Craniosacral Osteopathy:

"Personal Perspectives of Osteopaths with several years of professional experience"

M.A. Thesis for the academic grade

Master of Science in Osteopathy

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Declaration

Hereby, I assure of having independently drafted the master thesis at hand.
All passages that have been adopted either literally or contextually from published or non-published works, are marked accordingly. I have indicated all sources and auxiliary material used in this work. The thesis in the present version has never before been submitted to another board of examination.

December 2006 Sandra Wojna

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1. Introduction

1.1. Personal interest

It was important to me that in the course of my M.A. thesis I would be working on a topic that has a precise reference to the people, as well as on something that both interests and concerns me personally.

Since the beginning of cranial instruction at the **Vienna School for Osteopathy** (VSO), the Cranial Concept was something fascinating, challenging and confronting to me. (a) Fascinating, because I noticed from the beginning, that it offered great therapeutic possibilities beyond the physiotherapeutic work, (b) challenging, because I did not perceive the movements, that were laid down by the cranial theory, as they were taught, and (c) confronting, because the topic was approached with an amplitude of theories, that deal itself primarily with tactile perception or sensing respectively.

At the end of the training, there were more questions than answers. The theory and practice that has been taught for years was juxtaposed by the statement of experienced osteopaths who claimed that there were no evidence for the existence of the PRM (Primary Respiratory Mechanism), respectively, that numerous studies refuted the hypotheses of the cranial concept (cf. 2.8.). I perceived the cranial models myself as a student in class as a "reality". Accordingly, I was puzzled when first

dissenting opinions from other lecturers and assistants appeared, who did not question the cranial concept *per se*, but its theoretical background.

Was cranial theory wrong and scientifically not supportable?

Did the mobility of PRM not exist and what did then constitute the success of the treatment?

Was I only uncertain or were there colleagues who had similar questions as I had?

Discussions with colleagues at the "Osteopathiestammtisch" (round table for osteopaths) showed that there were different points of view and methods. Immerging deeper into this topic and thereby getting to know personal points of views of colleagues was my motivation for choosing

"Personal Perspectives of osteopaths with several years of professional experience concerning cranial osteopathy"

as topic for my Master thesis.

The master thesis developed – whilst in the process of analysis – more to me than just deepening a scientific topic and getting a diploma for the completion of studies.

Thereto Strauss writes strikingly:

> *"The scientist, will, when he is more than only competent – with his feelings and his intellect – "be in his work" and will be deeply influenced by the experiences he has been making during the process of research." (Strauss, 1994, p.35)*

This statement is highly applicable to myself as, next to the professional occupation with the topic, a new interesting area opened for me: Communication (in my interviews) and the *comprehension* of the stated contents (during the phase of

evaluation). The personal acquisition while working on this thesis turns it for me, independently of its scientific impact, into a successful project.

1.2. Illustration of central question

After a six-year long (part time) training with 265 hours of instruction in cranial osteopathy (according to the inscription office of the VSO, Nov. 6, 2006), doctors and physiotherapists leave the Vienna School for Osteopathy (VSO). After the formation more than 50% opt for (i.e. since 1998 – 123 osteopaths) a further training in biodynamic cranial-osteopathy at the VSO. These numbers show the enormous interest that osteopaths have for the cranial concept.

The cranial instruction during the formation is in its content strongly based on the theories of William Garner Sutherland D.O: (1873-1954). Jean Arlot (teacher at the VSO) referred in his comments repeatedly to Sutherland's doctrine.

However, the cranial concept is being criticised strongly and the existence of PRM is being denied. (Hartmann & Norton, 2002; Picknett, 1999). On the other hand, osteopaths try to prove its very existence. But one can hardly find studies, that have been conducted after the present valid scientific standard. (Sommerfeld, 2001, p.50). There are hitherto – apart from quantitative methods of measurements – no studies that show how cranial osteopathy is implemented into practice and which attitude the osteopath that works on the patient takes vis-à-vis the cranial concept. This was for me the reason to choose a topic, that takes the practical application of cranial osteopathy into consideration.

In my thesis I concentrate on the following questions:

- How do osteopaths realise the syllabus of the formation in their own surgeries?
- Is there a strong orientation on the topics taught, or do therapists find their personal way to practice cranial osteopathy?
- Is there a critical preoccupation with the theoretical concepts?

Hence, the aim of this thesis is not to verify the hypotheses, but to gather material that shall give students and trained osteopaths, lecturers and the directorate of the VSO an impression on, how practicing osteopaths who have accomplished their training at the VSO realise the contents of cranial osteopathy and which attitude they take personally in this regard. Hence, further questions can be evolved.
Thus, I consider the thesis at hand a sketch of problems and a collection of indices concerning the topic "Personal perspectives of osteopaths with several years of professional experience concerning cranial osteopathy".

1.3. Structure of the thesis

This master thesis is structured into three parts. A theoretical part, a methodological part and the part, in which results are presented and discussed.

The **theoretical part** deals with the history of cranial osteopathy, its theoretical foundations, the cranial training at the VSO, the theory of practice as well as with research concerning cranial osteopathy.

In the **methodological part** I describe the way of method-finding for my survey and the theoretical bases of qualitative social research. Furthermore, I will go into the development of the interviewing guidelines, the data ascertainment via interviews as well as into the theory of evaluating the interviews.

In the **part of results** the interviews will be evaluated, compared one with each other and related to the theoretical part.

The following discussion of my thesis, shall show weaknesses and offer incitement for further questions.

2. Theoretical part

2.1. Historical overview

In order to provide the reader with a better comprehension for the direction cranial osteopathy has taken, I would like to give now an overview of the historical development of cranial osteopathy. It shows likewise on which foundations the instruction at the VSO is based.

The study at hand deals with a subject, its emergence and development, in a time period of about 100 years until today. In the VSO instructional concept the lecturers refer primarily to the works of W.G. Sutherland (1873-1954), H.I. Magoun (1898-1981) and in its basics to the works of J. Jealous.

Therefore the historical overview refers to the following sources: "Contributions of Thought" (COT, 1998), published by A.S. Sutherland and A.L. Wales, "Osteopathy in the cranial field" (OCF,) by H.I. Magoun and "Kraniale Osteopathie" (1998) by T. Liem.

First written works on the topic cranial osteopathy date back to the year 1929, when W.G. Sutherland, a student of the founder of osteopathy A.T. Still (1828-1917), at a meeting of the *Minnesota Osteopathic Association* (Sutherland, COT, p. 31pp.) lectures his ideas – that have still been in a phase of experimenting – concerning the impact of cranial membranes on influenza, and also offered first detailed propositions for treatment.

Starting point for the development of the cranial concept were exact anatomical studies of the scull, for which Sutherland came to the conclusion that the different

bevels of the cranial sutures must have the meaning to permit certain movements. In associating them with the bevels of gills of fish (cf. COT, p.146) and in applying a basic principle of osteopathy, i.e. the reciprocal dependence of form and function (COT, 1998, Foreword), initiated the idea, that there must be a mobility within the osseous and the membranous part of the skull, that expresses itself in a recurrent rhythmical respiration (ibid.). Extensive studies and self-studies of a theoretical and practical type, confirmed his theories.

The Cranial Bowl which Sutherland published in 1939, in which he explains the insights from his research and the resulting principles for cranial osteopathy, was for the time being rejected. Only in 1946 at a conference in Denver, Sutherland managed to obtain acceptance for his concept (Liem, 1998, p.3)

H. I. Magoun, a direct student of W.G. Sutherland, committed himself on the latter's deathbed in 1954, to teach cranial osteopathy also in Europe. In *"Osteopathy in the cranial field"* (1951), an opus, that is until our days perceived as a fundamental piece of work for every craniosacral osteopath, Magoun put Sutherland's comprising ideas into a structured and comprehensible form.

In class one works according to a concept that is more than 50 years old. A new type and advancement of the basic concept of cranial osteopathy, is offered as a seven-year postgraduate course "Biodynamic craniosacral osteopathy" and numerous students attend the three-year formation at the OCC (Osteopathic Centre for Children). The basics for both formations derive from J. Jealous (one of Sutherland's students) and are taught by himself and his students.

Other forms of advancements of cranial approaches like, for instance those of J. Upledger, Huge Milne or R. Fulford will not be analysed in this thesis, as they are not

considered in the training at the VSO and are therefore not of any relevance for my thesis.

2.2. Definition of cranial osteopathy

This chapter serves to present how cranial osteopathy was defined in class and literature, to which teachers at the VSO refer.

For Jean Arlot (my teacher for craniosacral osteopathy at the VSO), who was repeatedly referring to Sutherland and Magoun, modesty and humbleness towards the patient are a condition in the treatment. The treatment of the skull has an effect on the rest of the body. "*Via the skull, we engage into work on the whole body." (Arlot, 1995, my notes from the instruction)*. Therefore, a high sensibility for listening, observing, seeing and sensing has to be developed. An anatomic and physiologic knowledge is very important, the highest instance however is sensing. "*Sensing must not be submitted to the intellect*", was one of Jean Arlot's first sentences in the introduction to cranial instruction.

In the basic works of cranial osteopathy I have searched in vain for the the chapter of a definition of the concept. In Sutherland's and Magoun's works one can find statements that explain what they understand by cranial osteopathy. Here some of their thought shall be mentioned.

In the application of cranial osteopathy a thorough comprehension of osteopathic principles is necessary. "*The Cranial Concept is: A The application to the skull of the principles of Osteopathy proclaimed by the Founder of Osteopathy, Dr. Andrew Taylor Still."* (Magoun, 1951, p.1). The separation of structure and function is thereby impossible (COT, Foreword).

Osteopathy, as a *"comprising diagnosis and therapy-system"*, that is based on the interactions of anatomy and physiology, considers the body as an entity.

> *"It concerns the status of the whole human organism, a unit mechanism, in relation to its internal fluid environment, as well as the external surround."(Magoun, 1997, p.19)*

Furthermore, a body that is nourished properly, of which structure and physiology is correct, is able to heal itself or respectively stay in health. The objective of osteopathy is therefore to improve the structure and thereby the function.

According to Sutherland cranial osteopathy is not a part of osteopathy, but is for itself osteopathy and science.

> *"Osteopathy is here to stay. Osteopathy is a science, The cranial concept is osteopathy. It therefore is a science. It is not an integral part of osteopathy, it is osteopathy. It is not a 'therapy'. That is why I feel so intensely about the term 'therapy'. For this is a science that deals with the natural forces of the body."(COT, p.143)*

The craniosacral concept sees cerebrospinal fluids as the highest known element in the body. Its sufficient production and distribution is of essential importance for the person's health. The osteopath is able to guide the fluctuation of these liquids until an exchange of all fluids takes place in the body.

> *"It is possible to make this assertion without hesitation: The fluctuation of the cerebrospinal fluid may be controlled in its rhythm by thinking-feeling-seeing-knowing fingers to a degree where all the fluids of the body have a rhythmical-balance-interchange." (COT, p.215)*

Craniosacral osteopathy generally is seen as part of osteopathy. The osteopath approaches the patient with a high amount of esteem and attempts to comprehend him in its wholeness. When working on the head, this has an effect of the whole body. Primary goal is the reconstitution of the structure, to enable the body its whole function.

2.2.1. PRM (Primary Respiratory Mechanism)

The Cranial Concept is substantially based on the existence of the PRM. As this mechanism takes a central role during the treatment, I consider that an extensive explanation is important. This section tackles the description of components that make the PRM possible and its somatic expression, i.e. what the therapist perceives with his hands or should perceive with his hands.

The PRM exists independently from the thoraco-pulmonal respiration. It is called primary because in the hierarchy it is placed above pulmonal respiration and also because primary signifies also principle (Magoun, 1951, p.16). Respiratory, as it refers to metabolism.

> *"Physiological respiration is metabolism, the giving off of waste material and the formation of new by the cellular protoplasm (…)" (Magoun, 1951, p. 6)*

Sutherland never referred to a certain frequency of cyclical reoccurrence of the PRM, since Magoun's measurements there exists an indication of 10-14/minute. (Magoun, 1976/2000, p.57)

5 components enable the function of cranial rhythm:

a) The movements of the central nervous system

b) The fluctuation of the fluids

c) The plasticity of the cranial bone and the movement of the sutures

d) The movement of the sacrum within the pelvis

e) The balance of membranes of the skull and the spinal cord

a) The movements of the central nervous system (CNS)

During surgeries obvious movements of the central nervous system (CNS) can be observed. One of these movements is linked to cardiac contractions, another one to thoracic respiration and an additional pulsation could not be identified until now. A possible reason of this pulsation can be assumed in the CNS' response on the rolling-in movement of the two anterior bulges of the neural tube during the embryonic development. We call this an innate motility of the CNS. (cf. Magoun, 1997, p. 23)

b) The Fluctuation of fluids

The fluctuation of liquor is the core-element with which the therapist works during the cranial treatment and that he influences with his techniques in the centre as well as in the periphery.

> *The cerebrospinal fluid is the highest known element in the human body…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 is forever lost. (Magoun, 1997, Foreword)*

c) The plasticity of the cranial bone and the movement of the sutures

The form of the articular surfaces, their bevels and crests and the life-long existence of sutures without developing ankyloses, suggest the conclusion that

> *"every articulation envolves in relation to and in proportion to the slight amount of purposeful motion normally present, motion which persists throughout life." (Magoun, 1997, p.32)*

These movements cannot be recorded electronically (in not further described experiments – my comment).

d) The movement of the sacrum within the pelvis

The movements of the sacrum take place synchronously with the remaining craniosacral mechanism. The Dura mater spinalis acts as a transmitter for this mechanism, with the help of its lower protrusions.

e) The balance of membranes of the skull and the spinal cord

> *"Via the membranes (falx cerebri, tentorium cerebelli, falx cerebelli, pituitary gland, tentorium bulbi olfactorii – my comments) that are sent by the dura into the inner skull a transmittance, transmission, harmonization of tension takes place and hence a translation of PRM from the liquid to the periosteum." (Sommerfeld, 1998, course material)*

The origin of the falx cerebri and the tentorium cerbelli at the sinus rectus is called *"Sutherland's fulcrum"* (Magoun, 1976/2000, p. 44), that is similar to the centre of gravity in the body not of a subsumable structure but a notional point. In order to keep an equilibrium in the skull, the membranes must be able to adapt themselves. The *Sutherland's Fulcrum* can relocate itself in order to adapt to the changes (i.e. physiological changes like the movements of PRM and traumatic changes, the author). (cf. Magoun, 1976/2000, p. 48). *"It goes right on being a still point of rest from which the lever operates and gets its power"* (Sutherland, 1962, p. 50). Due to its ability of adaptation, this membrane is called membrane of reciprocal tension.

Magoun describes two phases of the PRM. These are **inspiration** and **expiration** with its corresponding effects. During the **phase of inspiration** (also called flexion or external rotation) there is a widening of the whole system, in the **phase of expiration** (also called extension or internal rotation) the whole system tightens.

Thereby the phase of inspiration is the more active part, the phase of expiration the more passive one.

The labelling flexion/extension refers to the bones that make their movement around the anterior/posterior axis, i.e. occiput, sphenoid, ethmoid, sacrum and further vomer, hyoid and mandibula. The labelling external and internal rotation refers to paired bones (Parietale, temporale, maxillaes, zygomas, the nasals, the lacrimales and the palatinum; Magoun, 1997, p.1-2).

Table 1 of Peter Sommerfeld (1998) describes the effects of cranial movements on the physiognomy and the scull system.

Tab. 1: Impact of cranial movements of the physiognomy and the scull systems

AREAL	FLEX-AR	EXT-IR
Vertical SkullØ	small	big
Sagital SkullØ	small	big
Lateral SkullØ	big	small
Kalvaria	flat	steep
Frons	receding	steep
Sutura metopica	retreated	salient
Tuber fontale	salient	flat
Orbit	broad	narrow
Eyes	salient	Lowlying
Zygomatic arch	flat	salient
Ala wing of the nose	broad	narrow
Palate	flat	high
Dental arch	big	small
Dental position	broad	narrow
Mandible position	posterior	anterior
Ears	distant	adjacent

Sinus	dissemination	close
Membranetension	big	small
Fluctuationdirection of liquor	to the centre	To the periphery

Three major factors are – according to Magoun – decisive for a normal cranial movement of the articulation: (1997, p.49)

- Sufficient plastic resilience
- Sufficient mobility within the sutures
- Restriction-free membranes of the dura with their reciprocal tensions

These explanations testify the clear theory the cranial concept is based on. It is not assumptions, but detailed determinations how each bone moves in a certain phase of the PRM and how the interaction of all sutures concerned works.

2.3. Curriculum of the VSO – Syllabus of the formation

In the following there is an overview on the syllabus of instruction which were taught at the VSO concerning craniosacral osteopathy. This is for me of importance due to the fact that during the survey a comparison should take place, how the syllabus taught is implemented into practice. In my explanations I refer to the notes I have taken myself, to the scripts, that were handed out during the formation (time period 1995 to 2000) and especially to the curriculum of the VSO.

You can find the complete curriculum of the VSO in the appendix. I have taken it as a computer print of the curriculum as it has been sent to me on September 29, 2006 by the VSO. It has to be taken into account, that this is the current curriculum and that

my interviewees have finished their formation 3 to 6 years ago. According to the office of inscription of the VSO indeed individual course-modules have been shifted, however the as regards content the structure has not changed in the course of the past years. Instruction takes place in 16 modules, with a total time of 26.5 days (i.e. 265 hours) and starts in the last week within the first year of formation.

The curriculum shows that the instruction deals with two areas.

The theory that craniosacral treatment is based on and the practice.

In an overview the theory comprises:

- Osteopathic concept Still, Sutherland – the history, Principles of "Breath of life" (Jealous)
- Extensive anatomy and neuroanatomy of the scull and the sacrum
- Function and mode of action of the liquor cerebrospinalis and the cranial membranes
- Models for the explanation of cranial movements and the effects on the body by its dysfunctions
- The three diaphragms
- Ears, Eyes, Face, Temporo-mandibular arcticulation
- Priority lesion
- Understanding the Neutral, Potency, Still Point
- SSB Patterns, intraosseous strains
- Theoretical background to the individual types of correction in the craniosacral treatment
- Theoretical part of the diagnosis
- Embryology

Practical experience:

- Tests: Palpation of the tissues, Ecoute, Induction, V-Spread
- Techniques: functional membrane-technique, indirect technique, direct action, disengagement, moulding, V-spread, Fluid Drive, sinus technique

One has to consider, that my interviewees originate from different years. During my work on the theoretical part I talked over and over again to colleagues and interviewees in order to obtain further information concerning the structure of instruction, the recommended literature and who was instructed by whom.
Thus, it appeared to me, that there was a standardised curriculum, however the manner how it was interpreted by the instructors, was very different.

2.4. Indications for cranial treatment

The indications for a cranial treatment are diversified. According to Jean Arlot (copies from the formation, 1995-2000) the diagnosis is based on three sources of information: *anamnesis*, *inspection* and the most important part, the *palpation*.
The precise *anamnesis* allows to draw conclusions on potential disbalances and helps to find out which tests should be conducted. Hence, congenital influences, diseases and in particular children's diseases, traumata, pain, physical and mental stress etc. are taken into account.
The *inspection*

> *"serves as detection of possible dysfunctions on the surface. It gives us indications on the basic defective positions of those bones, that are involved in the craniosacral mechanism and their consequences on the membranes, the cranial share on the*

CNS, the arterial and venous system and the system of fluids." (Jean Arlot, copies from the formation)

The aim of *palpation* is the sensing of tissues and the perception of movement. Assisted by a clear mental image of the craniosacral mechanism the therapist senses movements, tensions, elasticity, extensibility, induration and tonus of the cranial system. In particular the general contours of the skull, disorders of the sutures, decrease in the elasticity of bones as the individual sutures are examined. The Therapist deducts from his perceptions the form of treatment.

2.5. Schedule of treatment

While in the different therapeutic concepts there is a clear schedule of treatment, as for instance in a shiatsu treatment or a sports-physiotherapeutic training plan, the osteopath in the treatment orients himself on the previous examinations. That is, after a thorough anamnesis and an inspection the patient is examined. The treatment is based on the results of these three parts.

This chapter shall give the reader an impression, after which points of view the osteopath conducts his treatment. In the part of results, the presented theory will be compared to the statements of the interviewee and interpreted accordingly.

According to the instruction at the VSO there is no recipe in osteopathy how the patient is to be treated with various symptoms or diseases. Each person is seen as an individual and the therapeutic procedure is adapted according to the results of the examinations. However, some factors that should be comprised in a cranial treatment, can be described. Magoun lists them in his chapter "*Principles of cranial Treatment*" (1997, p.94-106). In the following I will summarize some of the principles which were

– in my opinion – also transmitted in this way in the instruction. I will also relate to the material that was handed out in the instruction.

The most fundamental aim of osteopathic treatment and therefore also of cranial treatment is correcting the structure in order to obtain an optimal function of the organism (Magoun, 1997, p.94) and to *"obtain via the fluids and membranes answers to traumata (pre-, inter and postnatal, as well as structural, energetic, psychological etc.)"* (Sommerfeld, 1998, teaching material). Thereby, one of the most important resource is the self-healing force of the human body.

> *"No external force that can be safely brought to bear upon the living body is as specific or efficient as the powers of self-correction within its own mechanism." (Magoun, 1997, p.106)*

In order to obtain an optimal function of the organism, Magoun describes several objectives in the treatment: (ibid., p.107 - 111)

- Normalisation of the fluctuation of cerebrospinal fluids
- Normalisation of neural functions as countermeasure to stress-initiating factors
- Elimination of circulatory stagnation
- Deliverance of membrane tension
- Correction of cranial articulation lesions
- Alteration of structural basis patterns

Therefore it has to be considered that factors as myofascial strains coming from below, infections of any kind and malnutrition have a negative impact on the cranial mechanism and have to be treated aetiologic (ibid., p.98)

> *"To provide the most favorable environment for normalization of structure, all patients should be guided into correct eating habits so as to provide the body with the necessary raw materials." (ibid., p.99)*

Normally the treatment starts in supine position, whereas the therapist sits at the patient's end of heading. A condition for the treatment in order not to evoke an aggravation of the fixation, is the détente of the therapist. With vigilance and the intelligent use of hands the therapist induces all movements with great care and gives the structure the time it needs to relax.

> *"Diagnosis is a never-ending part of cranial treatment. Every treatment, if correctly given, requires re-examination by palpation before further steps are taken." (ibid., p.104)*

For establishing contact the therapist poses questions towards:

- **Quality of the tissues**: elasticity of the skull and the sutures
- **Movement**: direction, amplitude, frequency and force of the MRP
- **Adaptation of the cranial base**
- **Localisation of zones of restriction**

Different techniques are applied for the treatment of cranial lesions, which are depicted in Table 2 (Sommerfeld, 1998).

Tab. 2: Cranial techniques

Exaggeration (indirect technique)	The articulation is lead gently into the direction of the lesion; the strengthened resilience of the membranes cause a reduction of the lesion.
Direct action	The therapist follows the way of the lesion in the normal starting position, as far as the tissues allow it.
Disengagement	Is used for compaction. The areas of the articulations are separated, before the point of balance is established.
Physiologic contrasting movement	Represents a combination of direct and indirect technique.
Moulding	Working on intraosseous Dysfunctions
V-Spread	Working on fluids in order to improve the flexibility of a suture.

As the indirect technique is the one that is used the most often I will describe it more in detail. The osteopath seeks the point of balance of membrane tensions. Then the fluctuation of the cerebrospinal liquor is made use of. The point of balance is kept carefully until the "resilience of the membranes brings about correction of the lesions" (ibid., p. 104). The point of balance of the resilience of the membranes (i.e. Sutherland's fulcrum) shifts into a normal position, whereas the therapist follows the movement. When the fulcrum has moved into the more physiologic position, the membranous levers can act freely and the restrained articulations have the possibility to free themselves from the restriction. (ibid., p.104)

Magoun describes the importance of human touch in a non-therapeutical sense. Although the physical relevance ranks above the psychological one,

> *"At the same time the mere laying on hands to pinpoint the difficulty and do something tangiable about it is a priceless ingredient on physician-patient relationship." (ibid., p.103)*

Recapitulating, we can record, that the osteopath uses different techniques in his treatment, on order to correct the structure and to restore the normal function. The technique that is used the most is the indirect one. Therefore, the question for the interviews occurs, to which extent osteopaths consider these principles in the cranial treatment.

2.6. Palpation – Perception

Here this topic will be elaborated in a theoretical way, as it takes an important place in the evaluation of the interviews in chapter Perception and PRM (4.2.4) which is related to the theory of palpation.

Palpation or sensing, respectively is of fundamental importance for the work of the osteopath.

> *"Trained tactile sense is one of the fundamental principles of Osteopathy, and is essential in diagnosis and treatment. This osteopathic tactile sense is essential in cranial technic." (Sutherland, 1994, p.67)*

This chapter explains how the therapist touches – according to the theory – the patient in order to receive a maximum of information. It also explains the conditions for palpation, what the therapist can perceive when palpating, and the problems that can occur in the context of verbalizing the perceptions from palpating.

For the findings of diagnosis the cranial osteopath uses three main tools: The interview, incl. an exact abstract of the anamnesis (cf. 2.4), the observation that gives us an indication of the defective position of the osseous structures (Magoun, 1997, p.77), as well as palpation.

Magoun describes the uniqueness of the human hand as diagnostic instrument, that cannot be replaced.

> *"The x-ray may show gross changes in Pathology; the laboratory, alterations in chemistry; but neither can possibly reveal the fine shades of tissue tone and tension, mobility, elasticity, resiliency, flexibility, extensibility, reaction to stimuli and all the other thins so essential to adequate diagnosis." (ibid., p.81-83)*

I have chosen this quotation, because it expresses indirectly which palpatory abilities the osteopath can and should develop according to Magoun. The therapist uses his

trained tactile sense in order to investigate the present status of the tissue. Delicate proceeding, soft touches and the own relaxation are absolute preconditions for the work with the patient. *"One must work with the tissues, not against them." (ibid.,* p.83). In order to interpret the palpated correctly, strong concentration is necessary.

"Palpation starts normally with the head of the patient that is in a supine position. The room where the treatment takes place should have a pleasant atmosphere." (ibid., p.84)

What does the therapist being instructed, trained in perception and being relaxed, feel at the first contact with the patient's tissues?

- The first impression will be the quality of the soft tissue. Warm or cold, dry or moist, soft or rough skin already indicate whether there could be adaptations and compensations in this area. (ibid., p.84)
- In addition to the inspection the therapist can palpate the position of the bones of the skull. One senses, for instance at a posterior-anterior lesion at the occiput on the side concerned a flattening and an anterior position of the occipital plate . (ibid, p.259)
- Further, the therapist senses, whether muscles or fascias of the scalp are shortened, tonic, atonic, oedematous, toxic or sensible. Magoun does not go more into detail how these aspects feel and how they can be differentiated one from the other
- As the most important aspect the osteopath perceives the movement (motility) of the skull and related to that, the missing or limited motility of the sutures.

Magoun emphasizes the importance of knowledge in anatomy and craniosacral mechanisms, and an involvement without intention.

> *"The first essential is a thorough knowledge and a clear mental picture of craniosacral mechanics, especially the shape and bevel of the bony constituents as guided and restricted by the reciprocal tension membranes. Second, one must be attuned to the permitted motion within the mechanism. No attempt should be made to impose motion upon it." (ibid., p.84)*

For the purpose of diagnosis, the therapist uses – apart from pure "sensing" – certain techniques, that give him information about restrictions and lesions of the craniosacral system. This comprises the inducting of movements and the sensing of the replies of the tissues (ibid., p.88). Concerning the cerebrospinal liquor this means the leading of the cerebrospinal liquor in a certain direction in order to establish a molar motion of the whole mechanism and thereby finding out about restrictions. Secondly, the liquor is used to recognize the extent of a fixation, by sending the fluctuation from one certain articulation to another. (ibid., p.107)

The movement in the cranial mechanism cannot be compared with movements in other articulations. These are very delicate deflexions, and it needs a lot of training and an exact knowledge to be able to perceive the function of the PRM.
For explaining to the amateur how the osteopath can sense these little movements, Sutherland uses the following comparison:

> *"See that office safe? You can't open it. Jimmy Valentine, the safe-opening expert can, with his educated fingers. That is the way with the osteopath. With his educated tactility, he unlocks the laboratories that feed the body." (COT, p.21)*
> *"The fingers are the thinking-feeling-seeing instruments at our command. Feeling and seeing the tissue as you move it is that skilful art known as osteopathic technique when applied to osseous malalignment." (COT, p.22)*

From the literature we can derive what the educated osteopath can sense: Mobility, resilience, elasticity, rigidity, tonus, extensibility,… (Magoun, 1997, p.83). Sutherland gives the following instructions how sensing can best be acquired.

> *"It may be best acquired be the student having the hands upon the site of the desired movement alongside those of the instructor; following therewith intelligently with tactile sense, feeling, seeing, thinking as the tissue is being guided carefully, gently, firmly, and scientifically, into normal relationship." (Sutherland, 1994, p.67)*

The difficulty that the osteopath faces, is to express his perceptions verbally (cf. Chapter 4.2.4 Perceptions and PRM) in order to document his impressions or to have a basis for discussion with colleagues. One can find a fine overview of these problems of palpation in Sommerfeld's thesis (2001) at the VSO. In his chapter about the problems of clinic relevance of manual technique he summarizes that perception is subjected to the phenomenon of illusion and a "noncommunicable event of consciousness". According to Wikipedia, perception is *"the entirety of the processes of perceiving (or sensing)"* (URL: http://www.wikipedia.org/wiki/Perzeption; 2, Nov. 2006; my translation). It is selective-subjective, as information from the outside are interpreted by the receiving persons in the way that relates to their view of the world and experience.

My survey will also tackle this difficulty to perceive and to express these perceptions. (cf. Chapter 4.2.2)

2.7. Biodynamic craniosacral osteopathy

Since biodynamic craniosacral osteopathy has been offered by the VSO (1998) 123 osteopaths, i.e. more than 50% of the graduates, have started with this seven-year

post graduate formation. According to the inscription office at the VSO there is an enormous demand and there are many osteopaths on a waiting list for the courses.
For this reason, and because two of my interviewees participate in these courses, I would like to give the reader an insight into the biodynamic craniosacral osteopathy.
The source for the following explanations is the CD: "Introduction into biodynamic osteopathy" (Jealous), as well as the course script that was distributed in March 2006, during the first part of the course by Tom Shaver, who holds the training. Tom Shaver, who also teaches other subjects at the VSO is a direct student of J. Jealous, who founded the concept of biodynamic craniosacral osteopathy. James S. Jealous calls his concept "A Biodynamic View of Osteopathy in the Cranial Field".

> *"It's called biodynamic, because it focuses on contact with Tidal forces as they specifically interchange in an ever changing motive from moment to moment. It is a living contact with life". Tide is that force created by the Breath of Life that fluctuates the fluid dynamics, like the ocean tide which moves water but is not the water."(Jealous, 2003)*

It is based on the successful clinical experience of his teachers and of his own experience as a general practitioner in the USA. The aim is the treatment of the individual by functional moves as a whole. People of all age-groups and with different diseases are treated. For Jealous osteopathy depicts a living clinical field of science, the character of which is a radical interaction. If osteopathy is seen as a tree, the single techniques build branches; the trunk and the soil representing the principles behind, being indispensable for comprehension. As today there is not enough time to study osteopathy in its traditional form students often study only the branches of the tree, without getting a picture of its entirety. In order to achieve a change all over one person, it is not enough, to treat only the segmental dysfunction.

A deep understanding for embryology, anatomy, the different types of craniosacral therapy and overall the principles of osteopathy are prerequisites.

The following table is an abstract from J. Jealous' course material (2002). It describes how biodynamic osteopathy distinguishes itself from cranio-sacral osteopathy.

TAB. 3: Comparison: Craniosacral osteopathy – biodynamic osteopathy

Biomechanical model (craniosacral O.)	Biodynamics
Reflects Sutherland`s earlier ideas	Reflects Sutherland`s later ideas and contributions to the continuing growth of the Science of Clinical Osteopathy
Reductionistic techniques using operator forces	Techniques follow the movement within the system. Transmutative ability of Tide is acknowledged. Tidal forces directly interface with pattern of disease. One follows, closely
Concept was modeled after ideas that were prominent in profession at the time	Concept based solely on sensory perception and clinical responses
Axial motion on bone	Transmutational, translational motion
Cranial Rhythmic Impulse (C.R.I) is primary expression of Breath of Life	C.R.I. is not an expression of Breath of Life, nor is it a therapeutic force
C.R.I. 8-14	Basic rate is 2-3/minute, slower rates are specifically identified as primary to the system
Central nerval system is primary mover of five phenomena	Breath of life is primary mover, motion is simultaneous and synchronistic in all phenomena
Perception is automatic Skills not delineated	Perception is a conscious, skillful act, requiring training and moment-to-moment adjustment, not automatic

No biologically active midline	Spational orientation is primary funktion on the organisation of motion. The midline is bioelectrically active
Breath of Life is not central to healing	Breath of Life has conscious intention and provides techniques
Primary Fokus is finding lesions and reducing them	Primary Fokus is on the intention of the Breath of Life and its priorities
Operator guided by expertise in defining restriction. Being Still and Knowing is not central to process although it is peripherally acknowledged	Guidance is through a Higher Wisdom on patine, sensed as Breath of Life, or a "little voice" within (Becker). Here direct, instinctual communication with generative conciousnesis appreciated as an art and necessary reality
Bones move in undulating patterns.	Bones move in undulating patterns that vary during inhalation period
Motion testing is applied to system	No motion testing; motion is observed during inhalation period
SSB is primary site of orientation for lesion activity. Lesions are diagnosed and reduced by conceptual sequences beginning at SSB.	Primary site is variable. SSB is not first area corrected unless Tidal forces act inthis area and indicate this is necessary. Lesions are nit automatically corrected, sequences are not conceptual. Priorities are established by the Tide
Lesions without motion are possible	Motion is always present on some level and can be utilized
Concept is nurtured by rational documentation	Concept is nurtured by clinical experience and observation of living system. Conscious work is instinctual rather than rational. The rational is supportive but secondary
R.T.M. (reciproke tension membrane) "Sickles create osseous mechanics	Dura acts as a unit and is mobilized by Breath of Life. Osseous motion is a response to the Tidal forces and the Breath of Life
Model is unchanged since its initial publication. Circa 1943	Model evolves with contribution from clinicians

As shown in the table, there are essential differences between the bio-mechanical and the biodynamical craniosacral type, even when both types refer over and over again to Sutherland. Palpating is replaced by sensing, instead of diagnosing lesions, one seeks for health in the body. I am myself at the moment in my first year of formation in biodynamic craniosacral osteopathy. There is an amplitude of terminology like *Breath of Life*, *Potency, higher Wisdom*, *Tidal forces*. All these concepts, that are explained in detail during the formation, should after long practice (that is why there is only one course per year) be realised and distinguished by the therapists. In my opinion, the verbal communication takes places on a very abstract level, and here one is also confronted with the difficulty of communicating a certain perception (cf. 2.6.). The approach of biodynamic craniosacral osteopathy represents for me a complete opposite to other osteopathic activities as, for instance, High Velocity Techniques, Muscle energy Techniques or Visceral Techniques, i.e. the therapist will have to re-orientate himself with this work. Jealous himself admits in his introductory CD that he was puzzled himself right after discovering this approach and that it took him a transition period of six years, until he familiarized himself with the concept.

2.8. Research on cranial mobility

The notion that osteopathy is no part of esoteric but scientifically accepted in the medical world, has been being emphasized during the formation. The exact anatomic knowledge and the knowledge concerning the functions of the body are conditions for working on the patient. The cranial concept was also told in a manner that did not leave any doubts for its correctness. My confusion was great when one assistant at

the VSO mentioned the thesis of one osteopath who doubted the existence of the PRM.

In order to meet the scientific claims, I would now like to describe scientific cognition concerning cranial osteopathy. I will come back to this topic later when evaluating the interviews. I will analyse how osteopaths tackle the topic "critical literature concerning cranial osteopathy". In research there has already been somebody who dealt thoroughly with this topics. P. Sommerfeld has written his thesis in 2001 on

> *"Inter- and intraexaminer reliability in palpation of the Primary Respiratory Mechanism as well as possible correlations with examiners' and subjects' respiratory rates: Discussion of the fundamental problem and experimental research,"*

and published his results in November 2004 in the journal *Osteopathische Medizin*. In the chapters *"Summary of scientific research on the hypotheses of the Cranial Concept"* and *"Studies on craniosacral palpation and its reliability"* he summarizes studies, that deal with the question of proving cranial mobility and discusses their scientific relevance.

In doing so, he discovers that all works that are quoted from osteopathic authors and that should prove the existence of the PRM (i.e. the basis for the cranial concept), do not meet the current scientific requirements. (for further information see Sommerfeld, 2001, p.42)

Thus, we can see that the cranial theory is based on preconditions that are hardly tested empirically and thus cannot be held as scientifically proved.

3. Method

This chapter should illustrate why I chose *qualitative social research* as the method for my survey. It should also depict its core elements.

3.1. Choice of method

When I started in January 2005 to deal with the methodology of my analysis, the drafting of a questionnaire seemed to me the appropriate means for examining the position of osteopaths towards craniosacral osteopathy. I had myself notions, which answers could be given by the interviewed persons und planned to find out by a simple questionnaire how the distribution of answers for the different set of questions would look like.

An appointment with Katharina Scholl, the mentor for M.A. theses at the Vienna School of Osteopathy, supported me in my concept, as well as she helped me in defining possible questions.

However, she advised me to contact Heidi Clementi who is specialised in the area of qualitative social research. In a meeting in March with Heidi Clementi we reached the conclusion that a quantitative questionnaire would probably not give adequate answers. Her main objection, that speaks against the use of a questionnaire for the exploration of my question, is that such a questionnaire limits the diversity of personal opinions and would reflect them only very reduced and simplified.

> *"A quantitative approach according to a scientific method would require that I myself as a scientist would formulate hypotheses before my study, and thereby would*

impose answers to the interviewee, that do not or only partly correspond to his view." (Lamnek 1995, p. 16 – transl.).

Additionally, according to Lamnek (1995, p.22), pre-formulated categories of answers could probably kill the willingness of the interviewees in volunteering information

"The hypotheses and the subsequently operationalizing in a quantitative approach determine what is relevant for the survey and how it is acquired. Thus, it is only surveyed what seems to be meaningful and necessary to the researcher concerning the cognition of the object. The perspectives and systems of relevance of the study objects concerned might be completely different ones. The researcher will never know as he forces his perceptions with standardized instruments on the subjects to be examined. An interviewee in an unstructured interview will rather provoke a discovery, by uttering something unexpected, than a participant, that ticks on one of six pre-coded answers in a questionnaire." (Becker/Geer 1979a, p.159; quot. after Lamnek 1995, p.16)

From these considerations I decided to approach the topic by the qualitative research, making use of interviewing guidelines.

3.2. Qualitative social research

When dealing more in detail with "quantitative social research", one finds a broad spectrum of different approaches. These approaches have been evolved within the last 40 years, originally as an alternative resulting from criticism towards one-sided quantifying processes. (Lamnek, 1995; Mayring, 1996)

While in quantitative research theoretically deducted hypotheses are being verified empirically, qualitative social research focuses on explorative field research. There is no a priori formulation of hypotheses. (Lamnek, 1995, p.22)

While quantitative research is testing models in order to find out about parameters concerning frequency, position, distribution and diversification and attempts to find

measures for certitude, and correlations, the subject of qualitative methodology is primary the "how" of these correlations, their inner structure especially from the point of view of the concerned. (Kiefl & Lamnek, 1984, p.474)

Qualitative processes are suitable for first approaches to hitherto unexplored areas, to *"explore relations"* (Kleining, 1982, p.227), for first categorization of the object of cognition. As there are yet no surveys in the area "practical application of cranial osteopathy of VSO graduates", and therefore an new area is subject of this thesis, this method of gathering material and thereby probably formulating new questions for further studies seems appropriate.

3.2.1. Principles of qualitative research

In the following, I will present some essential principles of qualitative social research (cf. Hoffmann-Riem, 1980; Kleining, 1982; Lamnek, 1995). These principles are openneness, communication, processuality, reflexivity and explanation.

3.2.1.1. Openness

This attitude demand to *"keep the spectrum of perception… as much open as possible, in order to gain thereby also unexpected, but even more instructive information"* (Lamnek, 1995, p.22). One should keep this openness towards the explored subjects as well as towards the situation of analysis and the applicable methods.

One has to consider that *"the theoretical structuring is kept back, until the structuring of the research object is defined by the research subject." (Hoffmann-Riem, 1980, p.343)*. Qualitative social research is open for new information. However, researchers

have already some knowledge about the object from their everyday-life as well as from their scientific experience, as it is in my case as self-practicing osteopath and cranial therapist. Therefore, *"it is wrong to think that we could start the seeking process with a 'tabula rasa', without prejudices. We have to overcome our previous knowledge, i.e. in the process of doing research" (Kleining, 1982, p.231 transl.)*. Throughout the research process there should be openness for unexpected aspects, new questions and topics, correlations, antagonisms and dimensions.

3.2.1.2. Research as communication

> *"The principle of communication says that the researcher gains an access to meaningful data in general only, when he gets into a relation of communication with the subject of research and thereby obtains the communicative control system of the subject of research." (Hoffmann-Riem, 1980, p.346 – transl.)*

While non-standardized communication between researcher and subject of research is seen as a disturbing variable from the point of view of quantitative researchers, for qualitative-oriented researchers research in itself is rather seen as a communicative process. The situation of research has to be adapted as much as possible to the communicative rules of everyday-life. (Lamnek, 1995, p.24). The more one is able to initiate and keep up a natural form of communication, the more one can expect valid data. (Mayring, 1996)

One element, in accommodating the principle of communication in this survey, is – in my eyes – leading the interviews in a pleasant, private and familiar surrounding.

3.2.1.3. Process-orientation of research and object

Research as communication always is processual. The notion of a not completely standardized interview leaves room for newly emerging aspects, correlations etc. The patterns of argumentation, the attitudes of the interviewees do not exist a priori but are being developed in the course of the interview. Thus, the interviewees constitute a part of their reality, which is happening in a processual way. (Lamnek, 1995, p.24)

The evaluation phase can also be seen as a process, as prior understanding and existing concepts of the researchers change while dealing with the object of the study; the prior understanding should be overcome step by step.

3.2.1.4. Reflexivity

Reflexivity is, related to the access to reality, a principle epistemological precondition of qualitative social research. Each meaning of human products of behaviour refers reflexively to the entirety, so that *"the meaning of an action or of a verbal expression can only be comprehensible by the recourse to the (symbolic or social) context of its appearance." (Lamnek, 1995, p.25 – transl.)*

The claim of reflexivity within the method exists also in the sense, that one is ready for reacting to new topics in the course of the survey.

> *"The reflexivity indicates the possibility to react to new constellations, a kind of openness for unexpected situations in the process of the act of research." (Lamnek, 1995, p.26)*

A reflective attitude of the researcher and the adaptability of the entirety of examination instruments are necessary prerequisites.

3.2.1.5. Explanation

Precognition, the proceeding of the researcher, the applied method and the rules of interpretation are to be revealed as far as possible, in order to make the process of research comprehensible. These factors, however, are no guarantee for the validity of the interpretations. As the knowledge of rules is mostly an implicated one, that is unconscious to the user, *"the principle of explanation…is more a claim than a practiced procedure within the scope of qualitative research" (Lamnek, 1995, p.26)*

3.3. Procedure in the survey

> *"After the intense occupation with the theory of qualitative social research it seemed important to me, to arrange the field phase in such a way that the object of research can be comprehensively highlighted without a priori formulated theories. The research area is no longer an entity to check on a pre-formulated question, but the starting point for this question." (Kaufmann, 1999, p.30 – transl.)*

The introducing questions of the interview can be summarized as following:

- In which form does cranial osteopathy find application in the daily practice?
- What does the therapist sense when examining and treating osteopathic?
- To what extent is the practical procedure related to the contents taught in the instruction?
- Is there a critical approach towards the syllabus?
- How is cranial osteopathy defined?

After the choice of the research method I will now give an overview on the various phases in the research process.

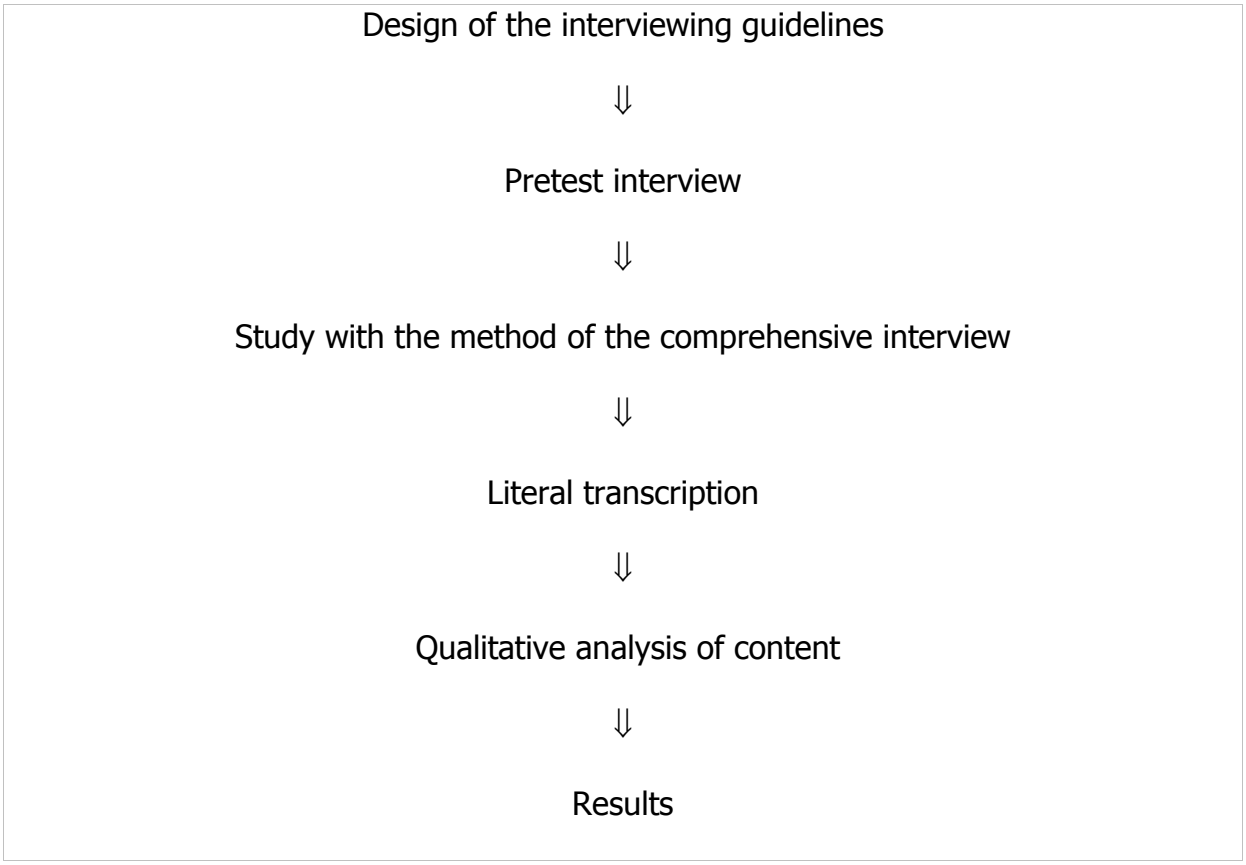

Illustration 1: Phases of the research process

3.4. Interviewing guidelines

The interviewing guidelines serve the interviewer on the one hand as a framework for orientation and as an aid-mémoire, on the other hand as support and differentiation of the narrative sequences of the interviewees. (Witzel, 1982).

While interviewing being responsive to the respective interviewee seemed important to me, but still tackling all the topics and questions of my interviewing guidelines. I attempted to separate the sequence of the topics dealt with chronologically from my

interviewing guidelines in order to avoid a "bureaucracy of interviewing guidelines" (Hopf, 1978). A deflection in the course of the interview from the interviewing guidelines can bring interesting contents to light which would not have been considered when keeping rigidly to the guidelines. I have incorporated relevant topics that have occurred in an interview to my guidelines for the following interviews. You can find the complete interviewing guidelines in the annex.

3.4.1. Development of the interviewing guidelines

For finding out which question would be of interest and how they should be raised, Heidi Clementi, when having a supervision with me, conducted a pretest interview. I noted the questions and deducted with further ideas on my part the interviewing guidelines. Atteslander's "Rough guide to formulating questions" (1976/2000, p.170) thereby served as my support.

According to him, questions should

- Be formulated short and simple, concrete and neutral (without biased words as honest, free,…)
- "only refer to one issue"
- "not overexert the questioned"
- not provoke certain answers.

I conducted the first interview, that was designed as a pretest interview, in February with a colleague from the formation. Due to several contextually interesting statements, I incorporated it into the evaluation.

The conversation was recorded with a mini-disc-recorder and took 40 minutes. When transcribing the interview I was confronted with the problem how to deal with the dialect. The consideration to conduct the following interviews in standard German in order to facilitate the transcription, was against my conviction that statements in one's "mother tongue" are more authentic and thus closer to the truth. In order not to lose information already in the first step, to create a familiar atmosphere and also in order to avoid an artificial situation, I decided to conduct the interviews in the language that was used spontaneously by my interviewees. I also posed my questions in dialect.

The pretest interview showed that I would have to formulate my questions in a simpler and clearer way, avoiding putting several topics into one question.

In the transcription I translated the conversations – due to the reason mentioned above – into a standard German and paid attention to reproduce the statements as exactly as possible. It was uniting in this context, that I come from the same field of specialization as my interviewees. The common professional terminology facilitated our communication.

3.5. Choice of interviewees

Although Lamnek (2005, p.386) recommends recruiting interviewees not from one's circle of friends, as he assumes that the questioned would be self-conscious and the content of the interview already probably unconsciously selected, five of my interviewees come of my circle of friends and acquaintances. In order to receive an as broad picture as possible, I chose people from who I had already a precognition of their attitude towards craniosacral osteopathy. I had gained these information from conversations with colleagues during the formation, from discussions at the

"Osteopathiestammtisch" (round table for osteopaths) in Salzburg and from conversations with my colleagues in the practice. As I had already previously lead conversations concerning different topics with these persons, I knew that I could count on their openness and an informal interview-atmosphere. These two factors, i.e. my precognition of their attitude and the intimacy, which depicted for me as a beginner in research a big advantage, were crucial for choosing also friends for my interviews.

The interviewees should have finished their formation of at least three years at the VSO (with graduation) and should work as osteopaths. Although the sex of my interviewees did not play an explicit role in the questionnaire, I wanted – in order to avoid one-sidedness – an equal distribution. Therefore, I chose three men and three women for my interviews.

3.6. Conducting of the interview

As a preparation for the data analysis I used Kaufmann's *"Das verstehende Interview" (1999)*. The explanations below refer to this book, the numbers in brackets indicate the page.

Although the interviewer sets the rules and poses the questions, a sort of balance can occur between the *"two strongly contrasting interviewees"* when the interviewee gets the impression that the information he volunteers is listened to carefully and considered important. This notion assures the informant and encourages him to even produce more information. The style of the interview should be close to a conversation without drifting to a mere chat.

The exchange between interviewer and interviewee should be as intense as possible, so that one gets the essential statements. (Kaufmann, 1999, p.76)

Thereby, the aspect of humour deserves special consideration. According to Kaufmann, informants often take over the *"role of the good pupil"* , trying to find the according answer for each question. The ambition they develop in this way is utmost positive, however the language loses it authenticity and starts resembling the language at school. (ibid., p.92). A sense of humour and a relaxed atmosphere can be useful means to *"break the seriousness and still keep working seriously" (ibid., p.92)*.

It were ideas and indications from "Das verstehende Interview" von J.-C. Kaufmann (1999, p.73-76), "Qualitative Sozialforschung" von S. Lamnek (2005, p.396-401) and Heidi Clementi (in personal communication) that helped me to compile the following instructions as guidelines for the conduction of interviews:

- to conduct the interview at a place that the interviewee is familiar with
- to tell the interviewee at the beginning of the interview the reason for it and, assuring him absolute confidentiality
- to listen carefully to what is said, reflecting it while the informant is still speaking
- to clarify antagonisms, without interrupting
- When not knowing how to continue: take a break, arrange material, sort out thoughts, pose a question from the interviewing guidelines
- Have no fear of breaks of silence, when they do not produce discomfort. Not filling these breaks with subsequent questions so that the interviewee has time to develop his thoughts.
- Receive all statements positively, also when it does not seem at first sight to be of interest

- Sense of humour and laughing is permitted, as long as the interview does not lose its seriousness.
- In case of lack of clarity, summarize how things were understood and ask whether it was meant in this way.
- Areas with which the questioned seem uncomfortable or that embarrass him can be dropped and can be raised – if necessary –at a later moment.

3.6.1. Transcription

Between the data analysis and the scientific evaluation of this data, there is the important step of the transcription, without which the analysis would not be possible. Tibault and Vincent (1990, pp.115) have the following understanding of a transcription:

> *"No transcription at all, as detailed as can be, can reproduce all characteristics of the oral. One of the most important functions of the transcription is to standardise oral production in a way that a locating and analysis of forms and structures is facilitated." (quot. in Dittmar, 2002, p.54 – transl.)*

For a better readability and auditability of the abstracts of interviews in the next chapters, I would like to explain the symbols of the transcription:

Tab. 4: Symbols of the transcription

Character	Explanation
Punctuation character.,?!-	Common use
...	Indicates a distinct break
CAPITAL LETTERS	Indicates emphasized words
(laughs)	Situational statements are put in brackets

3.7. Evaluation of data material

After determining the survey design, there is the analysis of the data material. In qualitative research this material will be subjected to a content-analysis, in order to interpret it. From the information one should draw conclusions about the intentions and attitudes of the questioned persons as well as about the characteristics of the society they live within. (Lamnek, 2005, p.478-479)

3.7.1. Analysis of content

3.7.1.1. Definition of the basic material

In a first step the data material gained from the interviews was read and the passages that are relevant for the topic were highlighted. Already while transcribing, it was striking that a multitude of statements could be used and that there were interesting topics emerging beyond the interviewing guidelines. These contents were gathered, assorted according to their content and in the following used for setting up further categories.

3.7.1.2. Definition of structuring dimensions

This part comprises the margins and explanations of the categories, which are preconditions for the exact allocation of the respective text passages. In the style of

the interviewing guidelines there are three major categories:

- Implication in the own practice
- Formation
- Personal matters

Major category "Implication in the own practice"

This category contains categories that illustrate in which manner therapists work with craniosacral therapy in their own practice.

- Category "Frequency"

To this category belong passages in the text relating to statements about the temporal extent of the application of craniosacral osteopathy.

- Category "personal indications"

To this category belong statements that explain when and why the therapist decided to treat cranial.

- Category "procedure and schedule of treatment"

To this category belong statements about the process of the inspection and the treatment.

- Category "perception and PRM"

To this category belong text passages about *what* and *where* therapists sense when treating cranial and where and how they sense the PRM.

- Category "certainty and self assurance"

To this category belong text passages with statements about the feeling of certainty in the treatment.

- Category "documentation"

To this category belong text passages about the documentation behaviour of the cranial inspection and treatment of the therapist.

- Category "explanation for the patient"

To this category belong text passages about explanations the therapist gives the patient concerning cranial examination and treatment and what he tells him.

Major category "Formation"

This category contains sub-categories that show how therapists have perceived the structures of formation at the VSO and who they consequently applied the syllabus. Therefore, answers from the questions "Which techniques do you often use", "Are there techniques that you do not use?" and "To what extend does your way of treatment relate to the way what we have learned in the formation?" are presented.

- Category "Application"

To this category belong text passages with statements, to what extent the syllabus is applied in the practice.

- Category "Specific literature"

To this category belong text passage with statements relating to the frequency and the extent, with which the therapist continues his studies with specific literature.

- Category "Critical literature"

To this category belong text passages to statement whether and to which extent the therapist deals with literature that question the cranial theory and practice.

- Category "Criticism on the formation"

This category deals with text passages about critical remarks concerning the syllabus at the VSO.

Major category "personal matters"

This category contains categories concerning personal attitudes, opinions and influences.

- Category "definition"

This category contains text passages about statements concerning the own definition of craniosacral osteopathy.

- Category "Effect of cranial treatment"

This category contains text passages about the therapist's opinion what actually did cause the success of the treatment.

- Category "other influences"

This category contains text passages concerning statements about other sorts of influence, which had an impact of the therapist's way of treating.

4. Results

This chapter describes the results of the study concerning perspectives of osteopaths towards craniosacral osteopathy.

In the first part the issue is raised how craniosacral osteopathy is realised in the individual practice, the second part deals with the illustration of results concerning the formation, in the last part the results concerning personal perspectives will be shown.

Quotations from the interviews shall underline the results, whereas the numbers in brackets mark in each case, from which interview the quote was taken (e.g. (IA, p. 4, l.16) signifies Interview A, page 4, line 16). Persons have been made anonymised.

4.1. Description of the initial situation

In the time period of March to June 2006 I conducted interviews with three male and three female graduates of the VSO. One interview took place in my apartment, two interviews in the respective apartments of the therapists, and three interviews were conducted in Gars am Kamp, at the master-seminar of the University of Krems. On average an interview had the duration of 38 minutes. The shortest interview took 30 minutes, the longest required 50 minutes. The first interview was interrupted after five minutes due to a mistake in recording and was thereafter re-started.

In the table below some of the data of the interviewees are depicted.

One interviewee finished his formation at the VSO in 2000, four interviewees in 2001 and one in 2003.

All interviewees are professional physiotherapists working independently in own practices.

Two practitioners are in the course of their formation of biodynamic cranial osteopathy, one therapist has finished his formation in children's osteopathy, and one female therapist is accomplishing her formation in children's osteopathy.

Table 5: Formation date of the interviewees

Interview-partner	End of formation	Profession	Further osteopathic training
A	2001	Physiotherapist	
B	2000	Physiotherapist	Biodynamic Cranial osteopathy
C	2001	Physiotherapist	Children's osteopathy
D	2001	Physiotherapist	Biodynamic Cranial osteopathy
E	2003	Physiotherapist	Children's Osteopathy
F	2001	Physiotherapist	

4.2. Realisation into the own practical experience

4.2.1. Frequency

On the question to which percentage craniosacral examination and treatment in relation to the working time in total on the patient amounts to, there was a range between 20% and 80%. Except two therapists each patient is treated cranial, one female therapist uses cranial work at least up to 50%, two even up to 80%. One female therapist declares that she considers visceral techniques also being cranial work.

> *"This varies very strongly…" (IA, p.1, l.12)*
>
> *"So, in any case with everyone…" (IC, p.1., l.9)*
>
> *"And even when I work in a visceral way, if I may say so, for me these are also cranial techniques, so listening, on the level, so, that when I work on organs, I do not mobilise but rather work with these gentle, craniosacral techniques."(IE, p.1, l.18)*

This shows me, that for my interviewees craniosacral work constitutes an essential part of their work.

4.2.2. Personal indications

Interviewee A starts already on the telephone to get an idea about the patient and to categorise him.

Interview A expresses in his own words that he *"tries to pick up the patient from where he is" (p.2, l.17)*, i.e. that he listens already at the first contact (telephone call) to clues to indicate him which approach he can choose for this patient. For therapist A

this depends not only on the results of the inspection *"what his hands say"*, but also on, which impression he gets from the patient (i.e. type of patient). It is interesting that he distinguishes between *"tough minded"* and persons who are open towards alternative methods. For him it is important to recognize, to which type the patient belongs, in order to consider where to start from. Another important point, whether cranial is appropriate for this person, is the experience of strong emotional incidents, such as in the case of a divorce, that the person has not overcome yet. Prior in the decision process which treatment he will choose always is the question *"how can I with this very person get most likely an influence on his body and also on his mind and sensation" (IA,p.2,l.3).* That is, to him allowing an encounter via the therapy seems especially important. For him, in the case that during the examination there is a fast rhythm palpable, as well as a slow strong wave that flows through the body, this body region does not require any treatment.

Interviewee B takes the decision in favour of a craniosacral treatment during the therapy, whereas this is more an *"intuitive" (IB, p.1, l.31)* than *a "decision out of knowledge or examination" (ibid., p.1, l.26)*. Prior is, whether the patient can emotionally "*go along with this kind of therapy" (IB, p.1, l.30)*. Thus, interviewee B is strongly responsive to the needs of the patient and tries to sense, which approach could be the best for the patient.

From interviewee's C statements results that he lets – after an inspection and movement tests – the patient lie down and starts in the majority of cases with the head. *"From the head I have the feeling, that one has everything in one's hand, the entire body (…) I have a look what shows." (IB, p.2, l.19)*. From what is then palpable for him, he derives the further procedures, whereas most of the time he works cranial. In the examination he tries to seek the topic behind the symptoms, deciding intuitively

or with the help of kinesiologic tests whether this area should be treated or not. The development to an exceeded cranial work can be traced back to the fact, that formerly there were many negative reactions to the application of fixed techniques of Typaldos. Interviewee D never starts cranial but treats first visceral and structural, in the following every patient's sacrum and cranium are examined and this result constitutes where she will treat.

> *"(…) when I observe the head and examine the head, i.e. when I examine the craniosacral system, so, this I examine with every person and when I examine it, I decide whether it is necessary to treat there or not" (ID, p.1, l.22)*

Interviewee E calls a lot of things cranial.

> *""And even when I work in a visceral way, if I may say so, for me these are also cranial techniques, so listening, on the level, so, that when I work on organs I do not mobilise but rather work with these gentle craniosacral techniques." (IE, p. 1, l.18)*

After the inspection in a standing position, the patient lies down and is, after an explanation of what will happen next, examined cranial and in the following treated accordingly. Interviewee E works in her practice with patients from the neurological area *"where one can well approach with a cranial therapy." (IE, p.1, l.14).* The fact that she is of a small and delicate physic, quickly turned her away from structural work and made the cranial one to her major specialisation.

The patients of interviewee F arrive already with the wish to be treated cranial in the therapy. Therefore, for her the question is not raised, when <u>not</u> to treat cranial. Furthermore, the results of the examination is decisive for how she proceeds.

According to the statements of the interviewees the manual examination result (the testing and sensing) is strongly relevant for the decision process (D,F), for two therapists the estimation of the personality and the things experienced *("strong emotional topic")* of the patient are of significant impact (A,B), moreover how the patient deals with alternative methods, as A calls it. Interviewees C and E use the cranial anyhow as a means of choice in order to examine the patient and to treat him. That is, here the question is not raised "whether" to use cranial, but rather in which form and where. Magoun's statement, quoted in Torsten Liem's "Kraniosakrale Osteopathie" *"The anamnesis is… indicating…The inspection is illuminating…Palpation with feeling, thinking, seeing and knowing fingers by far is the decisive."* (Liem, 1998, p.296) and *"And also our heart with its love, its empathy and its comprehension is involved in every approach to the patient."* (Liem, 1998, p.296) I rediscover in the statements of my interviewees. Intuition as guidepost, as Interviewee B and C remark, I could not find in the literature Sutherland's and Magoun's.

The steps anamnesis, inspection and palpation (cf. 2.4.) are not described in this order by the interviewees, whereas one has to consider here, that probably the interrogation "When did you know that you will treat a patient cranial?" does not explain the decision-making process but rather the point of time when the decision was taken. This happens during palpating, respectively during examining, as the interviewed osteopaths remark in their statements.

Whereas interviewee D follows more the studied examination scheme, I detect from the statements of the interviewees A, B, C and E a more individual handling of the theory.

4.2.3. Procedure and schedule of treatment

After an extensive anamnesis the patient is tested by interviewee A structurally and viscerally, and afterwards most of the time cranially diagnosed. In doing so, he normally uses three hand-holds. The examination result is decisive for his treatment. The patient concerned had a low rhythm and the tissue did feel tense. The primary reason for treating this patient increasingly cranial, was a very strong emotional reaction when having contact with the sternum, in the form, that the respiration changed and the patient started to cry. Simultaneously, the practitioner sensed that the tissue started to relax. At this moment also the patient felt, that the emotional strain had decreased.

Therapist A tried to sense the condition of the tissue and decides accordingly, if it represents a *"region worthy to treat" (IA, p.6, l.5)*. Thereby, an interaction between brain and hands occurs. During testing he poses questions to his hands, how the tissue feels, whether a change within the tissue happens and the brain gives him the feed-back.

> *"then my intention is, that I withdraw and just observe and just leave my hand trying to sense, whether any change occurs underneath my hand, an alteration in the sense of a long wave, or in the very sense, that the very tissue gets smoother." (IA, p.6, l.9)*

Of great importance for him is also, that he feels comfortable himself, because then he can take along the patient into the relaxation. For this, he should not ask too much of himself when working cranial.

Interviewee B describes the example of a breast-feeding mother with a stiff neck, who he first treats structural, and then in the last third of the therapy cranial. The decision

is an intuitive one. Thereby, he cannot separate the treatment from the inspection, and he orientates himself at the knowledge from biodynamic craniosacral osteopathy. Thereby he uses a cranial hand-hold, that was taught during the formation and attempts to focus on the medium axis. For him the treatment is a non-verbal communication and it is difficult putting the things going on into words.

> *"first of all I cannot remember explicitly what I do und because it is somehow difficult to describe as a technique because I do not really, when you ask me now for a structure and I can tell you, there I have done this and that, when I work cranial it takes place on a level which one can hardly explain verbally, what is really happening. Therefore, it is difficult to describe with words." (IB, p.2, l.31)*

The quotation shows me, that for interviewee B a treatment in the structural area is clearer than a cranial treatment. In the structural he feels assured and he can describe precisely what he is doing, the cranial treatment seems more difficult in grasping. I will come back to this difficulty in expressing sensations verbally in 4.2.4..

Interviewee C describes a patient with pains in his knee. After testing the knee "completely normal"; he examines further on the head, from where he has the entire body in his hand (cf. 4.2.2) Here he poses the question *"what comes first?" (IC, p.6, l.31)* towards the tissue, and stays during the whole procedure of examination and treatment in communication with the patient. The movements that C feels, have different qualities and thus different meanings. An emotional problem feels different to a vertebra blocking. In the conversation he explains what he feels and asks for additional information.

> *"(…) I can rely on this, as I observe partially at once physical reaction within the persons, which they can report to me in a feedback. So I often ask the people what they feel in that instance as a feedback for myself" (IC, p.6, l6).*

In this case, first the osteopath feels an emotional element in the area L5/S1, followed by the patient's confirmation to be having repeatedly problems there. Then he is lead further to the solar plexus, whereas it gets sensible there that the real topic is "birth". Interviewee C sees hence the following correlation. The topic is birth, the effect moves from the solar plexus to the lumbar spine and in the following via the musculature to the knee. He applies techniques in these areas, feeling how they lead to a resolution of the structures.

> *"I do not want to be too invasive, i.e. actually just observing and joining in" (IC, p.4, l.4). " then I try to seek the point of the central area, where is the fulcrum or however one wants to call it in our terminology and then this changes, (…) if you find it, then the patient remarks "now it is different, if feels different", and then we come again to this profoundness and then it happens that it blends with the other structures which I find, that a certain field is established." (ibid.4, l.28)*

For interviewee C it is especially important to proceed restrained in treating and to activate the self-healing forces of the patient's body.

> *"I think we as therapists have only the problem that we think we have to do something and that is the primary point, that one wants to do too much, so I do also have this problem and I try to reduce this more and more by moving to the centres where the patient can help himself." (IC, p.4, l.11)*

In relation to this quotation there is a statement by Magoun, who points out that one should not do too much in a treatment, but leave time to the tissues for correction. (Magoun, 1997, p.105)

Interviewee C seems to reflect his method over and over, he tries new things and he changes what proved a failure. For him treatment is *"that one opens doors for the patients, i.e., one opens the door which he needs, and then he heals himself" (IC, p.8, l.12)*. Hence the treatment for him is of a processual character, where he is lead and also physical factors play a big role. He tries to sense the "topic" that is hidden behind

physical symptoms and then decides intuitively or with a kinesiological test whether he should treat there or not.

Interviewee D describes a patient in a state after a cerebral tumour, whom she has already been treating for 1.5 years. Hence, she has not worked cranially for a longer time. The patient complains about augmented headaches and while examining one feels an increased tension in the dura. For interviewee D above all the membranes and fluctuation of fluids are of interest. Thereby, she uses an anterior posterior hand-hold at the head and tests which kind of rhythm she can perceive.

> *"observe, if there is any rhythm at all, (…) which this could be and if this is really primary respiration or it is already – according to the sound – the beta stadium (…) I take over the patient's rhythm, (…) then I take a look at the membranes." (ID, p.2, l.2)*

The treatment is the direct continuation of the test.

> *"when I notice, ok, there is this elastic band, this thick one, then I stay there and observe what happens, and when it starts moving in a direction, I follow, and shortly before this pendulum goes into reverse, in the other direction, I stay there, (…) where it lead me the first time and there I wait, and actually it is really like if tension is taken away and then actually it moves back to the normal position." (ID, p.4, l.33)*

Interviewee E always starts her treatment with a status in a standing position and tests of various types, then the patients move into a lying position on their backs and after a short explanation of what will happen next, she starts with the examination. In doing so, she often puts her hand under the sacrum and poses general questions concerning quality, vitality and whether there are possibly tensions in the vertebral column etc.

As interviewee E is due to her formation in children's osteopathy strongly influenced by the biodynamic, she also designs the treatment in this direction.

> *"This means for me, that all that I sensed, that I have very well noticed, what we have discussed now, quality, vitality, and that I really stay simply an observer, so I notice, aha, ok, now we are going more into flexion, now it stays, now it has reached the stillpoint, now the piriform loosens, now I sense how the blood circulation in the rectum improves, yes, but simply from an observer's point. Hm… for me during the treatment it is like being in a constant inner dialogue with myself, I ask myself "how is the quality, how is the vitality, what happens now". Then I remember some issues from the anamnesis, "How does that fit in?" in this I then get very analytical, and then there appear doubts, what am I actually doing here (laughs) just to be the observer and yes, this is then often hard." (IE, p.3, l.29)*

In this context it is interesting to take a look at a posterior quotation concerning the schedule of treatment:

> *"Whereas, when we now talk about it like this, I already interfere therapeutically (laughs), I am not just an observer any longer. This again is a conflict situation (laughs) for me, I am actually in a kind of development phase, a little bit getting into biodynamics, but still using techniques."(IE, p.7, l.25)*

I consider these two quotations of interviewee E as very meaningful concerning the conflict that emerges from physiotherapeutic working, in which I think the "activity" is given the priority and the biodynamic approach where the primary focus is on sensing and observing . From the statements in the interview the critical attitude of interviewee E is visible, who constantly challenges and analyses her therapeutical procedure. Pure observing as a treatment, as she describes her procedure for biodynamic working, is in physio-therapeutical as well as in osteopathic working unusual and hence with the analytical approaches of interviewee E hardly compatible. Despite these tensions, she has strong interest to work in this manner, as in doing so she gets better access in sensing (cf. 4.3.4.). Here we can see a parallels to J. Jealous' statements. He also reports about himself, that he was very confused when working for the first time in this manner. For him only waiting and sensing was very unusual

and after 15 years working as an osteopath, there followed a six year transition period toward working in this new way, which was very difficult for him (CD, Introduction to Biodynamic Craniosacral osteopathy)

In the context of the topic "pure sensing and observing" emerges the question for me, whether this is possible at all, or whether not also each touch comprises an active element.

Interviewee F cites as an example a patient with knee problems of unclear symptoms, but continues quickly with more general formulations about schedules of treatment.

> *"there I simply observe the states of tension in the pelvis, in the leg, in the articulation itself, in the talocalcanean joint and I mostly balance the membranes of these areas,…when there are structural distinctive features, they are treated structural und then I observe it at the end… yes, just on this level of membranes." (IE, p.1, l.30)*

In the treatment she distinguishes between a structural and a non-structural level, whereas the structural concerns the work on the bones and the sutures. When working on membranes, that in the definition of interviewee F do not belong to the non-structural area, she has a *"holistic image" (IE, p.2, l.32)* in her head, where it was not about anatomy in detail.

> *"Most of the time I make the treatment via a balancing of tension, putting the focus where I have sensed a problem and expecting an alteration, or letting it happen or observe, in the case it is a suture, I sometimes work with fluids." (IF, p.4, l.30)*

She positions her finger left and right from the suture and imagines that more liquid moves there, in order to release. During the treatment she often thinks *"intentionally nothing at all"* or about *"something all-embracing positive" (IF, p.6, l.8);* that is a means for her, to let alteration happen.

As regards the formation, cranial techniques were taught at the head and sacrum. Resulting from the interviews is, that four of the interviewees use the cranial treatment for the whole body, always where it is needed. Two of the interviewees work primarily on the head, the sacrum and the sternum, as on the ribs (ID) and the feet (IA).

In examining a central topic for four interviewees is the posing of question to the patient's tissue or the waiting for what the body will show. Although some of the questions partly are not posed correctly, this is a procedure as transmitted in the formation. For nearly all interviewees the treatment is focused on the forming of a focus, observing and accepting alterations. So they are aligned to the concepts of "biodynamic craniosacral osteopathy". Four of the six interviewees have – due to postgraduate courses, children's osteopathy or biodynamic craniosacral osteopathy – achieved intense access to this type of approach of Jim Jealous. Interviewee A was also influenced by discussions with colleagues into this direction of treatment.

> *"(…)second what influenced me stronger, were discussions with a colleague who assists me at school and who has accomplished a formation in biodynamic craniosacral osteopathy and the discussions with him were in such a direction that I changed even more strongly my mode of working"(IA, p.7, l.2.)*

For interviewee E "withdrawing" is always hard and also interviewee C remarks that the therapist tends to do too much. For me this is a sign of a therapeutic understanding which is characterised by being active. During the formation teachers repeated that "less was more" and that the application of many techniques do not lead to a success. However, the notion was also transmitted that a good osteopath can and should reach great success within few treatments and in a short period of time. This in turn leads – I think – to an increased personal pressure. The consequence could be probably that therapists again tend to do too much.

In the context of "pure sensing and observing" the question emerges whether this is possible at all. Does not every touch also contain an active element?

The manner how the interviewees reacted to my question is very interesting. To the question *"Can you cite one example of how you proceed with the cranial by means of a patient from last week?"* not a single interviewee cited spontaneously the example of a concrete case. All talked generally of the normal schedule of treatment. Most of the time three requests were necessary until a concrete case was described, whereas it got clear, that the therapists had problems to recall what was actually done or to put it in words. This insecurity is for me reflected in the category documentation (4.2.6), as likewise there the "putting in words" was considered as inhibiting. During the formation there was examining and treating, however less importance was attached to formulating and describing or the presentation of cases with a detailed description of the perception. The insecurity in this respect is expressed in the following quotation:

> *"first, I cannot remember explicitly, what I do and because it's somehow difficult to describe as a technique, as I do not really, when you ask me now for a structure I can tell you exactly, there I have done this and that, when I work cranial it is on a level, one can also only explain with difficulties, what actually is happening. That is why it is hard to describe with words." (IB, p.2, l.31)*

It is important to put the own doing into words as the discussion and the exchange of experience plays for me a decisive role in the therapeutic development. As well, on the part of the Vienna School for Osteopathy this necessity is expressed. Concepts of the Master formation are inter alia supervisions, portfolio-coaches and clinical reasoning.

As a résumé one can say that each therapist incorporates diverse aspects from the formation and interprets the concepts in his personal way. The Schedule of treatment

– as it was taught – is only kept in a very limited way. Many techniques from the formation are not applied, which for me is comprehensible due to the multitude of concepts presented during the formation. The strong interest for biodynamic craniosacral osteopathy show, that the therapists after accomplishing their formation basically were enthusiastic about craniosacral osteopathy, but not entirely pleased with the performance at the VSO. On the other hand, biodynamic work demands completely new aspirations for the osteopaths (e.g. not acting but observing), with which two of the interviewees are confronting themselves with at the moment and searching their own approach.

4.2.4. Perception and PRM

To the question "What are you sensing when working cranial?" the most and longest pauses in the answers occurred. The interviewees had – as will be shown later in 4.2.6 (Documentation) – major problems in expressing their perceptions verbally.

The perceptions either relate to a certain patient, but often the therapists chooses a more general form of description.

Interviewee A describes how the tissue of a concrete patient felt at first contact. The question that he poses himself is: *"How does the tissue feel?" (IA, p.9, l.20)*. There are different qualities which can result as an answer, such as: rigid, firm, few liquid in the tissue, hard, curbed or hardly palpable rhythm, but also warm, easily shiftable, feeling of good blood supply. During the treatment, he notices the changing respiration of the patient. The part being treated gets restless, loses tension and *"I get into contact with his body tissue. But this took a long time." (IA, p.5, l.5)*. Simultaneously to the change in the tissues, in this special case, there appears also an

emotional reaction, in the form of crying on the patient's side. Concerning MRP, he palpates often a fast rhythm that comes immediately in the hand, and then potentially a slow wave, that moves strongly through the body. When both is palpable for him, this zone does not need a treatment.

Interviewee B feels insecure concerning his perceptions and considers it difficult putting them into words. Related to a concrete patient he explains: *"it feels somehow like a body, but there is no dimension, there is no beginning and no end. "Body" is already too much defined." (IB, p.4, l.32)*. For his description he uses words like: pull in a certain direction, tension, non-verbal communication. He utters his doubts concerning MRP as following: *"the question is posed in the same manner, when one feels the craniosacral rhythm, whether this is my own imagination or whether it is something that really takes place." (IB, p.4, l.16)*. For interviewee B there are considerable doubts, whether what he feels springs actually from the patient or whether it his vision that is being projected on the patient.

When interviewee C gets himself really involved in the treatment,

> *"then the boarders blur, then the whole becomes somehow a big field, so there is no longer patient/therapist, that merges, you cannot separate it anymore. Then, there is a very profound process according to my opinion. It moves rather deeply from the surface." (IC, p.3, l.15)*

Probably there is first an unclear cycle-wise movement, but then he feels a rather besotted, delirious state.

For interviewee D the membranes that will be treated feel like a stringy, thick rubber band that is not elastic, in contrast to the problems in the liquid where she feels vibrations and has the feeling " *like there was somewhere a vortex that does not belong there" (ID, p.3, l.24).* In addition, she perceives firmness and fixation, as well

as a balking feeling like in a bloc. Concerning the MRP she has a picture in her mind that supports her in her perception.

> *"Well, simply when you impose your hands, you have the feeling that something approaches you like a wave, and then it withdraws again, this is like when you lie on the beach, your legs half in the water and then the next wave approaches, wets your feet and then moves away again. And then the next way approaches." (ID, p.6, l.15)*

The frequency of this rhythm equates probably 2-4 per minute. The frequency of the MRP with 12-14 per minute, she could never find, and therefore she stopped seeking for it. For her the rhythm seems to be an artificial one that is not produced by the body, as the velocity seems to high.

> *"I can remember, as I imagined from time to time, how it feels for me, this velocity, for me this is actually a racing tempo, this is hilariously fast, that the brain is involved in this rhythm (laughs), I think, this you can find with these hyperactive children, but when you initiate it in the patient's body, you stimulate him completely, I have the feeling,… instead of calming him down." (ID, p.11, l.7)*

Interviewee E feels next to her cranial inspections also emotions, that she perceives at herself, but knowing that this is something originating from her patient.

> *"I feel anxiety (…) and then I feel something inside myself, that emerges, where I know, this is not belonging to me, but ok I take it also for me from the examination, so in the pelvis there is anxiety." (IE, p.3, l.27)*

Further interviewee E palpates, whether there is fluctuation and a good respiration in the tissues, she perceives gravity, density, a vibration or the pull in a certain direction. During the treatment, here as an example of a muscle, she tries to reach a state of balanced tension by approaching the origin and the insertion in her imagination and adding the movement elements on all levels. When the state of balanced tension is established, she waits until the density eases and the tension loses. This feels as if something would widen and increase the volume. Interviewee E uses for illustration

the comparison with muscle stretch, where one can track how it feels when the tension eases. When the density loosens, there exists no longer a pull in a pathological direction and a cranial rhythm in the sense of flexion and extension is palpable.

Interviewee F describes how she perceives restriction at different structures. She finds a restriction at a suture when the imagined movement in one direction is harder than in the other. A problem in drain appears when a stop or a congestion is palpable. When testing the membranes she has an anatomical image in her head how tension lines draw and feels, whether tension strains exist. When seeking the balanced tension she focuses on a certain region between her hands, imagining that there less tensions should occur and waits. When relaxation happens, she perceives this region loosened and more permeable. Interviewee F considers it difficult to express these feelings verbally and needs a lot of pauses for consideration until she finds words.

She experiences the MRP differently to how it was taught in the formation. When the head and the vertebral canal feel permeable (she tests it by sending mentally liquids from up down), it represents for interviewee F respiratory respiration. However, she does not like to use this concept vis-à-vis her patients, as she has not yet defined for herself, what this means.

All therapists start their acquisition of information by finger and hands. However, interviewee B highlights that hands are the tool to palpate, but ultimately the whole body palpates, especially an area of the forehead.

Also interviewee E talks, next to the hands, about a holistic sensing. She senses emotional aspects in her abdomen.

For interviewee C boarders between therapist and patients are blurring and she perceives a big field, when getting involved in the procedure of treatment.

"Sensing must not be subordinated to intellect", was one of Jean Arlot's first sentences when he started our instruction at the VSO in 1995. The therapist occupies himself via the scull with the body and thus, the prerequisite was hearing, observing, seeing and sensing. The difficulty to express the palpated can be seen in the interviewees' replies and in the long pauses they took. Summarizing the following words are used in order to describe what the therapist sense when examining and treating: rigid, firm, feeling of few liquid in the tissue, hard, warm, shiftable, delirious status, stringy, balking, fixated, stop, congestion, vibration, vortex, bloc, a field. Although, the essence of their statements vary, interviewee B and C use similar expressions: *the body has no beginning and no end, no dimension (B), delirious, blurring boarders, big field (C)*. Interviewee's E statement concerning her experiencing of emotions that are related to the patient is interesting. Concerning the position of the cranium, respectively a false position of a suture there is only one statement of interviewee F, who senses very rarely a "*crest*" and a *"lump".* (ID, p.9, l.12) Concerning the PRM there are hardly descriptions that go along with the theoretical part. When the therapists find a PRM, then in the form of a long wave, that passes through the body (A,D) or when the head and the vertebral canal feels permeable when sending through liquids (F). This corresponds with the statements of biodynamic craniosacral osteopathy, however does not match the concepts of the formation at the VSO, which are presented in 2.2.1 (PRM).

To sum up there is to say, that only for a small part the answers of the interviewees reflect the possibilities in sensing during palpation that were described in the theoretical part.

4.2.5. Certainty, self-confidence and doubts

Not always did the interviewee A feel certain, but most of the time. Especially, when he can reach the patient, he feels comfortable with his present manner of working. Interviewee A has established a simple system for himself in which he trusts. In treating cranial he can build up a good relation to the people which is of great importance form him and he can create a focus for the patient's self-healing forces. For interviewee B the prerequisite in order to feel certain in a cranial treatment, is the feeling that emerges when working.

> *"When I have the feeling that a flow emerges between me and my patient, then I feel very certain, but this does not happen very often. (…) In comparison to another type of working, when I feel completely certain and do not mind how I feel or who it is, there I feel simply certain, I could not claim this in cranial working." (IB, p.6, l.2-11)*

Interviewee C meanwhile has a lot of confidence. He sees the positive reactions on his patients, who often provide him with feedback in the course of the treatment. Nevertheless, he poses himself sometimes the question, how more profound structures, as for instance the kidneys could be reached when treating.

Interviewee D is certain, that what she senses is not verifiable, anyhow she feels certain as the result of her treatment is a good one. She trusts principally that her body can distinguish whether he treats for instance the dura or not. *"the body can understand this very well, if you work or the dura or not. Or imagining (laughs) whether you are at the dura." (ID, p.4, l.18)*

For interviewee E the working atmosphere is decisive for how certain she feels. While in the classroom situation she feels easy with sensing, she feels often uncertain being alone in her practice. She repeatedly doubts whether her treatment is necessary for the patient's healing process.

> *"Yes, especially because I am a very structured, analytical person, and what we have just talked about are things, that you can really count on, because it is like a treatment report, let's say, but then there is a certain point, after the stillpoint, where you become only an observer, and the body loosens itself, and there in an inner dialogue the doubts start to emerge, okay, for this you require money, that you stay as an observer, I mean, the body acts itself and you sit next to, and observe, and there is always the question whether the body needs you now really as an observer or does the person anyhow loosen these lesions every day in his sleep, so, this is for me an essential question." (IE, p.5, l.14)*

To interviewee F yet no uncertainties occurred in the cranial work on a patient. She cannot tell what is leading to a success in a treatment, there are always periods in which she doubts but this is not especially related to cranial treatment.

> *"Is it the attention one gives to a person or to a certain area that helps or is it simply the patient's changing attitude when he goes to consult someone, doing something for himself and consecrating himself to this area and this problem. Does the technique help for itself or it is a conglomerate of all the factors and which one would have the main focus, this is not really clear to me." (IF, p.7, l.14)*

From these statements of my interviewees I deduct conflicting areas between the confidence in the work – especially because of the positive reactions and feedback on part of the patients – and the uncertainty concerning the question what therapists really do when working cranial.

Four of the interviewees feel – despite these doubts – certain in their procedure, the two others (B, E) are repeatedly and strongly doubting their perceptions.

The questions that the osteopaths raise in this context, can be summed up as following:

- What is leading to the success in the treatment?
- Is what I am doing actually necessary for the patient?
- Is one really linked with the structure, that is being treated or is one sensing what one is imagining oneself?

4.2.6. Documentation

In his documentation interviewee A keeps notes on the area on which he has worked cranial. As a form he therefore uses statements as "Cranio Sacrum, Cranio Sternum." Sometimes when a region appears dominant, he names for instance also an organ itself. On the question, why his documentation in the cranial is kept in such a general style, he answers:

> *"when I had to formulate the findings even more in detail, when someone would say, now do not concentrate on the sacrum, but detect where in the sacrum, is it S1, S2, S3, where is this tension? Then is this more left or right, or when do you have the feeling, in which phase of development did this happen, that this intra-osseous dysfunction did appear, these are set of questions that lead to far for me, they make me tense." (IA, p.8, l.29)*

Interviewee B uses in his documentation for cranio only the abbreviation CS, probably describing the reactions the patient tells him, sometimes only in the following therapy session.

Interviewee C generally documents only few things as he does not consider it useful.

> *"now I am only noting very few things because for me this is finished, and everything one writes down, becomes so, I suppose, becomes so … manifest." (IC, p.7, l.14)*

Interviewee D also documents in a very general manner. She describes the approximate area, where she has found a problem, whereas

> *"I do not – as I pointed out before – think of structures, when working cranial. " (ID; p.5, l.19). This could look like the following: at the right side the height of the temporal, or rather more profound." (ibid., l.18)*

As she works primarily indirectly, there are not that many techniques to write down.

Interviewee E uses a system of three categories (subjective, objective, Therapy) in her documentation, to each of which she takes notes.

The term subjective comprises the syndromes that the patient claims, objective comprises *"what I find out during the examination, for instance temporal at the right side in external rotation, tentorium at the sinus rectus in tension, liver compressed.* " *(ID, p.11, l.8)* for the term therapy she notes, what she has actually used as techniques and what has loosened. For her every therapy session is a newstart, where she is not immediately checking her file, but again, seting in anew, probably one layer deeper.

Interviewee F documents the result in a form

> *"that I note the area, and add a sign, … I don't know, an exclamation mark, … I add high tension, or membranes – exclamation mark, or I also relate somehow an organ, and then there is written… or another area of the body that I link and then there are the two written down there and a circle or something like this." (IF, p.8, l.5)*

As she does not treat that many patients, she normally remembers what and how she is treating, therefore a more exact documentation is not necessary.

Five out of six interviewees use a very general and short manner of documentation that shows me, that the formulation of sensed results is often linked with problems or that respectively the results themselves are often unclear. The therapists perceive an area, but they cannot or do not want to define, what is happening there exactly.

> *"I try not to relate to whether this is happening now in the temporal lobe, is it the nucleus, I do not know or some basal ganglion (…) or do I leave this, I am drawn there, there I am sensing something and so I stay there, whatever it is." (ID, p.3, l.14)*

This represents for me a strong contrary to the formation where an focus was put on anatomy, and a multitude of handholds and techniques were taught which should lead us to concrete results. The discrepancy between theory and practice is also reflected in 4.2.3 (Procedure and schedule of treatment).

4.2.7. Explanations for the patient

When a patient consults a masseur it is rather rarely explained why this or that group of muscles is being treated. The patient knows why he consults the masseur and he will normally do what the patient expects. Concerning massages there is clarity what it is about.

Concerning osteopathy I have a different experience. Although in Austria osteopathy is no longer unknown, I am experiencing with my patients, that they do not know, what they will be confronted with during the treatment. Putting the hands on the head and then staying "passive", needs an explanation. During the formation there is not a single point in the syllabus that tackles this issue. How the interviewees handle this topic, will be shown in the following descriptions.

All interviewees at least have a "minimal programme" of explanations to their patients when working cranial.

Interviewee A points out to his patients that he will work calmly on the head in order to get an impression of the central nervous system and that the patient will hardly feel anything.

> *"The cranio-sacral therapy is based on the hypothesis that the central nervous system has a certain motility as the heartbeat, or as the diaphragm moves, without you having to think about it (…) and that this movement is essential for building the brain and the tissues of the spinal cord." (IA, p.11, l.15)*

Interviewee B has limited his explanations as he considers his justifications no longer necessary. He attempts to arrange his explanations in a way that he supposes the patients can best understand and accept. The cranial membranes – the meninges – are linked via the skull with the muscles in the neck and can influence these. With increased tensions of these membranes, there can also emerge effects in the area of arterial and venous maintenance. Furthermore, therapist B explains the function of the liquor, and that it transmits information into the nervous system. The liquor's circulation can be influenced by cranial techniques.

Interviewee C starts with his explanations, while already working. Throughout the treatment he keeps in communication with the patient (as already pointed out in 4.2.3 – procedure and schedule of treatment) by explaining what he is feeling an by stating his way and aim. The patient is asked to communicate his own perceptions.

Interviewee D describes her way of explaining cranial as *"rather simple" (ID, p.5, l.30)*. For osteopaths the head is an important area, which she will also examine. The cranial rhythm is a life-rhythm, that activates the self-healing forces that every person needs when having problems. Most of her patients are pleased with these explanations, those who want to know more get more detailed information.

Interviewee E uses a take-apart skull, where she shows the patients how the bones move one against the other. She uses this model, in order to illustrate it to the patient *"whereas I am not completely convinced myself that these movements exist to this extent" (IE, p.2, l.18)*. For further explanations she refers to the pulse at the wrist, and that she can feel this pulsation, that also exists in the cerebrospinal fluid, on the head. Further, it is important to take a look at the muscles of the temporomandibular joint, and if there are rising tensions form the cervical spine. After the examination

she potentially explains the patient what she has found and then starts with the actual treatment.

Interviewee F explains that in her case she will test with her hands the respective tension between two bones. The patients often have perceptions that partly correspond with those of the therapist.

The explanations that the therapists offer their patients concerning cranial treatment are diverse, whereas there is a certain accordance from three therapists. A, B and E refer to the cranial theory in their explanations and try to present it in the best understandable way for the patient. It is interesting that only one therapist uses the concept of hypothesis to underline, that we are taking about models and assumptions and not about scientifically proved facts. Further, they establish a relationship to the very patients, as for instance E, who lets the patients feel the pulse, or B, who links to tension in the neck muscles. Interviewee C refers in his explanation to what he is feeling at the moment and asks, as partly does interviewee F, for the patient's feedback. Interviewee D describes the way of giving information as *"rather simple"*, choosing words like life rhythm as well as referring to the body's self-healing forces.

Thus, there is no standardised procedure concerning the information transmitting as osteopath. However, each therapist sees the need for explanation and implements it according to his own ideas.

4.3. Formation

4.3.1. Application

For interviewee A the basis for the tracks he is using today in his treatment, was laid during the formation. Over the years it was getting clearer how he can transport what he considers important on these tracks. Thus, exact anatomical knowledge is the prerequisite for exact visualising. The foundations for this current way of treatment was laid by Tom Shaver. He does not use a multitude of techniques that we have learned during the formation, as for him the emerging feeling is more important than the techniques themselves.

Interviewee B approximately uses five techniques from the formation.

Interviewee C does not consider the technique *per se* as mportant but the principle behind.

As was pointed out repeatedly by Bernard Ligner in the instruction, the important thing is understanding the concept and then being creative oneself in the treatment. Most often he treats with fluids techniques, he does however not use techniques on the sutures, what he calls *"moving of the bones" (IC, p.8,l.21)*. Although the model of the axis does not seem plausible to him, it was important to him, to get this structure transmitted during the formation,

> *"Because I do not think that one can start right from the beginning in the way I am working now, I don't know, whether I would have made it." (IC, p.9, l.14)*

The way of treatment he is applying now, was strongly influenced by the VSO, in particular by the children's formation, the energetic work of Tom Shaver and his own experiences.

Interviewee D only uses the basic principles of the cranial osteopathy as presented in the formation. While working she does not consider important to know which structure she is treating right at the moment.

> *"before I rack my brain, where I am, it is more logical for me just to work, I also have the feeling that I would slow down in the treatment, it would not be so round, so rounded the treatment, if I consider all the time, where exactly I am." (ID,p.8, l.7)*

Interviewee E is in her work strongly influenced by the children's formation. During the formation she experienced the instruction unstructured and chaotic and thus she acquired the theoretical background in home studies for herself.

> *"So especially the cranial was very chaotic, muddled and not very structured by the different lecturers, and I am for myself a very structured learner, i.e. overall the theory, I have the feeling, I have acquired all this by myself, talking about the cranial, I have really confronted myself with it, I do not have the feeling, that I got much from the formation. And concerning the practical part it is now the children's formation, that there is a framework, to learn something practical and to implement it." (IE, p.12, l.26)*

Interviewee F considers her approach of being rather *"global" (IF, p.10, l.10).* When there were lecturers teaching whose approach was not interesting to her or to whose approaches she did not find any access, she did not participate in class.

> *"I have to admit, I also often just left (…) and this was most of the time, yes a teacher of cranio who fussed around with this bone and that bone, I did not like this… and else…yes there were simply teachers with whom I did not assort well and this was needless, because then mostly I could not cope with the content." (IF, p.10, l.25)*

Additionally, it has to be reckoned that my interviewees originated from three different years of the formation. While working on the theoretical part I was constantly talking to colleagues and interviewees, in order to ask for further information concerning the

structure of the instructions, the recommended literature and who was teaching whom.

This showed, that there was a standardised syllabus, but it was in the lecturer's discretion how it was interpreted. One cannot compare the statements of the interviewees directly, as the starting point, i.e. the instruction, was different.

Nevertheless one can see, that all interviewees orient themselves very much on biodynamic aspects and use only some of the multitude of techniques that were taught during the formation (cf. 4.3.1)

One could raise the question whether it would not make more sense to consider more aspects of biodynamic craniosacral osteopathy from the beginning. In the documents of the formation of biodynamic craniosacral osteopathy (2006) it is pointed out explicitly that a basic formation in cranial osteopathy is a condition for the postgraduate formation. "*The curriculum is designed for clinicians with prior training in the Cranial Field of Osteopathy" (Jealous, 2003, Introduction)*

4.3.2. Literature

Interviewee D and E regularly deal with specialist literature, for instance, works of Sutherland, Magoun, Still and Liem. Interviewee C occupies himself with course material from formations.

Interviewee B rarely reads articles in the journal *Osteopathische Medizin* and interviewee F, who reads little in general, does hardly deal with cranial specific literature.

Since the end of the formation five years ago, interviewee A has read four or five articles in a journal of osteopathy.

Compared to the strong interest that osteopaths have for cranial osteopathy (cf. Introduction), the occupation with specific literature concerning this topic is strikingly little. There is a big choice, starting with Still's books to journals there is a broad range of different material at one's disposal. However, this lack of interest cannot be interpreted as a reduced willingness for further education. The six year formation in osteopathy, further education as biodynamic craniosacral osteopathy (currently 7 years) as the children's formation in osteopathy (2 years) stand for themselves. In my opinion this fact reflects that the major interest of osteopaths is in the application, i.e. in the practical doing and not in the theoretical occupation.

4.3.3. Critical literature

Four of the therapists interviewed replied a clear *no* to the question whether they would be dealing with critical literature concerning craniosacral osteopathy. Interviewee B remarks to have read an article by Paul Klein. Interviewee E, who gives lectures on osteopathy at conferences and at the academy for physiotherapy, where she attempts to justify osteopathy, did – when searching the internet for scientific studies – hardly find any proof for osteopathy (and there within cranial osteopathy). For her the criteria, that are applied to scientific examinations in the medical area, cannot be transferred to osteopathy.

> *"Simply because the criteria of orthodox medicine or the present science….simply this is not dimensioned for testing it, there you simply have these facts, or all patients of one group are summed up, and one syndrome is taken and one medicament and then it has to work and the efficiency is tested, and in osteopathy each patient is seen purely individual, and there can be 100 patients with the symptom of stomach-ache, but we work differently with each patient, so there is no really standardised treatment, and therefore it is so hard, to evaluate it really scientifically." (IE, p.14, l.25)*

In fact during the formation it was referred to models in theoretical principles of osteopathy, however these models were never critically questioned or proven by studies. From several statements of the interviewees we can deduce that they do not believe in the theory that was taught, but that this theory only serves for a better imagination.

> *"As the theory is not proven, I do not tell them (the patients, my comments) exactly. (IF, p.8, l.15); this is rather inconvenient, I think, when you want to explain it to a physician and you have no supportable theory, I consider this a pity. (IF, p.6, l.33) I did not believe in this principle system (IA, p.7, l.10) I have made a lot of research in the internet looking for real studies provinge it, with scientific criteria going along with the orthodox medicine. Yes, this is extremely hard, there is not much, it was always quite troublesome, to approach physicians and be prepared for their questions, "How can you prove this scientifically", and there is simply very little in this direction. (IE, p. 14, l.18). This model of axis as you learn it at the beginning of the cranio gives you somehow a certain structure , even when it is not plausible." (IC, p.9, l.12)*

The interviewees do hardly or not at all occupy themselves with the question whether the models for explanation that are transmitted by cranial osteopathy are scientifically supportable. From the chapter Application (cf. 4.3.1) however it is visible that after some years of practice hardly anybody keeps working with these models. Most therapists are searching for another form of the cranial, as the tendency to biodynamic craniosacral osteopathy shows. Additionally, it is important to them, that is simply works, no matter how it could be explained.

For me there are two contrasts:

On the one hand having a structure is important when learning – this is regarded as useful by all interviewees (cf. next chapter). On the other hand during the formation it is completely waived questioning the structure and the models that build that structure. In order to enforce osteopathy's claim that it represents next to philosophy

and the arts a science (cf. 2.2), craniosacral osteopathy should be regarded scientifically during the formation and elaborated by respective studies. Consequently, the necessity of screening the current model of instruction would possibly arise and to reason why the instruction is held in the current way.

4.3.4. Criticism on the formation

This chapter about criticism on the formation is composed by answers to several questions. First, the question *"In what way is your manner of treatment related to what you have learned in the formation?"*; then *"Are there techniques that you use often and others that you regard dispensable in the formation?"* and from the last point *"Is there anything else, you would like to see mentioned in my work?"*

Interviewee A regards the approaches, how craniosacral osteopathy was transmitted at the VSO, as a dogmatic way, where the diversity of life was strongly limited.

> *"this dogmatic procedure, so when one demands the truth for oneself or supposes to know a lot about the body, so that you can say, THIS handhold in THIS performance, that's it exactly. For me, this is like squeezing the complex world and the complexity of the human being into a simple mould, that does not come up to it, this is a dogmatism, I cannot deal with, this is not representing life as I see it, which is much too multifaceted." (IA, p.15, l.13)*

As he does not believe in the principle system, working in this way was meaningless for him.

Nevertheless, he would not like to miss what he has learned, because it instructs him also in these aspects he does not like. For many therapists it is probably necessary to

follow for the time being this structured way. Hereafter, they can find their personal manner of treatment, which they then can appreciate even more.

Interviewee B had, before the formation at the VSO a very good access towards energy work, seeing there within the ability to perceiving and sensing phenomena. The formation caused the opposite effect to him. He experienced the extreme knowledge transfer in the area of techniques and models as very intellectual, so that it was going more and more in the direction that *"I had the feeling of forgetting the ability to work energetically (IB, p.8, l.8).* The conviction which he saw in instructors and in colleagues alike, created negative feelings inside himself.

> *"I am not that smart, I cannot do this, I do not feel it, and all the others are able to do it, i.e. it was actually stress, that was growing inside me." (IB, p.8, l.11)*

According to his opinion the syllabus of instruction is not being questioned enough, and he posed the question, if it was not more useful, to teach the craniosacral in another way. Whilst in the formation the focus was primarily put on the right application of techniques, for him it should be rather put on the training of perception and sensing.

Although to interviewee C the model of axis does not appear plausible, it was important to him getting such a structure transmitted during the formation.

"Because I do not think, that one can do much with it right at the beginning, as I am working today, I do not know, whether I would have made it" (IC, p.9, l.14). Additionally, knowledge always helps, as sometimes out of sudden he remembers techniques which he has not applied for a very long time.

Interviewee D estimated as positive that from the multitude of knowledge she has gained during the instruction, she can choose what she considers as good. What she

like the least, was the demand of having to know at every time, which structure she is treating at that moment.

> *"Although I knew the anatomy certainly well, it did not really suit me, having to claim all the time, where I am at that instance, because I always thought, ok, nobody can really check on this, I think, this is not really honest, somehow. Because pretending to the teacher and saying, there I am, what can he possibly reply, at the end he cannot prove, that I am not there. Well, there it was necessary and now it is not necessary any longer." (ID, p.8, l.14)*

Interviewee E experienced first contact with cranial osteopathy and with its way of sensing when being abroad.

> *"There I made this experience of palpating and sensing and I was simply fascinated by what one can feel and these kind of things, before I even started with osteopathy." (IE, p.12, l.18)*

During the formation at the VSO she experienced the cranial instruction as chaotic, unstructured and muddled.

> *"100000 techniques were shown and so we have also studied being oriented on the exams, so only how do I touch, what am I doing there, so we have only trained these external optic things – also to one another, without really approaching this feeling." (IE, p.12, l.4)*

After six years of formation, in which she felt as a pupil busy with studying, she has now found the framework to learn the practical side within the formation for children. After she had distanced herself already rather from sensing, she can now leave her knowledge aside and return to intuitive working and being guided.

Interviewee F often left the instruction when there were topics without interest to her. *"yes, this was mostly a teacher for cranio fussing around, with this bone and that bone, I did not like that (IF, p.10, l.25)*

From the category application, personal definition and the category criticism on the formation one can see, that the therapists have found their very personal way to implement the syllabus of instruction or respectively that they are in the process of finding their own cranial. From the multitude of techniques and models that were taught, only a small part is being applied, especially the part, that deals with the treatment of sutures, is rarely being applied.

Interviewees C and D consider the structured procedure with model as a help and the multitude of techniques as a possibility to abstract from the plurality what one considers suiting.

For Interviewees B and E the formation had a strong negative effect on her ability of feeling. They experienced a contrast between what they have been sensing before and what the have "forgotten" in the course of the formation, as the focus was put too much on the transmittance of techniques. There should be more time explicitly for the training of the tactile sense. Concerning this aspeckt, Sutherland writes already in 1925:

> *"Time now occupied in demonstrating manipulations to students could be devoted more advantageously to the training of tactility. Tactility is essential in treatment as well as in diagnosis. Without it, treatment is nonintelligent, savoring of the blind thrust of the imitators." (COT, p.16)*

I draw the following conclusions from the statements of my interviewees:

As chapter 4.3.1. (Application) and the statements in this part show, in the practice only a small fraction of the numerous techniques that were taught at the VSO are used. Especially the work on sutures, which was named structural osteopathy by three interviewees, is rarely applied. Further, it becomes apparent that the interviewed therapists do only conditionally trust in the models that cranial osteopathy is based on. When one considers how much time is used for the instruction of these theories, and

that all techniques build on these theories, the question emerges for me, whether one should not screen these concepts thoroughly.

4.4. Personal matters

4.4.1. Definition

For interviewee B cranial osteopathy remains a query, where he stands himself in the decision process, whether this works suits him at all. Therefore, a definition seems difficult, but in any case it represents energetic work for him.

> *"It is energetic, where I would say it is for me not the quickest and best way to reach the goal working on the energetic body, but it is the way that was offered me here at work." (IB, p.10, l.20)*

In order to get yet another access to the cranial, he decided to attend the postgraduate courses for biodynamic cranial osteopathy.

For interviewee C the structures move in delicate rhythms, whereas there are different ones. He distinguishes among liquor, blood circulation, lymph and other kind of circulations. The therapist senses and analyses these rhythms with his hands, with very delicate techniques. For him the question raises, to what extent this represents work in the energetic area.

Interviewee D treats cranial, when working with cerebral fluids and reciprocal membranes. Thereby, the essentials are the movements of the SSB (part of the PRM, my comment) that have significance for them.

Interviewee E considers cranial osteopathy as a part of the entire osteopathy, that deals with fluctuation of fluids on the cerebral and spinal level, as well as with membranes and tensions in the area of the head.

For interviewee F cranial osteopathy is *"to grasp a person in his centre – mentally, so in the imagination, strengthening and boosting the axis" (IF, p.11, l.2)*

Three out of five interviewees that commented on this issue, consider the fluids as an essential part when treating cranial, as described by Sutherland and Magoun in their works (cf. 2.2). Interviewee D and E are in their statement closest to the theory. Whilst literature never refers to the notion of energy, two of the interviewed persons see in their work probably an energetic element. Interviewee B, E and F have not sought for a definition yet, they took some time for their answer. Additionally, the answers in generally were kept very short.

For me there are three directions. Two osteopaths, whose definition follow the definition from the formation (D, E); two osteopaths, for whom energetic aspects play an important role (B, C) and one osteopath, who has a more global view, without going into details (F).

4.4.2. Impact of cranial treatment

The question what was actually causing the improvement, when working cranial, was unfortunately not part of the interviewing guidelines. Therefore, not all interviewees commented on it. When evaluating the interviews some interesting opinions could be found to this issue, which are now summarized in the following.

For interview A alterations in the patient happen by contact on an emotional and a physical level. The conversation thereby builds an as important aspect as the physical touch. The meeting takes place in ample silence and the own relaxation represents an essential factor in the treatment. As a therapist he puts a positive focus on a certain region in the body that is connoted with *"fear, (…) solidity, with some locking in at*

some stage in life, by mechanical or psychic influences" (IA, p.1, l.31). Then, the self-healing forces can get active and fill the zone positively. What thereby happens is movement, an improved blood circulation and a boosted metabolism. For the patient the change in the body gets palpable, sometimes he senses also the touching moment in the treatment, the large part however takes place in the unconscious.

When interviewee C really involves himself, the structure of therapist/patient disappears.

> *"then the boarders blur, then the whole becomes somehow a big field, so there is no longer patient/therapist, that merges, you cannot separate it anymore. Then, there is a very profound process according to my opinion. It moves rather deeply from the surface." (IC, p.3, l.15)*

At this point the self-healing forces of the patient are touched upon.

> *"Where I do not as someone with intentions (…) administer some technique to the patient, but that I am seeking for, where the patient can help himself, this is my main objective." (IC, p.3, l.23)*
> *"When I remove the hands an I tell the patient he shall trace, when it is a patient who is able to sense it, he can tell me exactly what is happening in the body, i.e. this is like a mechanism that was triggered, and it starts working." (IC, p.3., l.32)*

Interviewee D mentions the self-healing forces of the body in her explanations for the patient (cf. 4.2.7)

What is causing the improvement is unclear to Interviewee F. She poses herself the question whether it is the attention one gives to the patient, the patient's attitude itself, who wants to give himself a special treat, whether it is the technique *per se* that helps, or rather all in conjunction. As she is successful in her practice when treating cranial, the theory, on which everything is based on, is not relevant for her.

For three of the four interviewees who commented on this topic, the major impulse for the healing are the body's self-healing forces, which get activated in the treatment.

This is a primary objective of osteopathy and therefore also of cranial osteopathy (cf. 2.5).

For interviewee A the psychological element plays a big part. A symptom at a certain area of the body signifies that this region probably has memorised an emotion. His approach of readjusting this certain region is his own interpretation of theory and practice from the formation.

4.4.3. Other influences

The preoccupation with the Japanese energy flow 'chi' has an influence on the work of interviewee C. He tries a lot on himself, and with these exercises *"one can test immediately whether one is within this flow or not" (IC, p.8, l.4).* Additionally, thereby for him osteopathy is explained in another way.

Interviewee D deals a lot with dietetics and systemic constellations. When she notices, that it is rather in these areas that a treatment would be needed, she sends the patients to qualified specialists.

For interviewee E it is important to centre herself in her work. Due to own health problems that occurred while treating, she discovered meditation. However, she does not call upon her patients to attending a meditation-course.

As can be drawn from the chapter application (cf. 4.3.1) all therapists are in their way of treatment strongly influenced by the approaches of biodynamic craniosacral osteopathy. As further influences interviewee C and E state the preoccupation with energetic factors, interviewee D in turn deals with systemic constellations and dietetics. Magoun – as described in the Chapter Schedule of treatment (cf. 2.5) – points out the importance of a balanced diet.

Here it is striking that the interviewees are using the notion of energy (A, C, E). Neither during the formation nor in the literature can one find an indication on the link between cranial treatment and energetic work.

5. Discussion

5.1. Synopsis of the results and comment

The following questions have introduced my survey and should have been answered by the interviews.

- How do osteopaths implement the syllabus of instruction in their own practical experience?
- Is there a strong orientation on the contents taught or do the therapists find their personal way to practice cranial osteopathy?
- Is there a critical preoccupation with the theoretical basis?

Further subject areas that have developed in the course of the survey to focal points were:

- What do therapists perceive when treating?
- Is there criticism on the syllabus?

I would now like to summarise the results of the interviews' interpretation.

Craniosacral osteopathy has been rated high concerning their own application by all interviewees. Concerning the implementation of the syllabus into the practice the following picture shows:

Concerning indications for a craniosacral treatment the perception when touching the patient (by testing, posing questions or only sensing) takes a primary position.

Intuition and the patient's personality also play a role. The difficulties that emerge in the verbalisation of perceptions are striking.

They do not believe in the traditional hypotheses about the PRM, however it is important for all interviewed osteopaths to find their own rhythm. For all osteopaths perception takes place via the hands. Two interviewees claim in addition to sense with the whole body, for one interviewee the boarder between himself and the patient starts to blur when treating profoundly. The statements about the quality of perceptions are diversified.

> *"a vortex that does not belong there", "a faster and then potentially slower rhythm", "a wave like the sea swirling around the feet", "warm, shiftable", hard, soft tissue, emotions at one's body, that origin from the patient, a big field, density, gravity, fluctuation, delirious status, congestion, stop,…*

There were no statements concerning SSB lesions and lesions at certain sutures. From the multitude of techniques from the formation only a fraction is used, whereby working with fluids is being preferred. However, for most of the interviewees the issues that were taught were important for the establishing of their own way of treating. All interviewees characterise the schedule of treatment by biodynamic approaches. Linking the contents of biodynamic craniosacral osteopathy with the model that was taught in the instruction, or respectively changing to this other way of treating, represents for some of the osteopaths a difficulty.

Four of the six interviewed osteopaths are not interested in cranial literature and except one, none of them deals with a scientific discussion concerning the topic.

In consideration of the fact that there are yet no scientific studies that prove the basis of the cranial concept, i.e. the existence of the PRM, this is astonishing. On the one hand I consider the lacking confrontation with this topic during the formation and on

the other hand the osteopath's interest in the practice rather than in the theory as responsible for this limited interest: when it works, it does not matter how.

Although they have constant doubts concerning the question what they are actually doing when treating, four of the osteopaths feel relatively certain as the results are good. Two of the interviewees are repeatedly doubting their perceptions. While for tow interviewees there is little need for explanation, tow consider communication utmost important. The other two persons work with a "minimal programme" explaining that the treatment should activate the self-healing force of the body.

Two of the questioned persons report negative effects on their ability of sensing being caused by the formation. This negative effects occurred because the focus was strongly put on the instruction of techniques.

As palpation, sense or perception – no matter which notion one chooses – is the core topic of osteopathy, one should in my opinion search for further possibilities of training the tactility sense and of communicating the results.

Common wisdom says "Afterwards one always knows better" – which is also applicable to my survey. Therefore, the discussion is going to save me. It shows, what I would handle better or differently if I could start all over again, it should propitiate the jury that assesses this paper and it should give the reader the possibility to put the survey results into perspective. A thesis in the area of qualitative social research has not been a custom at the VSO so far and I failed in finding a supervisor. For those readers who will soon have to write a thesis themselves, this might spare them some aberrations, when having an example in their mind how it could work and what one could improve.

5.2. Critical reflection of the study

In my critical reflection, I concentrate – as far as possible – on the issues Choice of method, Choice of interviewees, interviewing guidelines, Conducting of interviews and their interpretation.

Conducting the survey with the method of qualitative social research proved of value and showed aspects that would not have been possible with a questionnaire (as I had originally planned). Regarding the choice of interviewees it was important to me to interview persons with different views. I have known these views from previous conversations. As the formation is not only attended by physio-therapists but also by physicians, it would have been interesting to include a physician in the sample. Due to the small number of interviewed persons the survey cannot be regarded as representative for all graduates of the VSO. However, it meets the demands of a sketch of problems and a collection of indices that I have designed in the Introduction.

In order to a obtain an as comprehensive picture as possible I included very divers questions into my guidelines. Consequently, some questions were given too little space in the interviews.

Now, it seems more useful to me asking less question but treating them more in detail, i.e. to demand what exactly is the meaning of a statement. Being familiar with the topic as an interviewer had the great advantage that I started with great insight into the interview-situation. However, it also had the great disadvantage that I sometimes did not go into some questions in detail as I assumed to know what the interviewee wanted to express.

I prepared primarily theoretically for the interviews. Therefore, I only realised the weak points in practice when transcribing and evaluating the interviews. After the first three interviews, Heidi Clementi indicated in a supervision some of these points to me, which I tried to implement in the following interviews. That leading of interviews was an art, that one has to acquire in a practical way (as, for instance, in the study of sociology), I realised in the course of the survey. The reaction of my interviewees were very positive. They also replied to badly posed questions (e.g. more than one topic in a question) in such a way that I got a lot of useful information. Their special willingness made up to my not most mature competency in leading interviews.

When evaluating the interviews I attempted to be as objective as possible. However; I would like to point out explicitly that this procedure is linked to a strong subjectivity. Kleining (1995, p.323)indicates that prejudices and subjective point of views are natural and that no scientist is immune against them.

Statements can be interpreted in a different way, according to previous experience and personal opinion. The part of results represents my interpretation of the six interviewee's statements. Readers, who would like to form their own opinion, may read the transcription of interviews.

5.3. Suggestions for further research

In the chapter *Criticism on the formation (4.3.4.)* it becomes apparent how my interviewees adhere to cranial osteopathy. For further research a survey with a bigger sample would be interesting. Therefore, one could probably create a questionnaire from the statements of my interviewees.

Another point that would be interesting in highlighting is the topic of *explanations for the patient*. My question was only what therapists explain their patients about cranial treatment. However, it would be interesting to find out how osteopaths deal in general with this topic. Do they tell their patients also in different areas of osteopathy (visceral and structural) what they are sensing, why they are using a certain technique and what theoretical background there exists?

The VSO distinguished itself – in my opinion – especially by the different approaches of their lecturers and their own interpretation of osteopathy. The students benefit from this, as they get to know a multitude of different approaches about this matter.Hence they can choose which one suits their personality most. That finding one's personal way is a process that is not always simple can be derived from the statements of my interviewees. Whilst some to them have developed an individual philosophy of treatment in the area of craniosacral osteopathy, others are in the middle of finding the "right" one. It would be interesting to interview the same persons again in some years. The comparison of statements could give information about the development in the occupational area of osteopaths. In this context I would like to mention a statement of interviewee C , who called me shortly before the conclusion of my work, asking whether he could add something to his interview. It was especially important to him, that his statements refer to the present situation and that his views and osteopathic approaches are changing according to his experiences.

Due to the small sample of interviewed persons, my thesis cannot be seen as representative for all graduates. However, I would like it to be seen as inspiration for a reflection concerning the syllabus of instruction.

6. Bibliography

Atteslander, P. (2000). *Methoden der empirischen Sozialforschung.* Berlin: De Gruyer.

Bilden, H. (1991). Geschlechtsspezifische Sozialisation. In K. Hurrelmann & D. Ulich (Hrsg.), *Neues Handbuch der Sozialisationsforschung* (S. 279-302). Weinheim: Beltz.

Bortz, J. & Döring, N. (1995). *Forschungsmethoden und Evaluation.* Berlin: Springer.

Dittmar, N. (2002). *Transkription: Ein Leitfaden mit Aufgaben für Studenten, Forscher und Laien.* Opladen: Leske + Budrich.

Girtler, R. (1984). *Methoden der qualitativen Sozialforschung: Anleitung zur Feldarbeit.* Köln: Böhlau.

Hartman, S. E. & Norton, J. M. (2002). Interexaminer reliability and cranial osteopathy. *The Scientific Review of Alternative Medicine, 6*(1), 23-34.

Hoffmann-Riem, C. (1980). *Die* Sozialforschung einer interpretativen Soziologie. *Kölner Zeitschrift für Soziologie und Sozialpsychologie, 32*, 339-372.

Hopf, C. (1978). Die Pseudo-Exploration: Überlegungen zur Technik qualitativer Interviews in der Sozialforschung. *Zeitschrift für Soziologie, 7*(2), 97-115.

Jealous, J. (n.d.). *Einführung in die biodynamische Osteopathie* [Audio CD; übersetzt und gesprochen von T. Esser]. Berlin: Biodynamische Osteopathie.

Jealous, J. (2002). *A biodynamic view of osteopathy in the cranial field.* Handout, Internationale Schule für Osteopathie, Wien.

Kaufmann, J.-C. (1999). *Das verstehende Interview.* Konstanz: UVK Universitätsverlag.

Kiefl, W. & Lamnek, S. (1984). Qualitative Methoden in der Marktforschung. *Planung und Analyse,* 11/12, 474-480.

Kleining, G. (1982). Umriss zu einer Methodologie qualitativer Sozialforschung. *Kölner Zeitschrift für Soziologie und Sozialpsychologie, 34*, 224-253.

Kleining, G. (1995). *Lehrbuch Entdeckende Sozialforschung, Band 1: Von der Hermeneutik zur qualitativen Heuristik.* Beltz: Weinheim.

Lamnek, S. (1995). *Qualitative Sozialforschung, Band 1: Methodologie* (3. korr. Aufl.). Weinheim: Beltz.

Lamnek, S. (2005). *Qualitative Sozialforschung: Lehrbuch* (4. vollst. überarb. Aufl.). Weinheim: Beltz.

Liem, T. (1998). *Kraniosakrale Osteopathie: Ein praktisches Lehrbuch* (2. Aufl.). Hippokrates: Stuttgart.

Magoun, H. I. (1997). *Osteopathy in the cranial field: The application to the cranium of the principles of osteopathy, based on the arduous study and keen clinical observation of William Garner Sutherland* (3rd ed.). Kirksville: The Journal Printing Company.

Magoun, H. I. (2000). *Osteopathie in der Schädelsphäre* (G. Schneider-Muntau, Übers.). Montreal, CA: Editions Spirales. (Originalversion 1976 veröffentlicht)

Mayring, P. (1985). Qualitative Sozialforschung. In G. Jüttemann (Hrsg.), *Qualitative Forschung in der Psychologie* (S. 187-211). Weinheim: Beltz.

Mayring, P. (1996). *Einführung in die qualitative Sozialforschung: Eine Anleitung zu qualitativem Denken* (3. überarb. Auflage.). Weinheim: Psychologie Verlags Union.

Picknett, D. (1999). *Interrator reliability in palpation of craniosacral motion.* Unpublished master's thesis, British School of Osteopathy, London, United Kingdom.

Sommerfeld, P. (1998). *Theoretische Grundlagen der kranialen Osteopathie nach einem Kurs von Jean Arlot.* Kursunterlagen, Internationale Schule für Osteopathie, Wien.

Sommerfeld, P. (2002). *Inter – and intraexaminer reliability in palpation of the Primary Respiratory Mechanism as well as possible correlations with examiners' and subjects' respiratory rates: Discussion of the fundamental problems and experimental research.* Unpublished master's thesis, Vienna School of Osteopathy, Vienna, Austria.

Sommerfeld, P., Kaider, A. & Klein, P. (2004). Inter- und Intratester-Reliabilität der Palpation des "Primären Respiratorischen Mechanismus" innerhalb des "Cranialen Konzeptes". *Osteopathische Medizin, 5*(4), 4-10.

Sutherland, A. (1962). *With thinking fingers.* US: Cranial Academy.

Sutherland, W. G. (1994). *The cranial bowl: A treatise relating to cranial articular mobility, cranial articular lesions and cranial technique* (2nd ed.). US: Free Press Company.

Sutherland, W. G., Strand-Sutherland, A. & Wales, A. L. (Eds.). (1998). *Contributions of thought: The collected writings of William Garner Sutherland* (2nd ed.). Portland, OR: D.O. Rudra Press.

Sutherland, W. G., & Wales, A. L. (Eds.). (1990). *Teachings in the science of Osteopathy.* Portland, OR: Rudra Press.

Witzel, A. (1982). *Verfahren der qualitativen Sozialisationsforschung.* Frankfurt: Campus.

Witzel, A. (1985). Das problemzentrierte Interview. In G. Jüttemann (Hrsg.), *Qualitative Forschung in der Psychologie* (S. 227-255). Weinheim: Beltz.

7. Annex

a) Central questions of the interviewing guidelines

- Umsetzung in der eigenen Praxis
- Wie häufig verwendest du „Kranio" in deiner Arbeit?
- Gib mir ein Beispiel anhand eines Patienten aus der letzten Woche, wie du dabei vorgehst.
- Wann hast du gewusst, dass du kranial behandeln wirst?
- Was hast du gefragt?
- Was spürst du beim kranialen Untersuchen und Behandeln?
- Wo nimmst du das wahr?
- Was denkst du dabei?
- Wie sicher fühlst du dich dabei?
- Schreibst du das nieder?
- Wie?
- Erklärst du deinen Patienten, was du tust?
- Wie erklärst du das? Bitte nenne ein Beispiel.
- Ausbildung
- Wie weit hat deine Behandlungsweise mit dem zu tun, was du gelernt hast?
- Gibt es Techniken aus der Ausbildung, die du nicht verwendest?
- Gibt es Techniken, die du besonders häufig verwendest?
- Liest du Fachliteratur zum Thema „Kranio"?
- Beschäftigst du dich mit kritischer Literatur zum Thema „Kranio"?
- Persönlich
- Was ist deine Definition der Kranialen Osteopathie?
- Gibt es noch irgendetwas, wo du glaubst, es könnte für mich von Interesse sein?

b) Curriculum of the VSO

In the following table the specific parts are being listed:

General	
Approach of a cranialosteopathy treatment	theoretical
Introduction	
Still, osteopathic concept	theoretical
Sutherland – the history	theoretical
Overview of anatomy	theoretical
PRM Rhythmical shape change affecting the WHOLE of the body	theoretical
5 Core Principles	theoretical
Basic Embryological Development	theoretical
Observe the sutures	practical
Palpation exercises	
Quality of the tissues	practical
The midline and paired lateral structures	practical
Shape change	practical

Module 1; 1.5 days

General	
Palpation of the IVM – bones, fascia and fluid	theoretical
IVM as tool for diagnosis	theoretical
The PRIORITY LESION	theoretical
Understanding the Neutral	theoretical
Potency going to work	theoretical
Still point	theoretical
BMT/BLT	theoretical
Principles of treatment	
Direct action	theoretical
Exaggeration	theoretical
Disengagement	theoretical
Decompression	theoretical

Module 2; 1.5 days

Cranial base; Anatomy (basic, applied and functional)	theoretical
Ethmoid; Anatomy (basic, applied and functional) Ossification, Involuntary motion	theoretical
Occiput; Anatomy(basic, applied and functional) Ossification, Involuntary motion	theoretical
RTM; Anatomy (basic, applied and functional) Ossification, Involuntary motion	theoretical
Sphenoid; Anatomy (basic, applied and functional) Ossification, Involuntary motion	theoretical
Sacrum, Anatomy (basic, applied and functional) Ossification, Involuntary motion	theoretical
Temporal; Anatomy (basic, applied and functional) Ossification, Involuntary motion	theoretical

Module 3; 1.5 days

Frontal bone; Anatomy (basic, applied and functional) Ossification, Involuntary motion	theoretical
Occipital/Temporal; Anatomy (basic, applied and functional) Ossification, Involuntary motion	theoretical
Parietal bone	theoretical
SBS, Physiological–non-physiological patterns	theoretical
Venosuses Sinuses; Anatomy, Drainnage technique	theoretical

Module 4; 2 days

Occiput; Intraosseous strains and C0-C1 compressions; Birthprocess	theoretical
Principles of Treatment; Revision The principle of fluid drive for diagnosis Treatment sutures between occiput and temporal	practical theoretical theoretical
Temporal, Anatomy (basic, applied and functional) Ossification, Involuntary motion,7 ,8 , 9 ,10 ,11 cranial nerves Petro-basilar-/petro-jugular-/occipito mastoid suture	theoretical

Module 5; 1,5 days

CSF; Anatomy, Physiology, Funktion Ventricular and CNS Anatomy Breath of Life Principle (Still, Sutherland, Becker, Jealous etc.)	theoretical
Palpating the Fluids	practical
Working with the Fluids	practical
CV4	practical
Lateral fluctuation	theoretical
Fluid drives	practical

Module 6; 1,5 days

Fascial and Venosus Systems, Anatomy continued	theoretical
Fascias; The three diaphragms	theoretical
Sphenoid; Anatomy continued Revision of bony anatomy of the neurocranium Revision of the sphenosquamos suture IVM as a tool in diagnosis and treatment	practical

Module 7; 2 days

Eyes Anatomy (functional and emotional) IVM motion orbit and eye 2 layers of dura mater Relationship with CNS Pathology/functional problems	theoretical
BMT/Fluid drive orbit	practical
Balancing eye in orbit	theoretical
Balance muscular technique	practical
Face; general shape change face IVM Upper / middle and lower face	Theoretical

Module 8; 2 days

TMJ Influence of the whole body on TMJ and vice versa Anatomy and Physiology IVM motion Decidouos and permanent teeth/central occlusion Relationship with tentorium (base and vault)	Theoretical theoretical

Module 9; 2 days

Nose Anatomy, Physiology IVM motion nasal septum Anterior superior attachment RTM on Ethmoid Air sinuses and the speed reducers or shock-absorbers SBS influence on nose More detail palatine, spheno-palatine ganglion Pathologies and dysfunctions Midline	Theoretical

Module 10, 2 days

Revision course Revision course theory-practice, preparation for the oral exam	theoretical

Module 11; 1,5 days

Ear Palpation of eustachian tube and beginning differential diagnosis Structure and normal motion of the eustachian tube	 practical theoretical
Eyes Motion of orbit, eyeball and 3rd ventricle Structure, normal motion and clinical conditions of the eyeball Structure, normal motion and clinical conditions of the orbit	 practical theoretical theoretical
Face The osseous structure of the face	Practical

Clinical considerations Palpation of intraosseous changes of motion Palpation of palatine motion Palpation of pterygopalatine fossa/palatine, maxillary nerve Palpation of relationships between ethmoid, vomer, maxillae and zygoma Palpation of vertical depth and horizontal seams of the face Speed reducers Os palatinum, Ganglion sphenopalatinum, Ggl trigeminale	
General Appreciating the motion/effect of the Breath of Life Embryological motion of the face and effect upon its function Interosseous motion of face with effects of sphenoid and RTm	 practical theoretical practical
Mandibule Structure , normal motion and clinical conditions of the teeth, mandibula, maxillae	theoretical practical
Sinus "Plungers" of sinuses Checking intraosseous motion Clinical application of sinusitis Concept of "plumber"friends Motion Olfactory sense and pathways Palpating expansion of the air space Palpating facial sinuses as a unit of function Palpating quality of the mucosal lining Palpating reciprocal tension of the mucosal lining Palpating springyness of the "plumber`s friends" Palpating the "Breath of life" Sinuses development Structure, normal motion and clinical conditions of the sinuses Structure and drainage	 theoretical practical theoretical practical theoretical

Module 12; 1,5 days

Revision; Anatomy, Embryology, Temporal bone ABCD zones Development of the Scull, Development of the auditory system, anatomy, function Becker's theory	theoretical
Free approach to palpation Listening Temporale, changing in ABC zones Biodynamic CSO Visualisation of surrounding structures Test of the inner ear / acoustic transmission Test of the auditory system Principles of building up treatment	practical

Module 13; 2 day

Fascia and posture	

Module 14; 2 days

Introduction to the Biodynamic Model	
C0/C1 Liberation after Sutherland Balancing ligamental tension for C1/C2	 practical practical
Fascias The three diaphragms Techniques for the three diaphragms Deep fascias Fascial connections – scull/thorax The 3 diaphragms Techniques for the 3 diaphragms Diaphragm lift	 theoratica practical theoretical theoretical theoretical practical theoretical

Module 15; 1 day

Revision course	

Module 16; 1 day

8. Abstract

Topic: Craniosacral osteopathy: Personal perspectives of osteopaths with several years of professional experience.
Author: Sandra Wojna

In a qualitative study three male and three female osteopaths, having graduated at the Vienna School for Osteopathy (VSO) more than three years ago, were questioned concerning craniosacral osteopathy. These interviews were conducted via interviewing guidelines. The interviews were evaluated by a qualitative analysis of content. They were supposed to give answers to the following questions: How do osteopaths implement the syllabus of instruction at the VSO into their own practice? Is their a strong orientation on the instruction and is there a critical preoccupation with the theoretic principles of cranial osteopathy?
The results show that only a small part of the contents transmitted during instruction are being used. Especially techniques at the sutures are hardly applied. Two interviewees report negative effects of the cranial training concerning their ability of sensing, as they consider the focus being too much put on handholds than on perception. Nearly all osteopaths show little interest in scientific debate.
There is no standardised procedure in the area of cranial osteopathy. The questioned persons are making use of different aspects of the instructional training in their practice, developing their personal way of treating. Thereby, the approach of biodynamic cranial osteopathy has a strong influence.
The thesis shows how cranial osteopathy is put into practice and could be used to support a revison of the VSO syllabus of instruction.