

NORDIC OSTEOPATHIC JOURNAL 2024

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NORSK OSTEOPATFORBUND

Svenska Osteopatförbundet

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Danske Osteopater

OSTEÓPATÍA
OSTEÓPATAFÉLAG ÍSLANDS

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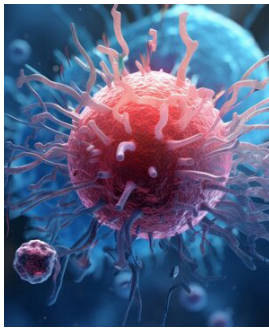
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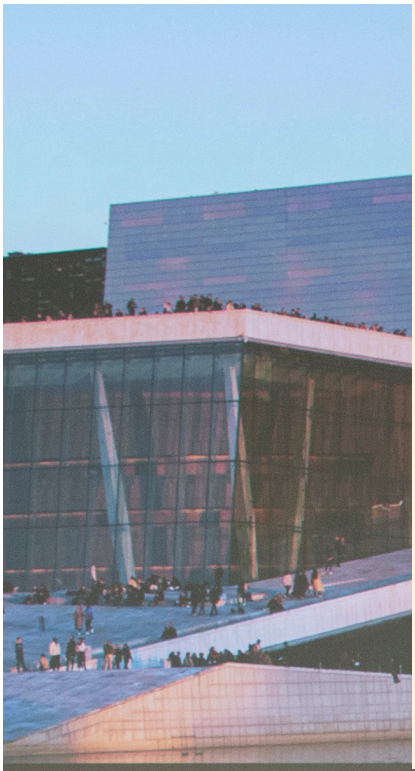


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Words from the editor

Dear readers and Colleagues,

Finally, we can show you our newest edition of the Nordic Osteopathic Journal. As the years before, this is a collaboration between the Nordic countries. I wish to extend my thanks to all our contributors, as well as the NOA leaders. As a part of a collaboration between the countries, we also strive to be an informative journal with focus on trying to reach a broad audience.

In this edition you will find a variety of articles, and I hope some of them catches you.

I wish you all a pleasant reading.



Ingrid Nicander
Osteopath and editor



26 Nordic Osteopathic Congress 2024

Nordic Osteopathic Alliance



Haraldur Magnússon
President of the Icelandic Osteopathic Association

Regulated since: 2005

Number of members: 3 and a few more pending

Tanja Kakko
Member of the Board of the Finnish Osteopathic Association

international@osteopaattiliitto.fi
www.osteopaattiliitto.fi

Regulated since: 1994
Number of members: 200 including students

Tomas Collin
President of the Norwegian Osteopathic Association

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Regulated since: 2022

Number of members: 452 including students

Emmelie Hansen
President of the Swedish Osteopathic Association

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Number of members: 289 including students

Hanna Tómasdóttir
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Regulated since: 2018
Number of members: 400 including students

Nordic Osteopathic Alliance



Stronger together!

We are committed to creating a sustainable and unified osteopathic profession across the Nordic countries.

Dear colleagues,

We are happy to announce that the Nordic Osteopathic Alliance (NOA) is still going strong and keep developing our role as the unifying umbrella for the osteopathic community of the North.

Our primary goals are:

- Establishing common regulations
- Aligning educational standards
- Ensuring high-quality osteopathic care
- Promoting patient safety
- Facilitating the ability for osteopaths to practice across borders without limitations, thereby increasing professional opportunities and promoting knowledge exchange.

We are steadfast in our mission to have osteopathy recognized as an integral part of the established healthcare systems in all Nordic countries. We continue to work for achieving regulation of the profession in all Nordic countries, and to maintain and promote high standards for osteopathic education.

The 5th Nordic Osteopathic Congress was held in September in Oslo. It was a great event, with over 120 attendees and a line-up of well renowned speakers. A wide range of topics were covered, from clinical considerations on headache and neck pain, to reflections on person centredness and qualitative research. NOA is committed to continue to deliver high quality congresses, and we are currently planning next year's event. We are looking forward to welcoming osteopaths from the Nordics and beyond to next year's Nordic Osteopathic Congress in Reykjavik, Iceland, 13-14th September 2025. Save the date!

Have you seen our newly launched website? Here you can find the lates news and information about future events. You can also find and read all editions of the Nordic Osteopathic Journal.

We wish you all an informative and pleasant read of this edition of the Nordic Osteopathic Journal and hope to see you next year in Iceland!

Kind regards,
Nordic Osteopathic Alliance,

The NOA leaders:
Tanja Kakko, Finland
Emmelie Hansen, Sweden
Hanna Tómasdóttir, Danmark
Tomas Collin, Norway
Haraldur Magnússon, Iceland

Scan the QR-code to visit our new website!

nordicosteopathicalliance.org

Managing breast-feeding difficulties

in collaboration between osteopaths and lactation consultants

Text: Minna Sillantaka

Breastfeeding difficulties influence a high proportion of families. They deserve appropriate and timely care from the health care professionals when they wish to continue breastfeeding. Osteopathy is increasingly used to manage breastfeeding difficulties when lactation consultation alone does not bring resolution. This article discusses collaboration between osteopaths and lactation consultants to manage breastfeeding difficulties in a multidisciplinary way based on a qualitative master's thesis.



Breastfeeding difficulties are common

Breastfeeding is an individual and multidimensional experience of the lactating parent and the baby. The World Health Organization recommends breastfeeding exclusively for the first six months. 30% to 70% of postpartum dyads are estimated to experience breastfeeding problems during postpartum period. The high prevalence of breastfeeding difficulties highlights the need for appropriate breastfeeding support for parent and baby to establish and maintain breastfeeding, especially during the first weeks and months. Most frequently breastfeeding parents suspect insufficient milk volume and are concerned over the supply. Many breastfeeding parents wean during this timeframe due to insufficient social or practical support, difficulties or uncertainties even if they have a wish to breastfeed longer. (1,2.)

Maternal breastfeeding pain, infant's poor latch and abnormal feeding patterns, like long duration or high frequency at the breast are common complaints when having breastfeeding difficulties.

These problems may suggest suboptimal attachment and positional instability of an infant at the breast. Possible reasons for abnormal infant behaviour should be evaluated to outline medical conditions. (1,2,3.)

Lactation consultation is an effective method to offer support and help to the family to overcome lactation-related challenges and continue breastfeeding. It consists of parental support, education, guidance for positioning, practical advice and help to process emotional and psycho-social elements involved with breastfeeding. Lactation consultation is offered by a health care professional with additional education and certification for breastfeeding. (4.)

Osteopathic approach to breastfeeding difficulties

Paediatric osteopaths treat common complaints of infancy, including breastfeeding difficulties in their private praxis (5,6). Paediatric osteopathy is suggested to provide positive outcome to breastfeeding difficulties, which have neuromusculoskeletal background, that interfere with optimal feeding. (6,7,8). Osteopathic research on the subject is limited but indicate favourable effects for supporting breastfeeding (9, 10, 11, 12, 13). Touch-based practices in paediatric osteopathic care are also suggested to have broad influence in neurobiological and social bonding, which can influence positive feedback loops in postpartum dyad and family-centred care (14,15,16).

Osteopathic assessment and treatment of breastfeeding difficulties are described in osteopathic literature with anecdotal and clinical experience-based evidence (7,10). From osteopathic perspective, infant's inability to maintain latch or generate sufficient intra-oral pressure may result from deficits of neuromusculoskeletal system in areas relating to feeding. Latch problems arise from infant's insufficiency to open the mouth wide and failure to create a seal around the nipple. Infant's posture, restrictions of movement and positional difficulties at the breast may influence proper attachment and sucking abilities. (7,10,11.)

In osteopathic literature, predisposing factors of insufficient sucking pattern are intrauterine constrains or uncomfortable positioning and trauma during delivery, which may lead to musculoskeletal strain and torsions. These strains presumably cause compensatory patterns and elements to other structures in the body and may compromise normal postnatal functions. (17,10,7.) Strains in sphenobasilar synchondrosis, occipital condylar compression, restriction of motion of temporal bone and somatic dysfunctions in cervical, thoracic, lumbar or sacral area in infants are common findings in osteopathic assessment (17, 18,19,20). Also, oral-fascial anomalies and structural abnormalities can interfere the success of latch. Congenital torticollis and ankyloglossia, meaning tight tongue-tie, are two common diagnoses related to the baby, when dyad is having breastfeeding difficulties. (21,22,23,8.)

Exploring collaboration

Master's thesis with qualitative research method was conducted in Finland in 2023 with lactation consultants and osteopaths. The aim was to explore collaboration between lactation consultants and osteopaths to manage breastfeeding difficulties in a multidisciplinary way. The purpose was to examine the potential of osteopathic care as part of multidisciplinary collaboration.

A qualitative research method was used to explore professionals' perspectives and experiences. Data was collected through two separate focus group dis-

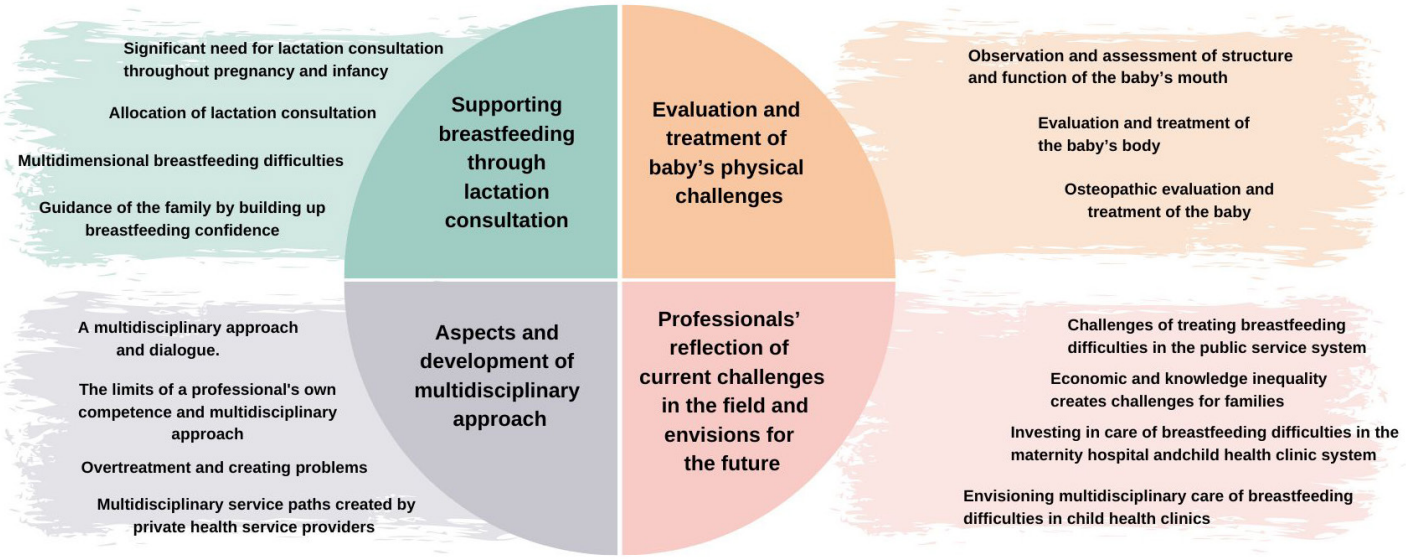


Figure1. Main themes with additional categories.



cussions including lactation consultants and osteopaths. The participants were private health care providers, who have worked in the field with multiple years of clinical experience. Four lactation consultants and four osteopaths were included. Each focus group consisted of two professionals from each profession. Focus group discussions offered professionals possibility for multidisciplinary elaboration and provided comprehensive data. The data was analysed inductively, which allowed four main themes to emerge from the data with additional categories.

Results

Main themes were supporting breastfeeding through lactation consultation, evaluation and treatment of baby's physical challenges, aspects and development of multidisciplinary approach, and professionals' reflection of current challenges in the field and envisions for the future.

Lactation consultation was seen as primary care for infant feeding from early pregnancy. Prevention, knowledge and early interventions were considered the most influential elements of care for breastfeeding difficulties. Effectiveness of supporting self-efficacy and breastfeeding confidence with family-centred approaches in biopsychosocial context emerged. Lactation consultation, guided by breastfeeding wish of the family, should be offered whenever there is a need or concern about breastfeeding.

Especially in multidimensional difficulties, evaluation and treatment of baby's physical challenges were emphasised as influential part of care practices. Biomechanical malfunctions were seen as a significant reason behind multidimensional breastfeeding difficulties. Breastfeeding difficulties related to motor coordination deficiency of the baby's mouth occur as baby's insufficiency to control milk-flow of the parent while keeping adequate breathing, swallowing and sucking sequence. The main malfunctions were anatomical restrictions like shorth and tight lingual frenulum, considerable tension in the baby's physical body, and restriction of movement or dysfunction of the mouth and tongue. Without addressing these strains and restrictions, lactation consultation may remain insufficient. As multidisciplinary approach was highly emphasised, osteopathy was seen an influential part of treatment entity.

Dialogue between professionals was considered essential when working with breastfeeding families. Information exchange from multi-professional perspective was seen to broaden the perspective reciprocally. It is crucial for professionals to understand their limits of own competence and refer easily. Medical care was described as an important part of treatment of breastfeeding difficulties, especially when anatomical restrictions like tight lingual frenulum occur. Though, overtreatment and creating problems were a concern of both disciplines. Normal variability of neonatal function and development should always bear in mind.

Breastfeeding difficulties cannot be looked at from one perspective or discipline, but rather as a multifactorial phenomenon, where multidisciplinary, psycho-emotional and family-centered approaches are key elements for efficient understanding, guidance and care. The findings underlined that lactation consultation and paediatric osteopathic interventions not only influence positional and biomechanical challenges, but also offer support for the whole family. Health care professionals' attitude, presence and possibility to address underlying factors were found to help family forward in their current situation. Multidisciplinary approach with a lactation consultant and an osteopath could offer a way to combine all these aspects and elements for efficient support, guidance and care with influential results.

Lactation consultation and the start of osteopathic care were ideally placed in the first days and months of a neonate. The professionals envisioned osteopathic care as a part of the care in maternity hospital after birth and saw value in having osteopaths in child health clin-



ics as a part of a multidisciplinary team. Results describe the current situation in Finland, where lactation consultation and guidance of the family are included in the responsibilities of child health clinics. All osteopaths in Finland work in private sector even though osteopaths are private health care providers registered by Valvira, National Supervisory Authority for Welfare and Health.

It seems that child health clinics are not able to respond to the need for care of breastfeeding difficulties effectively, especially when multidimensional breastfeeding difficulties occur. Therefore, multidisciplinary private sector services are needed.

Conclusion

It can be concluded that osteopathy was noticed to reinforce care practices and add value in managing breastfeeding difficulties in a multidisciplinary way. Collaboration of the disciplines was described influential and beneficial, and paediatric osteopathy was valued highly based on clinical experiences of the professionals. Restrictions, strains and anatomical features of infant's physical body were addressed by both disciplines with recommendation for evaluation and proper treatment of them when breastfeeding difficulties occur.

Article is based on Master's thesis Managing breastfeeding difficulties in a multidisciplinary way involving lactation consultants and osteopaths.

Scan the QR-code to read the thesis.



Minna Sillantaka
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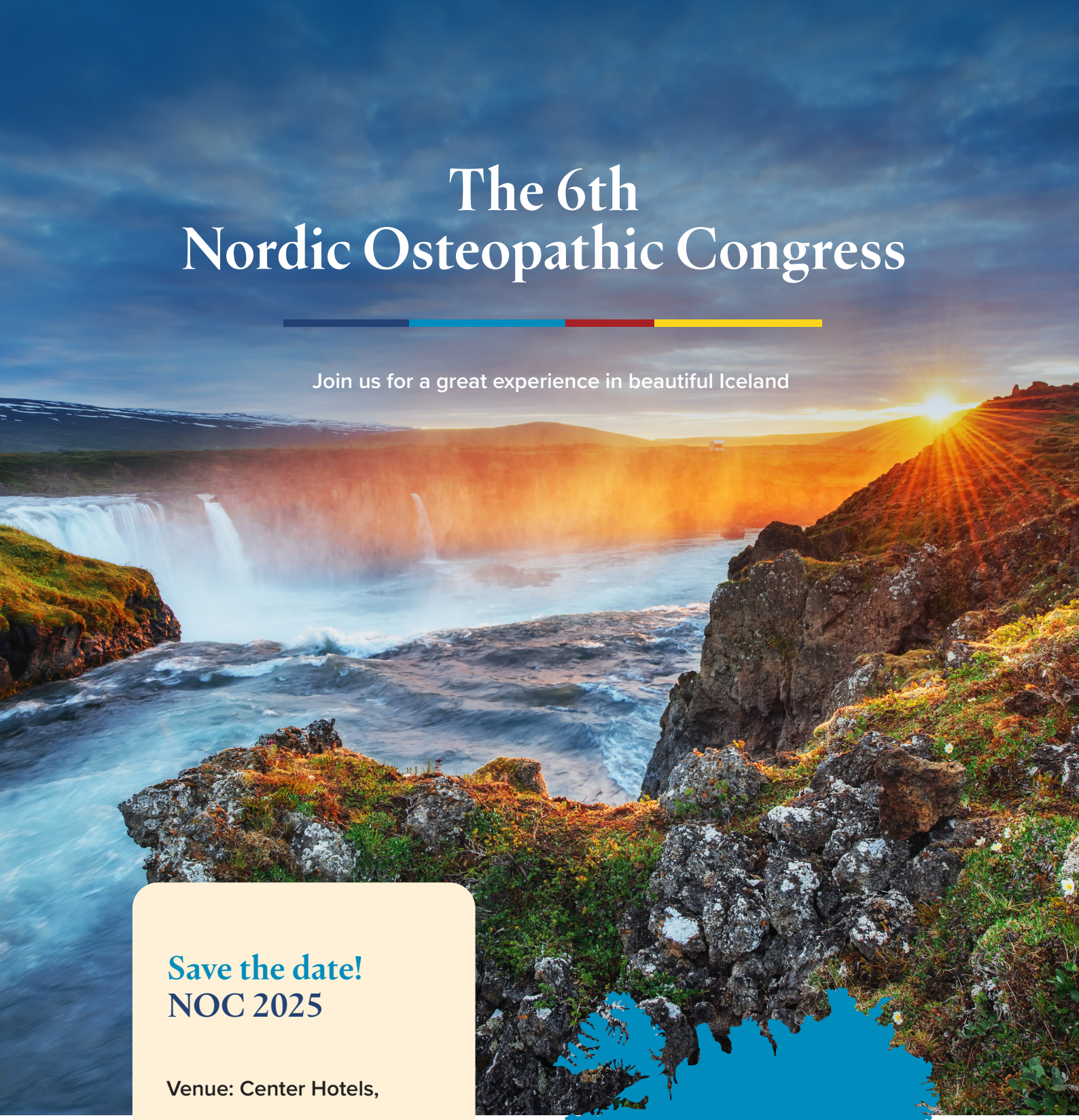
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NORDIC OSTEOPATHIC ALLIANCE

Women and baby clinic

Text : Christian Danø Møller & Frederik Bahne

An increase in C-section

Between 1998 and 2015 the caesarean section (C-section) rate increased by 49% percent in Denmark (1).

WHO reported in April 2015, that an ideal rate of C-sections is 10- 15% in a country (2). In Denmark, 21% of all births are done by C-section and a recent study report that it is 25% in Europe (3) and is increasing worldwide (Betrán et al., 2016; Rydahl et al., 2019). There is also seen an increased rate in maternal age women giving birth and this may contribute to increased risk of C-section (1). The most frequent pain complications following C-section are scar tissue formation, scar pain, lower back pain (LBP) and pelvic pain (4). The most prevalent pain, other than the scar pain, was back pain (4).

Women's Health – A Hot Topic

In recent years, the interest in women's health has grown significantly among osteopaths. More courses, seminars, and webinars aim to educate osteopaths, doctors, and other health professionals on the complexities of female health. This includes understanding hormonal cycles, psycho-emotional stress, and the unique challenges women face in balancing corporate careers with their roles as mothers. Osteopaths are showing an increasing interest in the challenges women encounter following a C-section. We see a significant need for women who have had C-sections to receive proper care in the form of osteopathy and physiotherapy after childbirth. Often, we encounter patients many years later who still experience unresolved pain, whether it's in their groins, lower back, or other areas.
In many cases based on our clinical experience, there is a link between the C-section and their ongoing pain.

The Spark Behind the Idea

This growing interest in women's health sparked an idea for my colleague, Christian Danø Møller, during his master's thesis at Buckinghamshire University and the International Academy of Osteopathy. He questioned, "Why aren't more osteopaths taking a deeper look into post-C-section treatment, especially given the rise in caesarean sections in recent years?"

This idea culminated in his masterthesis, The Effect of Osteopathic Visceral Mobilisation on Low Back Pain Following Caesarean Section (5). It also inspired our colleague, Simone Glad Christensen, whose thesis explored the various types of pain reported by women after C-sections and how osteopathic treatment could help alleviate their symptoms in a systematic review (6).

The body as a self healing mechanism

It is our experience that communicating the clinical findings and our treatment-recommendations was an essential part of the process. Most of the women we meet in the clinic have uncertainties, worries or anxiety regarding their symptoms and situation, which we try to incorporate in our treatment-strategy and communication. As osteopaths we try to help the body of our clients to heal itself. We try to increase mobility of tissue, give advices on exercise, training, nutrition or stress-management. We treat the body as a whole - the cranial system, the visceral system and the musculoskeletal system all gets our attention every day, with every client. But a lot of the feedback we have had from clients is not that the manual techniques we perform as osteopaths are better than other manual professions - the feedback we get is "aha, NOW I understand" or "this makes sense, finally someone understands me". To regulate a self healing body, the client needs to understand why we do what we do, and we as osteopaths need to understand the complex mechanism behind a self healing body - we need to be brilliant in theory and practice, but most of all, maybe in communication.

The Treatment Process

Based on our clinical experience, once the assessment is complete, treatment

> "To regulate a self healing body, the client needs to understand why we do what we do"



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Image: Regina Burganova | Getty Images



can begin. The techniques and systems we address vary between clients and may change from session to session. However, a common finding is that scar tissue and the surrounding abdominal tissues often exhibit significant mobility restrictions. Osteopathic visceral techniques are frequently employed to restore this mobility. Given that tissue restrictions may persist for over 20 years, it is essential to approach the treatment process with patience and care. Meaningful improvements require respecting the tissues and allowing sufficient time for recovery. Furthermore, our clinical experience initiating conservative treatment early after a C-section is critical for optimal outcomes.
Our primary goal remains consistent: to address the root cause of pain, rather than merely treating compensatory mechanisms. As the medical doctor and founder of osteopathy, A.T. Still, stated:

> "To find health should be the object of the doctor. Anyone can find disease.
>
> — Andrew Taylor Still

What if Time Is Our Greatest Asset as Osteopaths?

One thing that we have found particularly helpful in our treatments and meeting with clients is prioritizing enough time to perform a thorough examination, communication and personalized treatment plan. We never do short appointments; we do a minimum of 1 hour for first consultation and a minimum of 45. Minutes for the follow ups. Our women and baby project we see our task as osteopath, not only as a manual profession, but as a profession with the potential to help the body heal itself and educate and help our clients to understand how the functional body works. In the end I would like to quote our colleague Professor Dawn Carnes, that at the Nordic Osteopathic Congress in Copenhagen said:

> "What if our biggest asset as osteopaths is time?"
>
> — Dawn Carnes

A Lack of Guidelines

Currently, there are no conservative treatment guidelines for women who have undergone C-sections in Denmark. Clinical guidelines are absent, and the only advice typically given relates to movement. We hope that osteopathy can become an integral part of a multidisciplinary treatment model, helping women prevent low back pain and improve their quality of life following a C-section.

SpecHealth's women and baby project is currently collaborating with Hillerød Hospital to conduct research aimed at addressing this issue. We hope that our project can help raise awareness about the functional problems that can arise after a C-section. Our goal is to make osteopathy a standard part of postpartum care.

We hope this will inspire other osteopaths to contribute to research focused on this patient population. The increasing prevalence of C-sections and how osteopathy can play a crucial role in prevention management. Future studies should address this question with a larger sample size with more randomised control trials and validated outcomes to explain the optimal treatment most effectively treated by OMT and standardised guidelines are needed to optimize this treatment.

Christian Danø Møller
Osteopath, MSc, M.D.O, physiotherapist

Frederik Bahne
Osteopat D.O. MSc.

Managing stressaffected clients in osteopathic care

Text: Andreas Sønderriis



Introduction

While stress is not classified as a disease, stressors can profoundly affect an individual's quality of life, health status, and functional capacity, as well as increase the risk of developing various health conditions [1], [2], [3], [4].

The experience of stress is inherently subjective and is influenced by a variety of factors, including individual and environmental resources, as well as the ways in which individuals physiologically and psychologically respond to and manage stress, commonly referred to as 'coping strategies' [1], [4].

The term 'stress' is often used as a synonym for being busy[2]. The risk of developing a stress-related condition is referred to as 'stressors'; for example, the death of a close friend or family member, serious illness, divorce, significant financial difficulties, and unemployment[1], [4]. Other stressors may include the perception of being unable to meet obligations or demands, lack of control over one's life situation, and severe conflicts in personal or professional life [1], [3], [4].

While short-term stress is rarely problematic, prolonged or intense stress can be a significant health burden. Approximately one-fifth of the Danish population is believed to experience moderate to high levels of stress, and this trend has been gradually increasing over the past decade [1], [2], [3], [4]

Identification

Identifying stress is crucial for a timely response from healthcare professionals [3], [5]. In this context, understanding the impact of stress on the individual is essential for effective detection and diagnosis.

When an individual experiences stress, cortisol is released physiologically, triggering the release of glucose and fatty acids. This hormone also influences cellular insulin sensitivity, resulting in increased glucose uptake. In the short term, cortisol enhances the immune system by increasing the leukocyte count in tissues. [1], [4]

Activation of the sympathetic nervous system occurs concurrently, releasing adrenaline and noradrenaline. This leads to an elevated heart rate, increased blood pressure, and enhanced blood flow to the muscles. Additionally, there is an increased release of erythrocytes, and blood coagulation capacity is heightened. Psychologically, individuals may experience heightened arousal and emotional responses such as anxiety or anger, along with enhanced concentration and sensory perception. [1], [4]

In cases of prolonged stress exposure, various physiological changes may arise, including elevated blood pressure, increased heart rate, higher blood sugar levels, decreased insulin sensitivity, increased lipid levels in the blood, and suppression of the immune system. Neurotransmitter metabolism in the brain may also be affected, potentially resulting in damaging tissue changes in the memory and concentration centers of the hippocampus, as well as in the emotional center of the amygdala. [1], [4]

Psychological reactions to chronic stress can include anxiety, depressive symptoms, feelings of helplessness, irritability, difficulties with concentration, aggression, nervousness, impaired memory, reduced libido, confusion, indecisiveness, mood swings, and hopelessness. Additionally, individuals may experience physical symptoms such as headaches, palpitations, diarrhea, dizziness, abdominal pain, muscle tension and pain, fatigue, nausea, shortness of breath, excessive sweating, constipation, frequent urination, and chest pain. Often, behavioral changes occur, including sleep disturbances, increased consumption of stimulants, altered dietary habits, changes in exercise patterns, social withdrawal, and increased absenteeism. [1], [2], [4], [5]

Professional management

Stress management is often a multidisciplinary endeavour; therefore, collaboration with the client's physician is essential, as stress symptoms may arise from an underlying medical condition [5]. In managing clients experiencing stress symptoms, it is common practice for physicians to conduct blood tests to assess factors such as blood counts, vitamin deficiencies, liver function, blood sugar levels, calcium levels, infection markers, and more[5].

Several studies have demonstrated that Osteopathic Manipulative Treatment (OMT) can reduce both physiological and psychological stress in the short term, as measured by various biomarkers [6], [7], [8], [9], [10]. Typically, a combination of cranial osteopathic techniques - CV4, suboccipital soft tissue techniques etc., treatment of the cervical spine and thorax, as well as visceral techniques, is employed [11], [12]. However, there is currently no strong evidence to support the claim that OMT can reduce stress in the long term.

The healthcare professional's management of a client with stress should focus on the underlying causal factors (stressors) as well as the management of the physiological, psychological, and social symptoms caused by these stressors [1], [2], [5]. It is essential for the osteopath to recognize their own limitations and to collaborate with relevant healthcare professionals in an interdisciplinary manner.

The osteopath may benefit from utilizing a two-part treatment strategy that combines dialogue and manual therapy[13]. The aim here is to assist the client in managing stressors through supportive, person-centred dialogue, while employ-



ing manual therapy as a tool to temporarily reduce stress levels, alleviate any musculoskeletal symptoms of stress, and enhance the therapeutic alliance through touch, helping the client to feel more 'grounded' in their own body.

An osteopathic treatment process might look as follows:

First Session: A comprehensive assessment is conducted, which includes taking the medical history, identifying stressors, and evaluating the level of stress. Through dialogue and physical examination, both the somatic symptoms of stress and the social causes or effects of stress, as well as psychological burdens, can be mapped out in a collaborative discussion. Building trust with the client is essential at this stage. After identifying the stressors, the client and the osteopath can collaboratively develop specific goals and a plan for managing the stressors that can be modified. This may involve engaging other relevant healthcare professionals, providing manual treatment for somatic symptoms, and offering guidance on relevant health initiatives.

Second Session: In this session, the osteopath can follow up on the management strategies and further explore the impact of stress on the clients social situation. Manual therapy can be combined with discussions about stress management. The purpose of the manual therapy in this context may be to reduce physical symptoms, create a parasympathetic neurological response, help the client connect with their body, and alleviate the clients fear of harmless physical stress reactions, such as muscle tension or rapid breathing. The treatment may incorporate various techniques, including joint mobilization and manipulation, muscular and fascial techniques, osteopathic cranial techniques, and visceral techniques, among others.

In subsequent sessions, the osteopath follows up on the established goals and management strategies, adjusting the plan to fit the clients situation and health status. The clients level of health literacy should be considered, as general health initiatives often provide a solid foundation for a holistic, health-oriented intervention. For example, sleep, diet, exercise, and general health behaviours can be significantly affected by stress, while also acting as factors that contribute to its development.

Osteopathy is more than just manual therapy[14], [15]. When managing clients who experience symptoms of stress, it is essential for the osteopath to utilize manual therapy not as an isolated approach but to also incorporate the mapping of stressors, biopsychosocial barriers and challenges, goal setting, planning, interdisciplinary interventions, and conversational tools such as motivational interviewing, among others.

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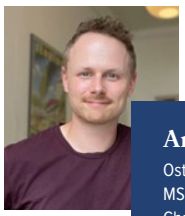
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Pain in migraine patients

Assessment tools and evaluation of pain in migraine patients: What measurement tools can be valid for this purpose?

Text: Ida Olaussen Bryn

Migraine is a widespread neurological disorder that has significant consequences—physical, emotional, and social—for many with this diagnosis [1].



Migraine is a chronic illness characterized by recurring moderate to severe headaches, often accompanied by light sensitivity, nausea, and vomiting. It occurs in two main types: migraine with aura and migraine without aura [2]. Migraines can last up to 72 hours and are often unilateral [3]. In addition to the pain, patients are cognitively affected during an attack, and the pain can make it difficult to perform daily tasks [4].

Living with a chronic illness can be all-consuming. Patients spend considerable time and energy trying to understand and manage the pain and discomfort they endure [5].

Pain, according to the IASP (International Association for the Study of Pain), is defined as:

"An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" [6].

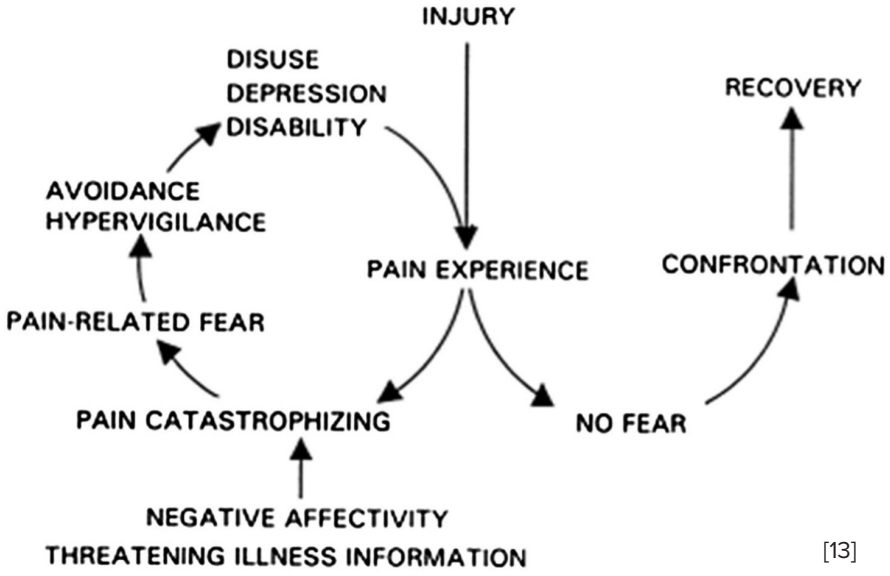
An important aspect of the definition is that it emphasizes that pain is both an affective and a physical or sensory experience, allowing us to understand pain as a subjective phenomenon. The experience of pain results from complex physiological and psychosocial processes in the interaction between the individual and the environment. Pain is thus a biopsychosocial phenomenon [7]. Pain is always a personal experience, influenced to varying degrees by biological, psychological, and social factors. The ability to feel pain is vital and is an integral part of the body's defense systems. A persons expression of pain should always be respected. Although pain is often useful, it can have a negative impact on physical, social, and psychological functioning, as well as on quality of life. Individuals learn about what pain is through their life experiences. Psychosocial and behavioral factors can exacerbate and sustain pain over time and influence its course [8].

We have different pain mechanisms: nociceptive, neuropathic, and nociplastic. It is possible to experience one or a combination of these. Nociceptive pain is from tissue damage, neuropathic pain results from nerve damage, and nociplastic pain arises from a sensitized nervous system [9]. Nociplastic pain is the source of chronic pain. This pain arises from altered nociception, despite no clear evidence of actual tissue damage. Central sensitization occurs, which involves an overreaction to pain (hyperalgesia), a reduced pain threshold to normal stimuli (allodynia), and an increased pain response to spontaneous activity [10]. Psychosocial factors such as stress, anxiety, and depression can contribute to the development and persistence of this type of pain. Nociplastic pain rarely occurs alone and is often accompanied by fatigue, sleep disturbances, cognitive hypersensitivity, and mood changes [11].

Chronic pain is defined as pain lasting more than 3 months [12]. Chronic pain is the leading cause of suffering and disability. The ICD-11 classifies chronic pain as primary and secondary. Chronic primary pain is defined as pain in one or more anatomical regions that lasts longer than 3 months, where no other chronic pain disorder is present. Chronic secondary pain is linked to another disease as the underlying cause [12].

"There are various models of pain. In this small paper, I have chosen to focus on the "Fear Avoidance" model by Vlaeyen et al. [13]. "

The "Fear Avoidance" model describes a set of cognitive, emotional, and behavioral responses that can potentially influence whether an acute pain experience develops into long-term pain problems [14]. The model explains how excessive fear and anxiety about pain lead to physical and social avoidance behaviors, which in turn result in increased pain and disability.



[13]

Catastrophizing, personal beliefs, self-efficacy, pain-related fear with avoidance behaviors, and the degree of mindful presence have been shown to be crucial for the pain experience and its duration. Therefore, it is essential for healthcare providers to be aware of and identify these aspects of pain and consider them in the patient's follow-up [15].

I conducted a literature search using the search engines Google Scholar and PubMed, as well as finding relevant articles in the Cosmin database (Consensus-based Standards for the selection of health Measurement Instruments) [16]. Cosmin has developed checklists for PROM, allowing one to review a study and assess its quality. Cosmin was developed to establish a common consensus and understanding of how we should develop and evaluate PROMs.

Measurement is a fundamental part of evidence-based medicine. The results provide the necessary foundation for making decisions about patient treatment [17]. PROMs (Patient-Reported Outcome Measures) are used to measure pain, and it is a direct report from the patient without interpretation by clinicians or others. Patient-reported instruments are relevant in most studies [18]. It measures how the patient perceives their health/symptoms and is divided into generic and condition/disease-specific categories [17].

Avoidance behaviors, or "fear-avoidance beliefs," are well-established in musculoskeletal pain but are less known in migraine patients [19]. The "Fear Avoidance Beliefs Questionnaire" (FABQ) is an established questionnaire used for chronic back pain patients. This questionnaire was developed by Waddell et al. in 1993 [20]. The purpose of the questionnaire is to reveal the presence of "fear-avoidance beliefs" in patients with back pain and to explore the relationship between pain, physical activity, and work. Since this questionnaire specifically applies to back pain patients, it cannot be used for migraine patients. Therefore, to assess "fear avoidance" in migraine patients, it is better to use "AEQ behavioral scores" [21]. The "AEQ behavioral scores" were developed from the Kiel Pain Inventory (KPI) [22]. KPI consists of three questionnaires for evaluating pain-related thoughts, emotions, and coping strategies. AEQ stands for "Avoidance-Endurance Questionnaire," and it can be divided into subcategories such as AEQ-ASAS (Avoidance of Social Activity) and AEQ-APAS (Avoidance of Physical Activity). There are 6 items in ASAS and 5 items in APAS, ranked from 0 to 6, where 0 is "never" and 6 is "always." The questions refer to the past two weeks [21]. AEQ is designed to assess emotional, cognitive, and avoidance behaviors related to pain response, and it has been validated and repeated in various chronic pain populations [19]. AEQ has proven to be a reliable and validated measurement tool for avoidance behavior and endurance related to pain response [21].

PROMs provide unique information about the effects of illness and treatment from the patient's perspective. There are many benefits to using PROMs in clinical practice [23]:

- Promotes active patient involvement
- Increases focus during consultations by prioritizing care around patient needs
- Improves the quality of care by enabling a tailored treatment plan
- Allows for standardized monitoring of outcomes over time
- Strengthens the relationship between the patient and the clinician

Several limitations were also identified:

- Negative limitations of PROMs by shifting/changing the focus during consultations
- Unrealistic expectations of treatment/care
- Incomplete information, and not suitable for everyone. "One size doesn't fit all" applies in this case.

There are some general weaknesses with questionnaires. They can be burdensome for patients, and some questionnaires may seem irrelevant to them. Patients often feel that clinicians do not review their responses or use them in treatment. Generic questionnaires may be less sensitive to changes for specific disorders or disease groups. Patients might find them irrelevant and too general. Furthermore, interpreting the effects can be challenging. The advantage of generic questionnaires is that they allow for comparisons of health and effects across patient groups.

Condition-specific questionnaires, like the ones I have chosen here, are less suitable for comparing results across disease groups. One may overlook unexpected treatment effects (positive/negative) that are not included in the measurements. It is often inconvenient for patients if multiple questionnaires are used. The positive aspect is that condition-specific questionnaires are often perceived as relevant by patients because they are designed for the specific condition and can be more sensitive to changes compared to generic questionnaires.

Reliability reflects how consistent and reproducible a questionnaire is. Internal

consistency indicates how closely related (correlated) the questions are to each other in a questionnaire. Measurement errors are systematic and random errors in patient scores that do not reflect actual changes in the phenomenon being measured. This is important to consider when using questionnaires in clinical practice. The validity of the questionnaire is also significant. It refers to the degree to which the questionnaire measures what it is intended to measure (phenomenon/domain). Construct validity concerns whether the questionnaire truly captures what it is supposed to and whether it aligns with the gold standard. Responsiveness is the degree to which the questionnaire can detect changes over time.

Recall bias also plays a role in this. In research, this is a systematic error that occurs due to individuals' inability to recall correctly. Mistakes can occur due to memory lapses, retrospective judgment, and altered perceptions [24]. Therefore, it is not certain how accurately patients remember past events, and some participants may drop out because they have forgotten previous experiences.

The AEQ with its subcategories primarily measures avoidance and endurance behaviors when experiencing pain during attacks, as seen in migraine patients. This can feel relevant and important to patients because it measures the pain and discomfort that arises during an attack. However, it would also be beneficial to measure avoidance behaviors between attacks. For example, how do individuals behave when fearing potential trigger factors that they believe might provoke an attack? Therefore, focusing on what happens between attacks and not just during them is also important to consider [19].

> "Responsiveness is the degree to which the questionnaire can detect changes over time. "

The AEQ questionnaire has not been modified for migraine treatment, meaning it does not measure the effects of interventions or treatments for patients. For the future, the treatment element should be integrated. Only then can we measure whether a treatment intervention is effective or if changes and adjustments should be made to the treatment plan for the patient.

Available and reliable patient-reported data are crucial for good communication between patients and healthcare professionals. If patients (in this case, migraine patients) have increased knowledge about common symptoms and concerns related to an illness, it can lead to improved coping, which may reduce the use of healthcare services [25].



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A global view

Text: Tomas Collin



Osteopathy is truly a global profession. There are osteopaths in soon every corner of the world, although the larger portion of the profession is to be found in North America, Europe, Australia and New Zeeland. To promote and maintain good standards for osteopathic healthcare provision is central to the Nordic Osteopathic Alliance, and a lot of work is done in cooperation with colleagues across the globe. Representatives from the Nordics hold positions within the global associations and regularly participate in meetings and conferences on the European and global arena.





Osteopathy Europe (OE) is the leading voice for osteopathy in Europe and beyond and is the umbrella for osteopathic institutions in 22 countries, constituting approximately 30 thousand osteopaths. This year OE arranged two engaging members conferences, in Milan and Luxembourg, covering mentoring, professional development, standards for osteopathic healthcare provision, and much more.

The Osteopathic International Alliance (OIA) is the global voice for osteopaths and osteopathic physicians and plays a vital role in promoting osteopathy, being in formal relations with the World Health Organization. This year's OIA conference was held in cooperation with Osteopathy Australia and New Zeeland, in beautiful Sydney. With representatives from osteopathic associations from all over the world, it was a great event presenting relevant and recent research, and global regulation of osteopathy. Next year's OIA conference will be in Toronto, Canada, hosted by the Ontario Association of Manual Practitioners.



Tomas Collin

Osteopath, MSc, NOA

Health and somatic pain

A mechanistic link between determinants of health and somatic pain

Text : David Josefsson

Last year I wrote an article in this publication about the advancements in our understanding of musculoskeletal pain (1). The major finding is that a host of specific and morphological factors such as bodily assymetries and weaknesses fails to predict pain, while most general determinants of health does it fairly well.

In other words, the types of factors that are most reliably going to predict development of musculoskeletal pain conditions are environmental, behavioral and demographical. For instance we know that smoking, obesity, physically demanding jobs and low socioeconomic status are key risk factors for low back pain (2).

What we don't know, however, is precisely how these factors are influencing the movement apparatus and/or the nociceptive system. Although there are multiple hypotheses and the answer most likely is multidimensional, there is one line of inquiry that has caught my interest in recent years.

Advancements in the study of inflammatory physiology is starting to present answers that might be relevant for our understanding of the multifactorial nature of somatic pain.
Technological progress has allowed for deeper studies into the different components of the inflammatory response, unveiling a more complex and perhaps less well defined physiological event than was previously thought. In fact the classic view of inflammation as a separate entity related to infection and/or overt tissue damage has been challenged (3,4).

The classic view of inflammation derives from Celsus signs and is based upon the findings of local swelling, redness, heat and increased sensitivity to pain (5). As study methods have progressed over the years, so has the understanding of the immune system and the role of white blood cells in the inflammatory event. It seems however, that counting leukocytes is not doing the trick and a lot of the mysteries of inflammation lies in the vast information exchange made possible by production and release of smaller molecules called cytokines that are involved in cell signaling.

We now know that inflammatory cytokines are involved in "defending" the host against even minor stressors or as have been proposed, in "maintaining allostasis" after disturbances from such stressors (3,4). Circulating inflammatory cytokines, in particular interleukins 1 (IL-1) and 6 (IL-6) and tumor necrosis factor (TFN) stimulates the liver to produce acute phase proteins, including the more commonly known c-reactive protein (CRP) (6). One of the main discoveries setting the stage for the current theory is that a wide variety of "health stressors" are associated with an elevation in c-reactive protein (CRP), even in the abscence of infection or traumatic injury. Among such stressors can be mentioned: smoking, obesity, sleep disturbances, physical inactivity, anxiety and depression, among many others (7,8).

As was already mentioned, we see the same type of relationship between musculoskeletal pain conditions such as back- and neck pain, headache, shoulder pain, fibromyalgia, TMD etc. and general health stressors such as smoking, obesity, sleep disturbances, psychological stress, anxiety and depression (2,9–11).

What's more is that not only does the same health factors coincide with musculoskeletal pain and elevated inflammatory markers, but the inflammatory markers also coincide with musculoskeletal pain. We now have a range of studies showing elevated CRP and/or different inflammatory cytokines in several conditions not previously thought of as "inflammatory", including back and neck pain, fibromyalgia, temporomandibular dysfunction (TMD), polyneuropathy and chronic regional pain syndrome (CRPS) to name a few (12-16).

Hence it seems reasonable to believe, that inflammatory processes or at the very least "chemical" processes that makes up the physiological response to all kinds of different stressors are, in part, the same ones acting on the nociceptive system after macroscopic tissue damage.

Clinical relevance

How is this information going to help us in our everyday clinical practice? At the very least, it helps take away the "fuzziness" around psychological/emotional variables and general health in musculoskeletal practice. We seem to struggle with proper explanatory models and patients in pain are demanding answers.

For myself as a therapist, I've found it tremendously helpful to have a more hardcore, well-defined, mechanistic base to lean on, when diving into discussions of why we need to consider really subjective elements (such as



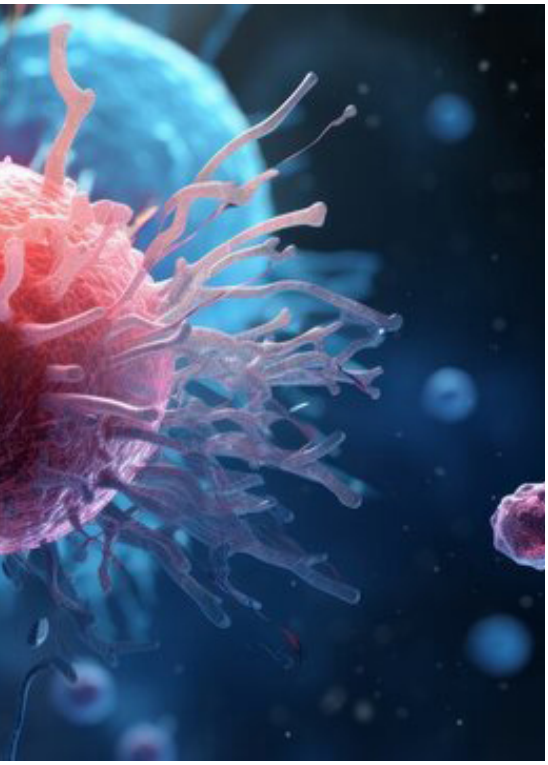
psychosocial factors) when managing patients with somatic pain.

It is also an effective tool in confirming the patient and to avoid the ”it’s-all-in-your-head”-trap. The pain science paradigm brought with it a very unfortunate trend of extenuating people in pain and leaving them with a sense of not having ”real problems”.

Just because the problem isn’t residing in the physcial structure of the painful area obviously doesn’t mean it is less valid or less challenging to deal with. The cause of pain after a ”valid” somatic condition such as a fracture is in fact the chemical event after the injury. If one can explain this to the patient and then communicate that the same type of chemicals are produced and released in response to systemic stressors as well, you are in a much better position to get the patient on board.

In fact, most patients seem ready to accept any explanation of their symptoms as long as it involves an actual alteration in physiology that they can relate to. No one likes to hear that their shoulder pain is just a consequence of ”sadness” or because you ”eat too much”. What is a lot more accessible is informing your patient that grieving the loss of a spouse is associated with release of chemicals sensitizing the nerves involved in pain signaling, and that this effect is exaggerated by their dietary habits.

When an understanding of these types of influential factors are in place it is easier to convey realistic expectations of recovery times, treatment effects and the degree of patient involvement. That goes for you as a therapist as well. Haven’t we all struggled to understand why some patients seem to respond immediately to a certain treatment strategy while others, while presenting with the same symptoms barely respond at all?



Maybe the symptoms and the (tissue specific) ”diagnosis” is only one factor influencing outcomes and we just need to be more aware of context. This is obviously old news and everyone has been taught to think that way in the era of person-centredness. But maybe one major reason this is actually reflecting clinical reality, is precisely because it affects inflammatory processes.

As such I believe this knowledge is helpful both for our own understanding as well as for developing better patient communication. In fact it is probably important to keep trying to attain as accurate mechanistic explanations as possible since this unavoidably will influence practice.
If inflammatory events are a key factor in musculoskeletal pain, we should also know manual therapy does not seem to majorly influence inflammation (17). That does not make it any less valuable a tool for treating pain, however it might indicate a need for other strategies to go with it.

I personally believe that counceling and coaching related to general health and management of lifestyle stressors can and should be a standard element of Osteopathic care. Espescially when aiming for long-term outcoumes and espescially when dealing with long-term issues.



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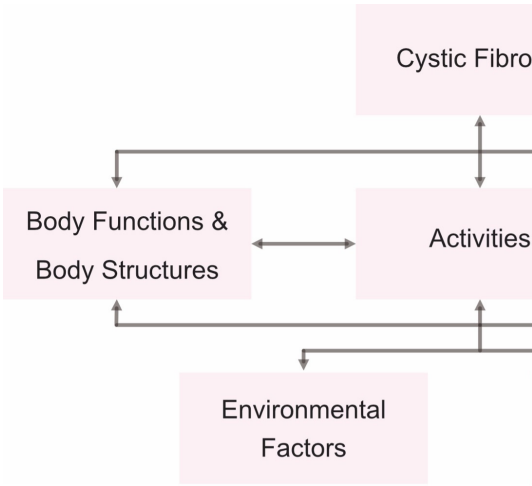
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Thoracic mobility in cystic fibrosis

An osteopathic perspective

Text: Niklas Sinderholm Sposato



This article focuses on the respiratory system, an area close to my heart and central to my research.

The complex relationships between the musculoskeletal and visceral systems discussed here are not only relevant to breathing and this particular group of patients, but also highlight a broader understanding of how the body's systems interact and influence each other. In osteopathy, such relationships have long been central to intraprofessional dialogue, though the theories surrounding them have often been loosely substantiated. Here lies, in my opinion, one of the greatest challenges: distinguishing what is clinically relevant and well-founded from what rests on mere assumptions and anecdotal observations.

The aim of this text is to summarise and discuss the research that my group and I have conducted over the past six years, and to build on this work in offering what I hope to be constructive perspectives on osteopathic practice as part of multimodal healthcare. I take a somewhat personal stance, occasionally sharing my own experiences and reflections. I hope this does not detract from the main topic or cause confusion, but rather enhances the discussion.

Our research explored both structural and functional aspects of respiration in people with cystic fibrosis (CF), as well as their experiences with musculoskeletal symptoms and manual therapy. This was achieved through four sub-studies:

• **The first study** was a retrospective, single-blinded cohort study, which assessed structural changes in the thorax of people with CF over time. A total of 344 high-resolution computed tomography images were analysed to evaluate thoracic configuration throughout life with CF. The primary aim was to explore how these structural changes correlated with respiratory function [1].

• **The second study** employed a cross-sectional comparative design to assess the functional musculoskeletal aspects of CF. A group of 21 people with CF was compared to 42 health controls. The study focused on thoracic expansion, respiratory muscle strength, and the presence of musculoskeletal tender points, aiming to reveal differences in musculoskeletal and respiratory function between the two groups [2].

• **The third study** was a pilot intervention study, where 15 people with CF participated in eight weekly sessions of manual therapy. Each session lasted 30 minutes and was designed to complement their existing physiotherapy regimen. Pre- and post-intervention measures were taken to evaluate the impact of manual therapy on thoracic mobility, musculoskeletal tenderness, and respiratory muscle strength [3].

• **The fourth study** was a qualitative interview study exploring the experiences of 10 people with CF regarding their musculoskeletal symptoms and the effects of manual therapy. Semi-structured interviews were conducted to gain insights into how these patients perceived the role of manual therapy in managing their musculoskeletal health and its influence on their daily lives and self-care practices.

Cystic Fibrosis and Respiratory Preconditions

Cystic fibrosis (CF) is a severe hereditary disease that primarily affects the respiratory and digestive systems [4]. The disease manifests as thick, sticky mucus in the lungs and airways due to a defect in the body's mucus-producing glands. This disrupts mucociliary clearance, leading to chronic lung infections, inflammation, and progressive lung tissue damage [4, 5]. In CF, both restrictive and obstructive impairments can affect the lungs and thorax. An important aspect of this is understanding the biomechanical properties of the lung parenchyma. In CF, the lung parenchyma becomes fibrotic and stiff, reducing its elasticity and ability to expand during inhalation. This increases the workload on the primary respiratory muscles, including the diaphragm and intercostal muscles, leading to earlier and more pronounced engagement of secondary and accessory respiratory muscles.
CF presents a unique challenge as it exhibits both restrictive and obstructive characteristics. Understanding these mechanical properties, including lung compliance (the lung tissues ability to expand) and recoil (its ability to return to its original state after inhalation), is crucial. In people with CF, reduced lung compliance and impaired recoil lead to increased effort with each breath [6-8].

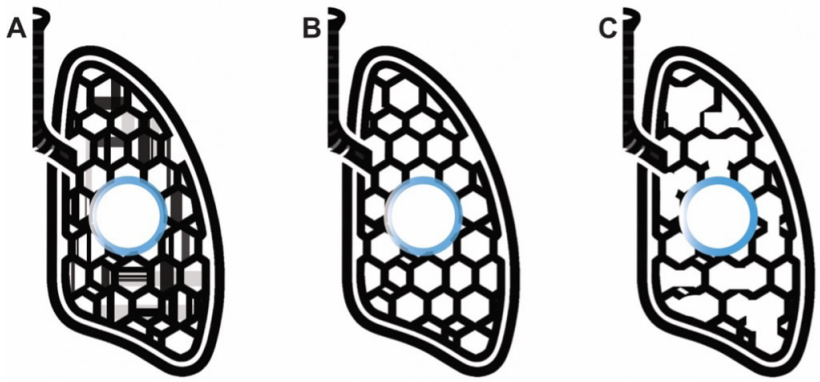


Figure: Schematic representation of parenchymal tissue texture surrounding an embedded airway in **A.** Restrictive lung disease, **B.** Healthy lung, **C.** Obstructive lung disease.
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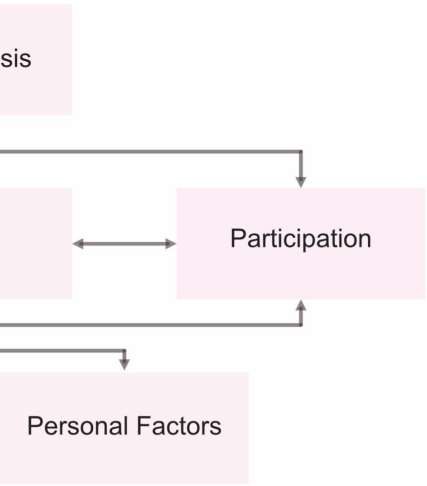


Illustration of the International Classification of Functioning, Disability, and Health (ICF) framework [99] using cystic fibrosis as the model's health condition.

Additionally, complex neurological circuits that coordinate breathing rhythm and pattern, such as the preBötzinger complex (preBötC) in the ventrolateral medulla, are also involved in these processes [9]. While I would be eager to delve deeper into the fascinating intricacies of respiratory mechanics and the potential implications of the preBötC role in this context, such a discussion deserves a more focused exploration, which I shall reserve for another occasion, though feel free to send an email, or dispatch a carrier pigeon if you'd like to have a talk sooner.

The Role of Osteopathy in Health and Disease

Historically, osteopathy has maintained a "whole person" view, focusing on the relationship between the body's structure and function [10]. While this is a sound principle, it often remains a rather vague concept, leading to overly far-reaching conclusions about causality, which are sometimes highly questionable. After more than 20 years in osteopathy, I have seen many potentially exciting areas for exploration lost due to a lack of specificity and rigour, which can hinder the field's credibility and effectiveness in addressing various health issues. As the field continues to evolve, it is crucial for osteopaths to strive for a more evidence-based approach, with further research needed to solidify osteopathy's place in the healthcare system. However, the concept of evidence itself warrants a deeper discussion, as the mere mention of "evidence-based" in some osteopathic settings often inflames tensions within the community. To understand where and how osteopathy fits within a person centered, multidisciplinary care model, we must try to be diligent and humble in addressing significant questions that lack simple answers. Our work serves patients best when we reflect and consider multiple perspectives, including those derived from the patients themselves.

In CF, osteopathic care involves managing musculoskeletal health issues related to the thorax and understanding how these affect respiratory mechanics, quality of life and independence. Manual therapy, a mainstay of osteopathic practice, aims to improve thoracic mobility, and relieve musculoskeletal tension and soreness. Our research has examined both the structural and functional aspects of musculoskeletal involvement in breathing and how people with CF perceive the role of manual therapy in improving their well-being. The studies indicate that, while structural changes in the thorax among people with CF are variable, they do not necessarily correlate with lung function [1]. However, people with CF exhibit reduced thoracic mobility and increased musculoskeletal symptoms compared to healthy individuals [2]. Manual therapy offers benefits such as reducing musculoskeletal discomfort, enhancing ease of breathing and respiratory muscle strength, and fostering improved self-awareness and self-care practices. These findings suggest that osteopathic interventions can play a supportive role in CF care, though their primary effects lie in musculoskeletal health rather than pulmonary function.

Uneven Regulation of Osteopathy: Challenges for Quality and Consistency

I know, this again...
Osteopathy is regulated unevenly across different countries. While some countries have strict standards for education and licensing, others lack this framework, leading to significant variations in care quality. This inconsistency can be risky when treating people with complex conditions such as CF. Our research indicates that musculoskeletal symptoms in CF, such as musculoskeletal pain, thoracic stiffness and reduced respiratory muscle strength, can respond positively to manual interventions as part of osteopathic care and as complement to ongoing physiotherapy interventions. However, successful treatment depends on the practitioners ability to evaluate the patients complete medical history and overall well-being. This level of care requires high-quality education to equip practitioners with the skills to make informed decisions about when a particular intervention is appropriate or should be avoided. To ensure safety and quality in osteopathy, global standards for education and regulation are necessary, requiring a concerted effort from professional organisations and educational institutions.

Finally, let's continue to reflect on our own role within the osteopathic community. How can we further deepen our understanding and refine our approaches? What collaborations could broaden our perspectives and enhance our ability to support both patients and colleagues? None of us have all the answers, I certainly don't, but taken together, the body of knowledge within this profession is immense. By fostering curiosity and collaboration, we can continue to grow, ensuring that osteopathy remains a field marked by both innovation and compassion.



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How do finnish osteopaths perceive themselves?

Text: Tero Honkanen

Osteopathy is classified as a manual treatment modality in the field of medical rehabilitation and one of the professions that form the field of rehabilitation in Finland (1).

The field of osteopathy in Finland and its treatment approaches have been claimed to be varied and internally divided (2,3). Osteopathic schools also have differences within their curriculums and one school is in disagreement about following the CEN standard for including cranial osteopathy (2,4). Osteopathys innovative approaches such as patient-centeredness have defined osteopathy for the first hundred years, but as other health care professions have adopted these approaches they might have become insufficient as elements to differentiate and identify osteopathy as a distinct and unique profession (5). Inability to identify as a unique profession can lead a profession to become obsolete under modern context and therefore professional coherence is needed (6). I would argue that the narrow position and definition as a limited treatment modality for specific musculoskeletal problems in Finland is a reflection of this problem. Conflict within the profession and problems to identify as a unique profession instead of just manual therapy call for more research both nationally and internationally. Therefore, my research question was: what perceptions do osteopaths have about themselves as professionals in Finland?

I conducted a qualitative interview study about the perceptions of Finnish osteopaths within the field of rehabilitation in Finland (7). In the study I interviewed eight osteopaths registered by Valvira independently. Osteopaths were recruited equally from different educational backgrounds and geographically non-dependently to ensure inclusion of various views from different kinds of osteopaths. I collected and recorded the material via remote access (Zoom) between April and May in 2023. I transcribed the interviews in verbatim and analysed the transcripts qualitatively using reflexive thematic analysis.

Perceptions of osteopaths about themselves as professionals within the field of rehabilitation formed two main themes which were built from four subthemes. The first main theme 'Osteopathy as professionalism' included subthemes 'Education as a requirement for professional skills' and 'Self-sustaining separateness as a profession and treatment modality within healthcare' which described perceptions of osteopaths about the importance of education and its position as a profession and treatment modality within healthcare.

Education both at the level of basic education and as continuing education was understood as a requirement for readiness to practice, professional skills, and professional valuation. This study didn't reveal what kind of post graduate education Finnish osteopaths value the most, but it clearly implies that they consider quality of education as an important standard for osteopathic practice which isn't limited to pre-graduation studies but continuous learning as a practicing osteopath. In Finland all registered osteopaths require a four-year education. Two out of three osteopathic schools follow the CEN standard and WHO benchmarks, and one doesn't because they do not want to include courses about cranial osteopathy (3). Despite this difference valuing professional education was a reoccurring theme among most participants.

Osteopaths perceived osteopathy as an official healthcare profession and as a manual treatment modality that has a self-sustaining and separate position within healthcare. I interpret osteopaths perceiving themselves as a healthcare profession in a way that osteopaths may see themselves as more than just a treatment modality or limited to rehabilitation. Self-sustaining practice within healthcare was represented by osteopaths often working individually and separately within private sector.

Multiprofessional cooperation was limited to referrals to and from other healthcare professions, but other kind of collaboration was lacking. The results also showed unutilized potential of osteopathy and often positioning osteopathic treatment in the end of patient care pathway after the patients had tried other options such as visiting a doctor or a physiotherapist. The participants perceived that osteopaths could work in several positions in healthcare, both private and public sector, for example in hospitals, in occupational health care and even in expert positions within healthcare.

The second main theme 'Osteopathy as an approach of care' included two subthemes: 'Osteopathy as responsible encountering of the patient' and 'Diversity as a defining factor of osteopathy and osteopaths'. Osteopaths perceived osteopathy's professional approaches and actions as diverse and colourful. It was seen as richness of osteopathy but also creating confusion caused by differences in schools of thought and varying ways of action. Some of the participants actually perceived this diversity as a defining factor which contributes to uniqueness of osteopathy as a profession. Based on the results some osteopaths value the kind of autonomy which osteopathic philosophy allows for practice. On the other hand, heterogeneity of approaches was also considered to be stigmatising because it creates confusion among patients about what kind of care they were to receive from an osteopath. In my opinion this can also be problematic when trying to integrate with conventional healthcare based on scientific evidence and guidelines instead of philosophy.

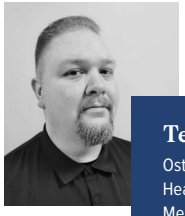
Encountering the patient responsibly was emphasized as an approach to treatment and it was based on the values of osteopaths about meeting the needs of patients. Encountering of the patient appropriately was emphasized to be the basis of osteopathic care and more important than any single treatment technique. Many participants



perceived being present and caring to be important. Working with patients in a safe, respectful, honest, realistic, transparent, communicative and straightforward manner was valued for creating a trusting and equal companionship. It was also mentioned that osteopaths can be active and interested listeners for patients to be heard. It is important to highlight that this was not to disregard manual expertise which was still valued highly.

Based on the qualitative results of my study there is indeed dividedness within osteopaths in Finland. However, this seems to be perceived as a defining factor for osteopathy. Osteopaths are government regulated in Finland but work solely within private sector which still ironically separates the profession from mainstream healthcare – even within healthcare. On the other hand, there seems to be willingness for better integration and osteopaths see greater potential in themselves which is currently being unutilised. On the other hand, many osteopaths value autonomy within their practice. My interpretation is that osteopaths are not a homogenous group which can be categorized in a single box. Therefore, the problems are how to integrate into healthcare while maintaining a unique professional identity and how to stay within healthcare without being too different from and for other professions.

As a qualitative study these results should not be used for generalization. They are also not transferable to any single school or school of thought. Based on this study it also remains a question what these different schools of thought actually are and how they are perceived. The results represent an overall view of Finnish osteopaths based on themes created by the author. Therefore, the results should be interpreted to include a personal bias of mine as a practicing osteopath. I personally believe evidence-informed practice, patient-centered care and osteopathic philosophy can coexist simultaneously in osteopathic practice. Especially when osteopaths learn how to look osteopathy through a scientific lense, know how to interpret research and find ways how to point out what kind of evidence we value from an osteopathic point of view. It is important to maintain professional identity and autonomy. Our practice consists of our expertise and education we value so much. It is a cornerstone that cannot simply be replaced. But it is also important to be scientific. To be realistic and honest – for encountering our patients responsibly. Now and in the future.



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Placing the person and its context at the centre

Considerations on person-centered care

Text: Lluís M. Horta

The first time I considered that osteopathy was a patient-centered approach to health was in November 2010, when I first read the "WHO Benchmarks for training in Osteopathy" [1].

It seemed to me then to be a very promising definition, although, over the years, and after exploring quite a lot about the subject, I must admit that, at that time, I probably did not understand the meaning of the concept to its full extent.

Since 2010, several authors in our field used this definition of osteopathy as a "patient" or "person-centered" approach to care [2, 3, 4, 5], and for some of them this could be one of the strengths of osteopathy [2] although it can't be considered an exclusive feature [6], nor perhaps involved in certain osteopathic treatment effects [7]. Despite all this, it seems that there is little research in our field in relation to the real knowledge that osteopaths themselves have about person-centered care (PCC), or about the level of clinical applicability of this approach in daily practice. In my view, that's an area that would be worth exploring beyond this article, and efforts should be made to fill this knowledge gap.

Patient-centered approaches consider the patient's values, needs and desires, and is achieved when they are involved (as experts) in healthcare discussions and decisions [8, 9]. Person-centered approaches are similar but emphasizing that individuals cannot be reduced to their health status alone, could be considered the practical and humanistic application of the multidimensional biopsychosocial (BPS) illness model [10], and represent an agreement between what really matters to the patient, the professional assessment and care incorporating evidence-based practice, and some national or local routines [11]. Both are, however, concepts whose interpretations are not always clear [12, 13].

From a daily practice perspective, integrating the principles of PCC at the clinical level can be challenging, and that is likely to be due to lack of knowledge or skills in relation to this approach, or perhaps time constraints [13, 14, 15]. Therefore, there are initiatives to incorporate them, and it would seem advisable to consider them when applying osteopathic care [16].

A key element in the development of PCC is the implementation of Therapeutic Alliances (TA), where meaningful connections should be stablished between therapists and patients, as they might lead to better clinical results and patients satisfaction [16, 17]. In other manual therapy approaches to care, those connections have been summarized in three categories: acknowledging the individual, giving-of-self, and using the body as a pivot point. Their use in a conscious and deliberate manner seemed to facilitate PCC [18, 19].
In the context of a global burden of musculoskeletal disorders [20], and that being the most frequent reason for consulting an osteopath [21, 22, 23, 24], that focus on the body, with the clear intention to help the patient while acknowledging the individual, should unavoidably be part of the care provided by those practitioners. The use of touch to establish connections, and to bridge a gap facilitating the patient's connections to its body through manual contact, might help the development of robust TA and play a critical role, as they seem to improve the biobehavioral synchrony between patients and therapists, particularly on pediatric patients [25]. However, osteopathy should not be reduced to touch-only interventions and should include hands-off elements like patient education, lifestyle advice and certain psychological support.

TA might assist patients in making sense of their experience of disease and develop new body narratives about their physical capacities [17, 25, 26, 27, 28]. But TA should be flexible and adapted to each situation that might be needed when working towards a "shared sense-making" [17] where the patient's narrative is re-established at the center of healthcare, allowing a proper focus on the whole organic person rather than on the mechanisms operating within the body [29].

Achieving such alliances can require time in the short term (i.e., the duration of consultations) and in the long term (the establishment of lasting therapeutic relationships), but also a clear empathetic attitude, the use of positive expectancy elements (i.e., matching beliefs) and an optimal use of the contextual factors [9]. In fact, harnessing the contextual effects to enhance therapeutic results represents an ethical opportunity that osteopaths should use to benefit their patients as they might lead to improved outcomes [30, 31]. The extent to which osteopathic practitioners are prepared to use them is another question that remains unanswered, although in view of their potential relevance, it seems necessary today to highlight their importance and promote their use. In any case, any initiative to improve the quality of PCC offered by osteopaths should be encouraged [32].

At a time when the practical application of the biopsychosocial model promoted by Engel is increasingly called into question [10], the development of updated and enactive versions of the model by researchers in our field is to be welcomed [17, 26, 27, 33]. Perhaps this can help to explain some of the results observed in practice and, above all, help to place the person (and "the patient within the person") at the center and within its context.



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Nordic Osteopathic Congress 2024

Text: Frederik Jahr

The weekend September 13th to 15th osteopaths from the Nordics as well as guests and speakers from other European countries and the USA gathered in Oslo for the annual Nordic congress. The conference offered world class speakers, discussions and hands-on workshops, and not the least time to socialize and celebrate with peers from around the world.







Precongress day at Kristiania
The weekend kicked off with a precongress day hosted by Kristiania University College and the Norwegian federation. We were excited to experience the new university building and its chic Scandinavian architecture.
The topic for this day was osteopathic education and Ronja Lund, head of the program at Kristiania University College, presented us with the milestones of the educational program in Norway. Prof. Christian Fossum took us through the historical development of understanding of osteopathy and osteopathic models of education, from the early days to modern practice.



Prof. Christian Fossum



Prof. William Devine

Pål Andre Amundsen followed up with a call for integrating more pain science in modern health educations. Then we were given a passionate presentation from Line Rølvaag on the modernization of clinical education and the importance of passion and enthusiasm from teachers to enhance learning and curiosity in students.

Prof. William Devine, who had travelled all the way from Arizona, a pioneer in the field of osteopathy, gave us an overview of the osteopathic education and healthcare system in the United States, where as much as 25 percent of graduating physicians are osteopathic physicians. Oliver Thompson presented the opportunities of qualitative research to strengthen evidence for osteopathic care, and Martin Engedahl furthered the topic with a dive into evicence based medicine in osteopathic education.



Matteo Turinetto


Workshop

Close to my heart

What an emotional way to kick-start the conference! Filled with compassion and love, Matteo Turinetto presented his project where 30 Italian osteopaths embarked on a project to provide osteopathic care to post-op and intensive care pediatric patients undergoing cardiac surgery at a specialized hospital in India. It was an emotional presentation for the audience, as well as a call for further research, as the findings from treating the pediatric patients proved promising.

With emotional music and pride in our profession, the tone was set for the congress! He proved that osteopathy is really about devoting our knowledge and compassion to helping others.

An osteopathic approach to headache

It was an honor for the audience to listen to Prof. William Devine and his take on headache and the application of counterstrain. With years of experience from osteopathy, surgery, family medicine and teaching, it was with great excitement he shared his clinical expertise, both during his lecture and in the practical workshop.

The cervical spine as symptom generator

Christian Fossum provided a detailed update on symptom causing tissue in the cervical region and its clinical manifestations, physiology as well as suggestions for addressing the patients' complaints. As always, he provided impressive insight that the participants could bring to the clinic. We were given up-to-date knowledge ranging from chondrocytes to venous congestion. The workshop was highly appreciated by all the participants.

> "Osteopathic practice should be person centered"





Osteopath Isabelle Aguilera



BodyART

We all got our coordination and movement challenged when yoga teacher and osteopath Isabelle Aguilera gave us an introduction to a BodyART movement session both days. A needed time to move and stretch gave increased focus to the next theoretical sessions. Motion is lotion!

Osteopathic research

Both Lluís Horta and Prof. Thomson gave excellent speeches on the challenges our profession, as well as other manual therapies, faces in the need for more research that matches the complexity of our patient interventions. They also provided ideas on how we can address some of the issues through qualitative and combined methods research. Osteopathic practice should be person centered, and there is a need for our research to reflect this nature of our practice. The final panel discussion highlighted these issues, as well as underscoring our experts' strong belief in the future of osteopathy.

Osteopathy 150 years

The conference and gala dinner celebrated 150 years of osteopathy. With bubbles, good food and great friends we got to celebrate the anniversary with pride and joy!



Frederik Jahr

Osteopat

NORDIC OSTEOPATHIC JOURNAL

The Nordic Osteopathic Journal is published annually by the Nordic Osteopathic Alliance

Published annually from November to December, the NOJ is not just a publication but also a crucial platform for sharing the latest news, updates, and research within the osteopathic profession. Each year, five journal versions are issued—one for each Nordic country—along with a comprehensive English version available for free online. The content is 80% common across all versions, with all articles written in English to ensure broad accessibility. The 2024 edition will mark the sixth publication of the NOJ, keeping you informed and up-to-date with the latest in osteopathy.



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