu öffnen und zu erweitern.") (ibid)*

[119] *„Wir müssen alle die ganzen schlechten Angewohnheiten loswerden. Die Menschen starren: Sie sind gewohnt in den Fernseher zu starren, sie sind gewohnt Computer anzustarren. Zudem gibt es in der westlichen Welt viel Augenkontakt. Und so ist keiner daran gewöhnt, die Person, mit der er spricht, so anzusehen, als wenn er in einem Ozean sitzen würde [...]. Man bringt also die Schüler dazu, den Hintergrund und den Vordergrund zu sehen - beide zusammen, solange, bis wir den Hintergrund in den Vordergrund schieben können. Wenn wir einmal den Hintergrund in den Vordergrund gerückt haben, können wir einen neuen Hintergrund dazu bringen. Was letztendlich passiert, ist, dass jeder Einzelne irgendwann den therapeutischen Prozess beobachten kann und auch das Läsionsfeld, alles auf einmal. Bewusstsein ist also wirklich eine sehr große Sache." (Jealous 2006, p. 7-8)*

[120] *„Möchte man sich um sein Bewusstsein kümmern, so muss man viel Zeit damit verbringen, nicht auf Informationen zu reagieren, die auf die Sinne einwirken. [...] Wir müssen lernen, dass man seinen Geist leise sein lässt - ihn leise sein lässt, ihn nicht leise hält - und wie man ihn einen völlig anderen Teil an Informationen wahrnehmen lässt. [...] Hinzu kommt, dass es dafür kein Unterstützungssystem gibt. Sollten Sie sich also entschließen, mit Ihrem Bewusstsein zu arbeiten und sich darum zu kümmern, werden Sie nicht viel Unterstützung bekommen. Sie müssen sich darauf wirklich richtig einlassen. Es ist eine große Verpflichtung"(Jealous 2006, p. 7-8)*

[121] *„Wir wissen, dass dabei der Blutdruck und Puls sinkt, die Atmung sich verlangsamt. Wir wissen, dass es Ihre Geduld fördert. Und es gibt einem auch das Gefühl, als wenn man in einer großartigen Weise ein Teil des Lebens ist, anstatt sich nur mit ‚dem kleinen Beruf' zu identifizieren." (Jealous 2006, p. 7-8)*

[122] *„Still hatte gleichermaßen Kraft und Gedanken dort angewandt, wo Knocheneinrenker hauptsächlich Kraft und Heiler hauptsächlich Gedanken eingesetzt hatten. Seine Hand und Bewusstsein hatten sich verbündet und zusammen massierten sie die Oberfläche und Tiefe. Heutzutage nennen die Osteopathen diese Fähigkeit ‚Visualisation'. Still war darin besonders begabt. Er glaubte, die Organe unter der Haut ‚sehen' zu können, was ihm ermöglichte, den Harnleiter, die Blase oder den Darm mit der gleichen Handstellung oder Handverschiebung zu ‚bewegen'. Man sollte sich darüber im Klaren sein, was ‚Visualisation' in der osteopathischen Tradition bedeutet. Visualisieren bedeutet, an die direkte Verbindung zwischen Bewusstsein des Therapeuten und lebender Materie des Patienten zu glauben. Die Gedanken des Therapeuten vollziehen sich im Patienten. Wahr ist, dass Still diese ‚Vision' von den ‚Heilern' übernommen hat, aber er veränderte die Vorstellungen seiner Lehrer grundlegend. [...] Seine Hände hörten auf, Hämmer zu sein, die den Patienten bearbeiteten, sondern wurden zu konkreten Verlängerungen seiner Gedanken. Seine Hände konnten so tief fühlen, wie sein Bewusstsein visualisieren konnte." (Abehsera 2002, p. 26-27)*

[123] *„Der Zug am Schweif muss langsam aufgebaut werden um sich den zu fühlenden Bewegungstendenzen des Pferdes anzupassen. Der Zug muss eine Weile aufrechterhalten werden, [...] und in der Folge wird sich das Pferd entspannen. Durch Absenken des Kopfes und des Halses wird das äußerlich sichtbar. [...] Es kommt zu einer ‚Dehnung' der Hirnhäute." (Langen, Schulte Wien 2004, p. 137,141)*