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Investigating Practitioners' Perceptions of the Role of Spirituality In Osteopathic Practice Using Interpretative Phenomenological Analysis.

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ABSTRACT

Background: There is a growing interest in a spiritual aspect to health and healthcare in many areas of medicine, but there has been little research that explores the potential spiritual aspect within osteopathic practice.

Aim: The aim of this phenomenological study was to explore the perceived nature, role, function and value of spirituality within osteopathic practice from a practitioner perspective.

Methods: Five experienced osteopaths were interviewed and recordings were transcribed and analysed using Interpretative Phenomenological Analysis. Themes were identified and a description of the lived experience of spirituality in osteopathic practice emerged.

Results: Three master themes were identified: [A], *A Holistic Approach to wellbeing*, drew attention to the role of the mid-body connection and a belief in self-healing; [B], *The therapeutic relationship*, recognised that the therapeutic relationship was mediated by a sense of connectedness and practitioner self-awareness; [C], *Intuitive Engagements*, recognised a transpersonal connection through touch and intuition, instantiated in sub-themes underlining the role of touch and other ways of knowing.

Conclusions: In this study spirituality in osteopathic practice was perceived to be reflected in a holistic approach to illness and wellbeing, facilitated by the therapeutic relationship. The Therapeutic relationship was seen to be influenced through a sense of interconnectedness, the role of touch and intuitive insights. We conclude that respondents identify a spiritual dimension in osteopathic practice, which served to support a holistic approach, and influence positive outcomes.

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Keywords

Osteopathic care; Osteopathy; Spirituality; Therapeutic relationship; Touch

Implications for Practice

- For some practitioners, osteopathic practice may include a spiritual dimension that emphasises non-physical aspects of the interaction between osteopath and patient
- This dimension is associated with the adoption of a holistic model in which physical complaints are seen as potential expressions of emotional, psychosocial and spiritual concerns
- Within this orientation, practitioners emphasise the healing power of the therapeutic relationship itself, a sense that that personal connection can lead to intuitive insights, and an acknowledgement of the importance of practitioner self-awareness.
- Touch was identified as a key vehicle for non-verbal communication, and for facilitating an intuitive connection.

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INTRODUCTION

Many people feel that their spiritual and religious beliefs are an important aspect of their daily life.[1] A Gallup poll in 2016 showed that 74 percent of American adults identified themselves as Christian and 26 percent as non-Christian or no formal religious belief,[2] while a wider cross cultural Gallup survey questioned 1,000 adults in each of 114 nations and found that 84 percent regarded religion as an important part of daily life.[3] However, Fuller[4] found that about 1 in 5 Americans surveyed considered themselves "spiritual but not religious", and Koenig et al., similarly found that more people described themselves as spiritual and not religious, compared with those describing themselves as religious but not spiritual, suggesting that these terms are not seen as interchangeable.[5] The term 'religious' has been used to refer to adoption of particular beliefs, rituals and formalised practices, whereas 'spiritual' has been defined as a way of being and experiencing that comes about through awareness of a transcendent dimension, characterised by values concerning the self, others, nature and life.[6] Spirituality may be expressed in a variety of ways, including finding meaning in life, identifying an aspect of oneself that is not reducible to material processes, developing a sense of connection to other persons or the wider world, reporting exceptional or transcendent experiences of some sort, and by the adoption of practices that cultivate these outcomes.[7] Spirituality has also been identified as an aspect of the holistic approach to health that takes into account emotional, psycho-social and spiritual aspects of the patient when creating a care plan.[8]

There has been a growing interest in spirituality in relation to health and its role in patient care, with recent studies in the UK showing that 96 percent of nurses had encountered patients with spiritual needs, with 41 percent saying they encountered them on a daily basis.[9] Over 3,000 studies have explored the relationship between health and religious/spiritual involvement, with many finding significant positive associations that range from lower likelihood of developing depression and of substance abuse to quicker recovery from major surgery.[10] Additionally, higher levels of religiosity/ spirituality have been associated with positive wellbeing, emotions of joy, optimism and hope, as well as

a greater sense of purpose and meaning in life, that may help people cope with stress, fear, loss and illness experience leading to greater longevity.[11]

A number of mechanisms have been proposed to explain how religion and spirituality might affect health and wellbeing. Behavioural effects may result from people within a particular religious or spiritual tradition having healthier lifestyles; for example, consuming less alcohol or tobacco, having a healthier diet and being less likely to engage in risky sexual behaviours.[12] Spiritual practices such as meditation and reflective contemplation have been shown to have direct effects on the immune system and healing via psycho-neuro-immunological mechanisms.[13,14] Cognitive effects of religiosity/spirituality are thought to be mediated by a stress response and subsequent coping mechanism,[5,15] or by providing a sense of structure and order for otherwise chaotic, unpredictable or simply unfair events.[16] Indeed, there is some support for the notion that an illusion of control in an uncertain situation can alleviate anxiety,[17] and by reducing anxiety the patient will feel better and is better placed for healing to occur.

Given that a spiritual component of care has been found to have a positive impact on health in many areas of medicine, including nursing, occupational therapy, mental health and areas of physical therapy,[1] it is perhaps surprising that little research has explored whether such effects might occur in the field of osteopathy. Osteopathy has been described as a holistic therapy[18,19] and so may also incorporate a spiritual component in this broad sense. Indeed, spiritual connection was considered by Andrew Taylor Still, to be a component within holistic osteopathic practice.[20] Although historical development of osteopathy has moved the profession away from some of Still's more esoteric ideas, important debates continue about what constitutes osteopathic practice[21] including whether the extended practitioner-patient relationship could provide a platform for a spiritual dimension. Such a focus would be consistent with a recent move to reorient the principles of osteopathy that argues for a shift away from treating the physical body alone, to an approach that includes psycho-socio-spiritual aspects, although as Tyreman claims, "spirituality is still to be interpreted".[21]

To our knowledge, only one previous study has explored the role of spirituality in osteopathic practice. Huggett[22] conducted in-depth interviews with 4 osteopaths of varied experience to investigate their spiritual beliefs and their impacts upon personal life and upon the osteopathic consultation. Analysis of interview responses gave two broad categories of discourse: encountering spirituality as a topic of conversation, concerning the patient's personal religious activities, etc.; and practitioners' experiences that were interpreted as of a supernatural nature. The findings concerning experiences in therapy are consistent with the discovery by Roxburgh, Ridgway, Roe[23] that psychotherapists and counsellors experienced anomalous events during consultations that served to strengthen the therapeutic relationship and supported communication between the therapist and client.[19] Some of the anomalous spiritual experiences that participants described in Huggett's study include intuitive insights and, interestingly, sensations felt by the osteopaths through touch—such as heat, tingling, and perceptions of energy—that were interpreted as one of the ways that spirituality was mediated in the consultation. This supports recent research by Consedine, Standen, Niven[24], who found that the function of touch in osteopathy was not only diagnostic, but also supported a "distinctive and powerful form of communication". However, given the limited work to date, we felt that additional research was warranted to explore practitioners' perceptions of whether there was a spiritual component to their practice, and this was the aim of the current exploratory study.

METHODS

Design

Since spiritual and transpersonal experiences are subjective and often involve various complex individual experiences, a qualitative psychological approach was used to provide rich accounts of participants' lived experiences. Given the emphasis on understanding how participants make sense of their own experience and practices, we analysed semi-structured interview transcripts using Interpretive Phenomenological Analysis (IPA).[25] IPA

involves a process in which the focus shifts from the experience and expertise of the researcher (which determines and acts as the impetus for the research question) to that of the participant, facilitated by attending as closely as possible to the participant's own account in a way that influences not only the trajectory of the interview but also that of the analysis. In this sense, it emphasises the positive process of engaging with the participant as a means of managing the process of bracketing the analyst's prior concerns or expectations.[25] The method represents a double hermeneutic in the sense that it requires the researcher to make sense of the participant's experience through the process of interpretive enquiry, focusing on two aspects: the phenomena perceived, regardless of whether whatever is experienced is objectively verifiable; and an interpretive evaluation of visible and hidden meanings within the account. The researcher plays a key role in creating an understanding of participants' experiences, drawing on their own knowledge and experience. The interview schedule was designed to explore participants' transpersonal experiences and elements of practice which were deemed spiritual in nature, drawing on the first author's own experience and that of practitioners with whom he had spoken informally; namely the role of touch, the therapeutic relationship and elements of spirituality such as interconnectivity, empathy, holism and trust. The schedule was refined in consultation with the second author to ensure that it captured common elements of spirituality as described in the academic literature on health care.[1]

Participants

As this study was intended to explore whether practitioners perceive there to be a spiritual component to their treatment of and connection with patients, five osteopaths of more than 5 years' experience were recruited and on the grounds that they would have developed sufficient expertise and confidence to enable deeper empathic connections with their patients. The primary researcher had experienced a transpersonal component

to therapy while engaged in osteopathic practice, and speaking informally amongst colleagues in his practice it became evident that other practitioners had experienced and valued similar phenomena. Participants were invited for interview in the knowledge that they were practising in a holistic way that was open to a psycho-spiritual component and/or had some experience or awareness of spiritual practices in their lives, such as regular mediation or church attendance. The primary researcher was aware of the need to forestructure the interview process by being aware of his own fore experiences and knowledge that could block appropriate exploration of the participants' experiences.[26] All participants were registered with the General Osteopathic Council. As the study was exploratory in nature, the therapists' osteopathic approach, gender, ethnicity, religious or spiritual affiliation were not considered in sampling (see Table 1).

Table 1: Participant details

Participant (Pseudonym)	Age (years)	Length of time in practice (years)
Amelia	50	16
Anne	35	11
John	40	5
Sarah	43	16
Tom	54	9

Data Collection

Potential participants were approached by an initial informal telephone call or email and were subsequently sent a study information pack and consent form. Interviews were arranged to take place at the participants' place of work. A semi-structured interview schedule was designed with open-ended questions that focused on participants' understanding of their experiences in accordance with guidelines recommended by Smith

et al.[25] These included questions asking about the therapeutic relationship, the role of touch, and themes based around elements of spirituality such as interconnectivity, empathy, holism and trust. Interviews were conducted face to face in the therapy room of the participant, to reflect research on place identity and attachment that shows a strong correlation between belonging and meaning a purpose in life.[27] The interviews allowed the researcher and participant to interact flexibly and responsively to participants' talk.[25] Interviews were conducted by the first author and ranged in length from between 45 and 60 minutes, which allowed a rapport to be developed, encouraging participant involvement and providing time for them to think about and express their experiences. To control for bias in interpretation, the interviews were digitally recorded and participants were sent a copy, which they were encouraged to amend to ensure that it fairly reflected their experience.

Ethical Considerations

The project was designed and conducted so as to adhere to the British Psychological Society's (2009) *Code of Ethics and Conduct*, and ethical approval was obtained from the University of Northampton's research ethics committee. The study involved no deception and participants gave fully informed consent. They were aware of their right to decline to answer any question put to them, and to withdraw subsequently from the project without giving a reason. Pseudonyms were adopted and all identifying information in the transcripts was changed.

Data Analysis

Data were analysed by the first author, in line with published guidelines.[25] The transcripts were read and re-read and analysed line by line to gain an initial clear understanding of the data. Interesting or significant comments were annotated in the left-hand margin and included paraphrasing and summarizing what was said as well as similarities, differences, associations and contradictions in what the participant said.

Once this had been done for the whole document the researcher returned to the beginning of the document and recorded emerging theme titles in the other margin. Concise phrases were constructed to capture the essential quality of what was found in the text. Expressions were found to allow for theoretical connections within the text but at the same time were grounded within what the participant said. Emergent themes were listed and connections between them were made. Direct quotes from the transcript were attached to each theme to ensure that the original meaning was not lost in the interpretation and these were clustered by relational connections and then checked against the original transcript to ensure that they held true against the interview. These themes were then formulated into super-ordinate themes made up of sub-ordinate themes. This process was repeated with the other transcripts, resulting in an expanded list of integrated themes that were felt to capture the essential features of the shared experience. New emergent themes were identified and were cross-referenced with earlier transcripts. This was supported by disciplined analysis, to discern repeating patterns, or convergence or divergence within the data. This process allowed the researchers to be aware of what had come before and what was new and therefore recognise how participants' accounts were similar or how they differed. By following this strict process and method of analysis, with continuous reference to the interview transcripts, and cross referencing looking for consistency within the accounts, the researchers were not only able to allow for consistent analysis of evolving themes, but were also able to minimise bias. A final table of master themes was constructed setting out names of themes (see Table 2). The second author independently reviewed coding and theme identification, and both researchers discussed and agreed on master theme identification. This process was intended to minimise individual bias in data interpretation.

Reflexivity

According to Elliot et al.,[28] it is good practice when conducting qualitative research to disclose theoretical orientations, beliefs or personal expectations prior to the analysis

stage. The first author, who conducted the interviews, is a registered osteopath and had a known personal interest in spirituality and had experienced a transpersonal component to therapy while engaged in osteopathic practice, and this influenced the development of the research question. The primary researcher was aware of the need to forestructure the data analysis so as to keep a check on preconceptions and remain focused on the phenomena being studied in order to allow the data to emerge in an open way.[26] Although experiences and interest in the field were useful in providing an insider's perspective when interpreting descriptions of the participants' in-practice experience, the researchers was aware of the need to rein in personal preconceptions in the data analysis, so as to avoid premature interpretations. The second author was not an osteopath but was very familiar with research relating to the potential therapeutic effects of spirituality and also had experience of applying IPA to the understanding of transpersonal experience. The relationship between the primary researcher (practitioner) and secondary researcher (academic) was helpful in the reflexive process mediated through regular meetings to share understandings of the data and to act as a foil for each other as a means of testing understandings. This process challenged any pre-existing assumptions and hypotheses and potential for personal bias, which they made every effort to minimise. Finlay[29] notes "dialogue within a group allows members to move beyond their preconceived theories and subjective biases towards representing multiple voices". Confirmation bias was minimised by a continual re-evaluation of the participant's impressions, and critical reflection during coding and theme identification. Individual researcher bias was also minimised by both researchers reading and decoding the transcripts individually, and then discussing the final coding together. This was supported by the participants being allowed the freedom to explore the topic in their own way during the interview process and to encourage them to revisit and amend the transcript so to ensure it fairly reflected their experiences. No theoretical expectations were discussed with the participants.

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RESULTS

Three superordinate themes and six subordinate themes of relevance to how practitioners experience spirituality in their practice emerged from the analysis of the data (see Table 2).

Table 2. Master table of superordinate themes and subthemes

Superordinate themes	Subordinate themes
Holistic approach to wellbeing	Mind-body Connection
	Belief in self-healing
Therapeutic relationship	Space and being present
	Sense of connectedness
Intuitive Engagements	Other ways of Knowing
	Touch

Theme 1: Holistic approach to wellbeing

When asked about how practising as an osteopath affects their views on the way they thought about illness and wellbeing, the majority of participants reported that they saw their practice of osteopathy as extending beyond physical health alone. They stressed the importance of recognising a strong connection between the mind and body and often described illness as reflecting or being mediated by psychological and emotional elements. This was reflected in two subthemes: Mind-body Connection and Belief in Self-healing.

Mind-Body Connection

All the participants asserted that osteopathy extends beyond addressing the physical, and that physical wellbeing is connected with psychosocial wellbeing. Anne for example, describes the symptoms of adhesive capsulitis (frozen shoulder) as extending beyond a physical cause:

> And the body creates them to show the body a message to release them … you are helping them to see the message or read the message and then move. Move forward in their life… So it's not a bad thing really, in a way. So, yes I often see it as, you know, people often get stuck in a way where they are and in their life because of what has happened to them … and the body shows that in a form like a frozen shoulder, stuck, so then by releasing the negative programming, the body will then allow itself to heal again. [Anne]

Anne explains the patient's symptoms in terms of their feeling stuck in some aspect of their life. Such a holistic, extended interpretation of the aetiology of the presenting condition can afford greater insight into the best way of treating or managing it; for example, in this case by releasing the negative programming around the aspect of life that is 'stuck', the shoulder problem may heal itself. Similarly, John identifies an interconnection between the mind and body, in which physical symptoms may reflect deeper emotional or psychological issues, rather than purely physical:

> I think that a vast majority of it is far more than I give it credit for is the emotional aspect I think that that starts this cascade effect, and I think the actual physical manifestations being the back or the neck or whatever, that's quite a way down the line. [John]

> I found when I qualified that it was [a] very structured box, like erm manipulate, massage, stretch, erm — but you're not really dealing with a box human being, you are dealing with an entity with emotions that are all over the place probably 24/7, and that's all going to have an effect on the physical aspects of the muscles and everything else. So I think how it's changed is that I'm a lot more softer in my approach and more, I listen a little bit more actually, rather than getting all the

> tests done and all the rest of it, I listen and talk and then, I think that helps, I certainly like to practise that way. [John]

Like Anne, John describes emotional and psychological aspects of wellbeing extending beyond the physical problem and he alludes to a cascade effect, suggesting underlying non-physical elements, effect and influence or causing physical symptoms. Experience had made him more sensitive and aware of this holistic dynamic, seeing his previous perception of the human being as a 'box' as oversimplified. He describes his approach to the patient as also becoming 'softer' which involves being more passive and sensitive within the therapeutic relationship.

Anne also alludes to the importance of practice and experience in developing an awareness of more holistic, psycho-socio-spiritual aspects of physical wellbeing; aspects that were inadequately covered in her training.

> Going back to when I first qualified, it was very much that people were there for the purely physical. That was it, they were very much coming for the physical side of it and now it is all entwined, I, I really recognise, because of my development how it is all entwined in them, and so the treatments have become more over the years more and more holistic, bringing everything into that package… in earlier days, I was, I needed to use my time to get the body better, but now I know that this person needs to talk about what else is going on, express this, because this is really important in the bigger picture of getting them better properly, in the long term and getting rid of the problem. [Anne]

Similarly, Sarah recognises that a holistic view of the person comes with experience, with more time in practice spent discussing patient's wider circumstances and less purely being focused on the body:

> I think they become equally important, erm I think with experience you are able to see the person more as a whole entity of different erm emotional being, physical

being and possibly a spiritual being, and you are able to have more overview. [Sarah]

Belief in Self-Healing

Among interviewees there was a common belief that the body had an inherent capacity to heal itself and that osteopathy was simply a means of enabling that process. If the practitioner can recognise the means to facilitate the self-healing process, the patient can be empowered to take responsibility for improving their own wellbeing. John feels that this is facilitated by giving time, and listening to his patients:

> Yeah it's more about listening to them, whether it be when they're on the couch, when you're treating them, or you spend a little bit longer with them before just talking about perhaps what's gone on in their lives. That seems to be quite cathartic for them, they seem to open up a bit more, more relaxed and I think that has a massive effect on how they heal... I don't think that osteopathy as a profession, I don't think we actually fix anything I think what we do is just to start the ball rolling to give you a massive boost of something and the body can start to do it itself and then we do a bit more and that boosts it again to a point where the body can do it for them. [John]

For John, listening is very important within the healing dynamic and he feels that having an understanding of past events and life experiences are important for him to be able to understand the triggers and mediators of symptoms the patient presents with. He values time taken to encourage disclosure and trust, which is seen as facilitating the healing process.

Sarah also talks about the value of self-healing, and links it to personal spirituality:

> Spirituality is their attitude and state of mind, positive thinking and that sort of thing, how positive and how sort of much life force they have got in them, how willing they are to get better. [Sarah]

Theme 2: Therapeutic relationship

A second theme we identified reflected participants' sense of connection with their patients, one that enhanced the therapeutic relationship and was experienced as a subtle awareness of the patient's health issues and how to effectively treat them.

Space and being present

Participants talked about the importance of being present and of creating a safe space that extended between them and the patient. For example, Sarah describes how this took on an almost sacred quality when a patient was disclosing information to her:

> I remember that distinctly and she was on her front talking through the face hole. I think that is often what people do they talk more when they are on their front talking through the face hole because they don't have to look at you. You are like the Catholic priest they don't have to see you. I think that is quite an interesting point, that they don't have to see you, you are just a voice and presence, they can forget that you are there…that sort of safe space, the treatment space, umm and how important it is for the practitioner to have that capacity or that ability to give the patient that space. [Sarah]

Sarah describes a type of therapeutic space (a 'safe place') that engenders trust, support, and empathy — all components of spiritual connection, as perhaps alluded to in the confession box analogy. She suggests that providing such a space enables healing and wellbeing to flourish.

Sense of connectedness

Participants talked about a sense of connection between the practitioner and patient that emerged within the safe space they had created. This was a quality of the relationship

that had not been experienced outside of this space, and was interpreted as reflecting a deepening of the therapeutic relationship.

Sarah describes how important the therapeutic relationship was to her and how she experienced a moment of connection during a treatment when a patient disclosed some very personal information to her:

> I think it's hugely important and I think that's something that I'm realising more and more, how important that is. Um, it felt like quite a profound experience in that we had a moment where she was really confiding and it made me think even more how important that really is [Sarah]

Tom expresses how important touch is in providing this sense of connectedness. He maintains a physical connection with his patients whenever possible, even when moving around the couch:

> It's right for me and it's a bit intuitive. I don't know why I do it, I can't put a clinical reason for it but it maintains contact with me and I just feel that you have to become 'as one' almost when you're working [Tom]

As an instance of his sense of connection with a patient that goes beyond the physical, John describes how he might examine an area of the body not associated with the presenting condition without being aware of why he had focused on that particular area but sensing that it could nevertheless be helpful:

> Areas that you go to automatically to treat although knowing they are not really the problem areas, that I've mentioned, and I've sometimes gone there even without me knowing about it, working on this part of it, and that's you know, sometimes I don't know why I'm doing it, and then it might be something they say like the knee may have been hurting for a while and you suddenly realize that you're doing it almost subconsciously sometimes. And then probably the more flash thoughts or sensations or feelings of that they are going through and if you think

> it's the right time to approach that you can sort of ask them and a lot of the time they sort of clarify and you're quite right. [John]

Theme 3: intuitive engagements

Participants' reflections on the ways in which they experienced subtle awareness of their patients and how to treat them led to an exploration of how that 'knowing' was realised.

Other ways of knowing

Some of the experiences of intuition and other ways of knowing were in the form of emotions or feelings, while others were more representational, in the form of imagery. One participant, Amelia, described how on occasion she felt able to visualize relevant incidents from the patient's history:

> When I treat some people — and it is [only] some people, usually people that have had a lot of emotional trauma — I do often see a lot myself…. sometimes I see the actual accident. [Amelia]

This event is characteristic of a synchronistic experience, which could be a result of the strength of the therapeutic relationship.[23] Another participant felt sensations in his body when he was treating, including heat from his hands and tingling, which were accompanied by images and thoughts that would enter his consciousness with no warning.

> I get certain sensations when I'm treating, I think, heat, cold, tingling from my hands — that's quite [a] common thing I seem to get. You get flash kind of thoughts or maybe occasionally pictures that come into your head about what's wrong and then just a feeling about people. [John]

Participants also reported that the intuitive connection was related to the quality of their relationship with the patient, particularly where it was relaxed and open:

> Oh, in terms of using my intuition? Yeah, I'd say so, if I am with a client who I'm feeling relaxed with and they are pretty open with me. [Anne]

Tom expresses his awareness of an intuitive non-verbal connection between him and his patients and a sense of knowing-through-feeling as a source of information:

> Whatever you do, I think that two people can stand in front of each other and there can be a dialogue without words… It's not spoken... I can feel uneasy with somebody, without even someone looking badly at me. I just know, I can just feel it. And I think everybody's got that ability. [Tom]

He goes on to describe a case in which he sensed that something was wrong with a patient, despite there being no overt clinical signs of anything to worry about which influenced a decision to refer the patient to his doctor.

> I just knew something wasn't right… and so I try not to ignore stuff like that. [Tom]

Touch

Participants' intuitive engagements between themselves and their patients were often mediated by touch. In the following extract, Anne describes a form of touch that she feels allows her to sense the body at a deeper, 'more energetic' level:

> So using that form of touch sometimes it is lighter to sense what is really going on underneath… While doing that, to feel what is happening in the body, sometimes you can feel the imbalances in energy in the body [Anne]

For Sarah the intuitive connection was also facilitated by touch, which she describes as a type of listening:

> Sometimes you get sort of vibes from people when you are touching them, you get ideas, not images but you get ideas sometimes about how they are feeling and what else is going on, not just from them speaking, I mean you get a lot of information from that but sometimes I feel that I get a little bit more from them through the touch... I think this is a more holistic way to treat because you are

listening to their body with your hands but you are listening to them as well [Sarah]

Sarah felt that touch facilitates intuitive insight of non-verbal emotional and psychological components of the patient's wellbeing. She interprets this as a holistic approach and is describing a kind of deep empathy.

DISCUSSION

The themes we identified have highlighted a number of 'spiritual' aspects within practitioners' lived experience of osteopathic practice. They all expressed an understanding of illness and wellbeing that emphasized a mind/body interconnection and the importance of the therapeutic relationship in facilitating wellness. This holistic perspective, which recognized emotional, psychosocial and spiritual factors as contributors to wellbeing alongside physical factors, seemed to develop with time and experience, suggesting that it was not explicitly taught but was an acquired skill that deepened through practice. Treatment was seen as providing a context within which the therapeutic relationship could provide the impetus for patients to harness their own self-healing capacities, particularly where physical symptoms reflected psycho-socio-spiritual causes. This approach is consistent with recent research on the role of compassionate patient-centred care[30] and studies on the positive benefits of caring for motivation and wellbeing.[31] The present study similarly suggests that for some practitioners the therapeutic relationship may be regarded as an essential ingredient in the osteopathic consultation, involving not only the desire to help the patient, but also the expression of behaviours that show an understanding of their predicament as well as addressing patient needs in a manner that is interpreted positively by them.[32] In such cases, the positive intention of one person to help another person may be a key to success in healing practice.[33,34]

Participants felt that the sense of interconnectedness they experienced in their interactions with clients was also evidenced through intuitive or synchronistic occurrences. These phenomena could be interpreted in various ways, such as unconscious connection; transference or counter transference; or so called anomalous/paranormal experiences. Despite the concept of intuition being poorly understood and vaguely articulated within the medical paradigm, there is some evidence to suggest that practising nurses use intuition and believe that its use can change outcomes for patients.[23,35-37]

Data from participants suggested that they regarded touch as a mediator of intuition and healing. These findings are consistent with research on touch and emotion in nursing[38] and recent research in osteopathy by Consedine, Standen, Niven[24], which found that touch was an important feature of the practitioner-patient interaction and communicated a sense of care, and attention as well as competence. Given that patient trust is influenced by belief in practitioner competence, touch could play a role in cultivating trust, and ultimately in influencing the therapeutic relationship and outcomes. If the practitioner can feel connected through intuitive engagement via touch, and offer information that strengthens trust, then not only might it influence the therapeutic relationship, but also reinforce belief in the practitioner and thereby have a positive impact upon healing outcomes. As an osteopathic practitioner the primary researcher was not surprised to find that touch played a role for an intuitive, nonverbal form communication with the patient, but was surprised to find that all interviewees experienced it in some way, and were willing to talk openly about experiences they regarded as transpersonal during the interview process. This is particularly interesting given the taboo surrounding such phenomena.[41, 42]

One possible mechanism for patient belief in the practitioner to translate into effective treatment involves the placebo response.[39] Recent literature suggests that manual therapists should utilise placebo mechanisms within their practice.[40] It seems likely that the 'spiritual' components that have been identified by practitioners in this study may

facilitate these placebo responses. Qualitative research necessarily involves relatively small samples and is not oriented toward generalisations. We can only speak here to the experiences of our few select participants. We would argue, therefore, that additional work would be beneficial to explore the extent to which perceptions identified here are shared with other members of the osteopathy practitioner community, and also to evaluate the extent to which these perceptions of the therapeutic process are shared by patients.

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