

Supporting patient's evolving motivations and expectations in Osteopathic Care for Chronic Pain: A Qualitative Study

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A thesis presented to ENOSI Centre d'Ostéopathie de Montréal in fulfillment of the requirements for osteopathic diploma

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SOMMAIRE

Soutenir l'évolution des motivations et des attentes des patients en matière de soins ostéopathiques pour la douleur chronique : une étude qualitative

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Mémoire présenté à ENOSI Centre d'Ostéopathie de Montréal en vue de l'obtention du Diplôme d'Études en Ostéopathie, grade de DO

Introduction : La douleur chronique constitue un enjeu de santé majeur touchant environ 20 % de la population mondiale. Les patients ayant recours à l'ostéopathie présentent souvent un parcours de soins complexe, marqué par des attentes fluctuantes, une perte de confiance envers les soins conventionnels et une recherche de sens au-delà du simple soulagement symptomatique. Malgré l'importance clinique des attentes et motivations des patients, leur évolution au cours du processus thérapeutique demeure peu documentée dans le champ ostéopathique.

Objectifs : Cette étude qualitative vise à explorer l'évolution des motivations et des attentes des patients souffrant de douleur chronique au cours d'un suivi en ostéopathie, ainsi qu'à comprendre comment la relation thérapeutique et le cadre de soin influencent cette transformation.

Méthode : Une approche qualitative descriptive interprétative a été utilisée. Deux participants vivant avec une douleur chronique ont pris part à deux entrevues semi-dirigées, réalisées avant et après une séance d'ostéopathie. Les données ont été analysées par codage thématique afin d'identifier les thèmes émergents et leur évolution dans le temps.

Résultats : Trois thèmes principaux ont émergé : (1) l'évolution dynamique des motivations et attentes, (2) l'élargissement du récit de guérison au-delà du soulagement de la douleur, et (3) le rôle central de la relation thérapeutique dans le développement du sentiment d'autonomie et de souveraineté du patient. Les participants ont montré un déplacement progressif d'attentes centrées sur la douleur vers des objectifs plus globaux de mieux-être.

Conclusion : Cette étude exploratoire suggère que les traitements ostéopathiques et le dialogue réflexif pourraient être associés à des changements dans la manière dont les patients décrivent leurs motivations et leurs attentes. Une prise en compte consciente de ces dimensions pourrait favoriser l'empowerment du patient et enrichir la pratique clinique ostéopathique.

Mots-clés : douleur chronique, ostéopathie, attentes du patient, motivation, relation thérapeutique, étude qualitative

SUMMARY

Supporting Patients' Evolving Motivations and Expectations in Osteopathic Care for Chronic Pain: A Qualitative Study

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A thesis presented to ENOSI Centre d'Ostéopathie de Montréal in partial fulfillment of the requirements for the degree of DO

Introduction: Chronic pain represents a major public health concern, affecting approximately 20% of the global population. Patients seeking osteopathic care for chronic pain often present with complex clinical trajectories, shaped by prior healthcare experiences, fluctuating expectations, and motivations that extend beyond symptom relief. While patient expectations are known to influence therapeutic outcomes, their dynamic evolution within osteopathic care remains insufficiently explored.

Objectives: The objective of this qualitative study was to explore how patients' motivations and expectations evolve throughout osteopathic care for chronic pain and to examine the role of the therapeutic relationship in shaping this process.

Methods: A qualitative interpretive descriptive approach was employed. Two participants living with chronic pain took part in semi-structured interviews conducted before and after an osteopathic treatment session. Data were analyzed using thematic analysis to identify key patterns and changes in participants' narratives over time.

Results: Three main themes emerged from the analysis: (1) motivations and expectations are dynamic and evolve throughout care, (2) healing narratives extend beyond pain reduction to encompass broader psychosocial and functional dimensions, and (3) the therapeutic relationship plays a central role in fostering patient autonomy and a sense of personal sovereignty. Participants demonstrated a shift from pain-centered expectations toward more holistic goals related to self-understanding, empowerment, and well-being.

Conclusion: This exploratory study suggests that osteopathic treatments and reflective dialogue may be associated with changes in how patients describe their motivations and expectations. Integrating awareness of these evolving dimensions into clinical practice may enhance patient empowerment and contribute to more person-centered osteopathic care.

Keywords: chronic pain, osteopathy, patient expectations, motivation, therapeutic relationship, qualitative research

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LIST OF ABBREVIATIONS

BSP	Biopsychosocial
CAM	Complementary and alternative medicine
PNE	Pain neuroscience education
MI	Motivational interviewing

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"Patients' expectations are not mere predictors of treatment outcome; they are dynamic, contextually embedded expressions of hope and personal meaning." (Eaves et al., 2015)

INTRODUCTION

There is a proverb that shares that 'pain is the greatest teacher' and this adage has been told throughout time and across religions and branches of philosophy. Although there is much to learn from our physical pain it's still a challenging aspect of life that many people struggle to make sense of or peace with.

Pain itself is described as an unpleasant sensory and emotional experience associated with, or resembling, actual or potential tissue damage (Raja et al., 2020). In the physical realm pain tends to be broken down into one of 3 categories: acute, episodic or chronic pain. Acute pain is pain that has a sudden onset and which ends when its cause is treated or healed. Episodic pain is pain that happens from time to time and may show up at irregular intervals. It often comes out of nowhere and can be caused by known triggers. The final category of physical pain, and the one which we will focus on in this research, is chronic pain. Chronic pain can start as acute pain but it differs in that it doesn't resolve itself in the normal window of healing which typically is within 3 months. Often chronic pain will not come from a known source and will show up in parallel with other chronic conditions. While every sentient being experiences physical pain at one time in their life it's not everyone that is exposed to pain that endures in a chronic state of 3 months or more. Incredibly, 20% of the world live with chronic pain and of these there is an astounding 10% whose chronic pain seriously impacts their ability to function in their daily lives. In their thirst to find relief from and manage their chronic pain people are willing to go to many lengths. The common routes for pain management often include a combination of pharmacological, psychological, and physical interventions and each of these is chosen based on the type of pain being experienced and the specific needs of the patient. In Canada, alternative approaches to chronic pain care, of which osteopathy is a part of, tend to be secondary courses of care for patients. Sometimes alternative care is combined with

primary care in which case it is called complementary care. Patients tend to explore these alternative options after they feel they have exhausted the primary care avenues. As patients are often coming to osteopathy after exhausting their primary care options without finding relief, resolution, or respite, we are left with a potential melting pot of uncertainty and sometimes despondence in terms of the expectations patients bring to their sessions with them. This complicates the task of osteopaths in terms of their ability to guide patients towards workable outcomes.

This thesis aims to use a qualitative research approach to discover how osteopaths can support chronic pain patient's evolving motivations and expectations. It will build on modern person-centred pain frameworks (NICE, 2021; *WHO Guideline for Non-Surgical Management of Chronic Primary Low Back Pain in Adults in Primary and Community Care Settings*, n.d.), which emphasize that chronic pain is a multifactorial experience involving biological, psychological, and social contributors. These guidelines support exploring agency, meaning, and therapeutic relationship as central elements of care. By better understanding what these client's motivations and expectations are, my belief is that we as osteopaths will be able to more effectively manage the expectations of clients, help them in bringing clarity to their motivations, and provide better results through this clarity building exercise that we undertake with clients. The end goal is to empower them in their health journey and be able to provide support, when possible, that is aligned with their true motivations and expectations. There will be a presentation of the problem, a literature review, a presentation of research objectives, a description of the research methodology, a presentation of the results, a discussion, and finally a conclusion.

Problematic

In this chapter we will be describing the scope of the research project and a definition of the problem being researched. The specific concepts will be defined and analyzed and the pertinence of the project will be highlighted.

What is Chronic Pain

Pain is an absolutely necessary function to living and continuing to live. Without the message of pain we are at risk of experiencing more injuries and potentially shortening our life (MedlinePlus, n.d.). Without the benefit of our pain response we would miss out on the dangers presented by noxious fumes, intense cold and heat, excessive pressure on our structures, and are likely to slow our healing processes. Thankfully our nervous system, via chemical neurotransmitters, sends messages between the brain and body to respond to these signals (NIH, 2023). The response might include physical movement to protect ourselves or a message to release endorphins to tell the immune system to start healing the injury. When pain becomes an issue is when those pain signals continue to fire after the bodily threat is removed or resolved or if there is no threat at all. When those signals persist or recur beyond 3-6 months, largely considered to be the timeframe required for healing, we consider the pain to be chronic (Treede et al., 2015).

Types of chronic pain

Chronic pain can be broken down into 7 different categories: chronic primary pain, chronic cancer-related pain, chronic post-surgical or post traumatic pain, chronic neuropathic pain, chronic secondary headache or orofacial pain, chronic secondary visceral pain, chronic secondary musculoskeletal pain (Treede et al., 2015). From Treede et al's research we understand chronic primary pain as pain in one or more areas of the body that causes significant emotional distress and physical disability while also not being explained by another chronic pain condition. The lack of biological findings explaining the pain is key to this kind of pain and it encompasses conditions such as fibromyalgia, irritable bowel syndrome, and back pain that is neither neuropathic or musculoskeletal. Chronic cancer

related pain is pain caused by the cancer itself or the treatment and can be either continuous or intermittent. Chronic post-surgical or post-traumatic pain, whose descriptions are self-evident, are typically neuropathic in origin. Chronic neuropathic pain can be spontaneous or evoked and show up as an overloaded response to a painful stimulus or a painful response to something that shouldn't cause any pain whatsoever. For pain to be considered neuropathic there has to be a history of nervous system injury such as via stroke, nerve trauma, or a diabetic neuropathy. Chronic secondary headache or orofacial pain is pain that shows up in at least 50% of days over 3 months time. Chronic visceral pain is pain that is typically perceived in the somatic or sensory tissues that receive the same sensory innervation as the affected viscera. And finally, chronic musculoskeletal pain is defined as pain related to diseases of the bones, joints, muscles or soft tissues.

Epidemiological presentation of chronic pain

In Canada, we see chronic pain affect a large swath of society with an estimated 7.6 million Canadians living with chronic pain across their lifespan (Canadian Pain Task Force, 2021). There are some demographic groups that are more affected than others. The groups that are disproportionately affected include seniors, people living in poverty or with mental health conditions, people in trades and transport, veterans, indigenous/ethnic/racialized communities, people of diverse genders, people with a history of sexual trauma, and finally but not least importantly women (Canadian Pain Task Force, 2021). Beyond the personal impact of chronic pain on individuals there is also the financial and societal burden of the disease. In Canada the direct and indirect financial impacts of chronic pain total $38-40 billion per year. This is broken down between direct costs such as the medical cost of physicians, medication, and both in/out patient care, and indirect costs which relate mostly to lost productivity in the workplace (Canadian Pain Task Force, 2021).

Impacts of chronic pain on the individual

The impact of chronic pain across the world has immense personal and social burdens. Chronic pain, especially that which is sustained and severely impacts people's quality of life (social, work, daily tasks) impacts as much as 20% of adult populations worldwide (Phillips, 2009).

With the varying and immense cost and impact on society of chronic pain being measured we can turn our lens towards the cost to the individual. We start to see the scope of the impact on a personal level which touches on the physical, psychological, and emotional realms, the social and occupational circles of the individual, as well as their quality of life (Geneen et al., 2017). Patients experiencing chronic pain typically see a reduction in their activity levels as well as their mobility. Their activity levels diminish and with that is seen a drop in their muscle conditioning. Consistent with this is a reduction in quality of sleep and the observance of a vicious cycle of reduced sleep quality which impacts recovery (Finan et al., 2013). We also observe links between a person's psychological/emotional state and their physical pain. There are observed and shared biological pathways and neurotransmitters between them both which stand that they benefit in being treated concurrently (Bair et al., 2003). Cognitive impacts are additionally seen in patients dealing with chronic pain. The neural systems involved in cognition are also closely linked to pain processing and thus modulate each other reciprocally (Moriarty et al., 2011). In terms of the social impacts that a person with chronic pain experiences, we see that they are affected, and potentially even threatened, in terms of their experienced ability to meet several basic needs. These needs include autonomy, the need to belong, and the need for justice and fairness (Karos et al., 2018). The need for autonomy is a profound and complex aspect of the human equation and pain can impact the fulfillment of this need in profound ways. The need for autonomy in the realm of pain can be seen as a dance with responsibility and agency which shifts from the individual to an outside source. With pain, an individual is often required to forgo complete agency and surrender control of their actions and outcomes to another outside of them (Karos et al., 2018). With this fracturing of the experience of autonomy the patient often feels uncontrollability and helplessness as they transfer the control of their wellness to family, friends, and health care providers. A

major consideration is that doctor-patient relationships are usually characterized by authoritarian and paternalistic physicians, further eroding patient autonomy and resulting in reduced patient compliance (Karos et al., 2018). People's need to belong is potentially impacted in several ways when chronic pain is present. It can interfere with social activities, work, and hobbies and is frequently met with stigmatization and invalidation, particularly when a medical diagnosis or pathology hasn't been established (Karos et al., 2018). A sense or perception of injustice surrounding chronic pain is both very common as well as detrimental to pain sufferers. This perception often manifests as attributions of blame, an increased experience of loss, as well the sense that this loss cannot be resolved (Karos et al., 2018). Collectively these manifested experiences result in real world impacts for individuals ranging from prolonged disability, impairment of their ability to physically function, resistance to adhering to treatment protocols, augmented pain protection behaviour, anger, and social isolation (Sullivan et al., 2012).

Factors influencing choice of care for chronic pain

Patients tend to pursue several avenues of care regarding chronic pain and those choices are dictated by several factors. Patients' choices of which avenues they pursue are impacted by their past outcomes with different care modalities, their level of satisfaction with various care modalities, their health beliefs (biomedical and/or holistic/alternative), their socioeconomic status, and recommendations from their social circles and current medical care team. Additionally, gender differences, length of duration or complexity of pain, cultural differences, and past experiences are factors that determine what avenues patients pursue in their quest for support with their chronic pain (Tangkiatkumjai et al., 2020).

Primary care for chronic pain

The World Health Organization discusses five classes of interventions for the management of chronic pain in adults including standardized and structured education, physical interventions, psychological interventions, medicines, multicomponent interventions

combing the different modalities (*WHO Guideline for Non-Surgical Management of Chronic Primary Low Back Pain in Adults in Primary and Community Care Settings*, n.d.). This research establishes that best practices for treating patients with chronic pain follow a biopsychosocial (BSP) approach. Interestingly, primary care physicians are quite apt to refer to alternative care (Astin, 1998) and surveys taken across a wide swath of physicians show 60% referring their patients to alternative health therapies in the previous year (Bee et al., 2016). While best practice dictates that BSP approaches best serve chronic pain patients, results from research show that theory and practice are not always in alignment. In one study patients who had consulted their primary care practitioner determined 'A shared participant narrative highlighted weaknesses in this process, with common criticisms suggesting a lack of professional empathy and/or a failure to adequately explain or resolve the condition.' (Bee et al., 2016). This points to shortcomings in the primary care models ability to deliver on BSP and a likely reason why patients pursue other alternative modalities. While there is strong conceptual support of using a BSP approach to treat chronic pain patients in allopathic medicine, challenges to its adoption are very present (Harding et al., 2010). They include a lack of consideration of the presence of social support networks for patients, lack of funding and infrastructure for interdisciplinary BSP programs, and variations in delivery in rural vs urban centers (Tompkins et al., 2017).

Complementary and Alternative care for chronic pain

Complementary and alternative medicine (CAM) are modalities that are either used in conjunction with allopathic/primary care or as an alternative to them. They include manual therapies such as massage, chiropractic medicine, osteopathy, and acupuncture, self practices such as yoga, tai chi, and meditation, approaches that modify biochemistry such as naturopathy, and homeopathy, and energetic practices such as reiki and energy healing (Fleming et al., 2007). The choice for chronic pain patients to pursue CAM options is multifactorial. While it is one of the reasons that people steer towards alternative care, dissatisfaction with primary care is actually not a big factor in pursuing alternative care

(Astin, 1998). Other reasons for pursuing alternative care include the benefits and safety of CAM, the availability and accessibility of CAM, influence from their social circles, and past experiences with CAM (Tangkiatkumjai et al., 2020). Expanding on the motivations for pursuing CAM we see that there is a consistency in people choosing CAM because these alternative approaches better align with their values and beliefs about health and life (Astin, 1998). As with allopathic medicine, there are limitations to CAM in terms of supporting patients with their chronic pain. A primary challenge to CAM, which is amplified by the lack of high-quality evidence supporting the efficacy of CAM methods and dosage, is a generalized lack of standardization in the aforementioned techniques and dosages (BMJ, 2000). Additional limitations to CAM effectiveness and adoption include the lack of regulation and quality control due to the absence of professional orders (Nahin et al., 2016), cost and/or lack of insurance coverage, and of note for this research the expectation bias and placebo effects of CAM (Kaptchuk, 2002). The areas of placebo in question include the attention paid to the patient in alternative care vs allopathic care, the level of compassion that is present in CAM treatments, and the management of expectations, anxiety, and patient self-awareness.

Osteopathy and chronic pain

Osteopathy is a holistic manual therapy that focuses on self-healing and structural integrity of the body and is one of the CAM modalities that chronic pain patients will pursue in their search for relief and treatment. Chronic pain patients typically seek out osteopathy for musculoskeletal issues (spine, thorax, pelvis, limbs), perinatal and paediatric needs, head, visceral issues, general concerns, and finally as preventative care (Morin & Aubin, 2014). Chronic pain is encompassed in these categories but doesn't explicitly show up as its own category. The expectations that patients have of osteopathy include a considered listening

by the practitioner, feeling respected regarding their health condition, the sharing of information between practitioners (Leach et al., 2013), as well as a feeling that their personal agency is respected, that professional expertise will be shared by the osteopath, that the customer experience will be excellent, that the therapeutic process is aligned with their beliefs and needs, and that an interpersonal relationship will be fostered (Cross et al., 2015). Limitations and unmet expectations of osteopathy treatments centered around patient confusion and a lack of clarity around the treatment (Strutt et al., 2008). They expressed confusion from receiving different interpretations of their condition or treatments, frustration that the practitioner couldn't get to the root of the problem, a sense that the continuity of care was inconsistent, and challenges or problems regarding booking and follow ups. The question of personal agency stands out as a critical element in people's expectations as it isn't one that is often fostered in the primary health care-patient relationship. Shifting of the paradigm from responsibility from the practitioner alone to the patient with the practitioner in a supporting role is fundamental in this creation of personal agency (Jerome, 2017). In this paradigm shift we move from a relationship where the physician is in charge of symptoms, and where medication is the agent of change, to a patient-practitioner relationship with shared goals that are determined by the patient and supported by the practitioner.

In defining the above concepts and the observed problems we emerge with our preliminary research topic: Supporting patient's evolving motivations and expectations in osteopathic care for Chronic Pain: A qualitative study. The current research on this topic will be explored in the following Literature Review.

LITERATURE REVIEW

The purpose of this literature review is to assess the current research regarding patient's evolving motivations and expectations in CAM therapy. The first part will involve a description of the strategy used for determining the documents of the literature review and then the chosen research papers will be analyzed. Key concepts from the literature will be presented, limitations and bias will be discussed, and a critical summary of results will conclude the review. This process will lay the foundation for a qualitative osteopathic study focused on enriching patient support and therapeutic alignment.

Eligibility/selection Criteria

The eligibility criteria for the studies of the literature review included studies between 2000 and 2025 and that are written in English. All types of studies were included and exclusions involved any studies not specifically looking at one of the 7 categories of chronic pain. Studies had to be related to osteopathy or other manual therapies.

Databases and Terms

The databases used for this literature review were drawn from the University of Sherbrooke Library list of databases and included MEDLINE with full text (EBSCO), CINAHL Plus with full text, and AMED. The keywords/terms, illustrating the three main concepts to be explored, can be seen in the PRISMA diagram below:

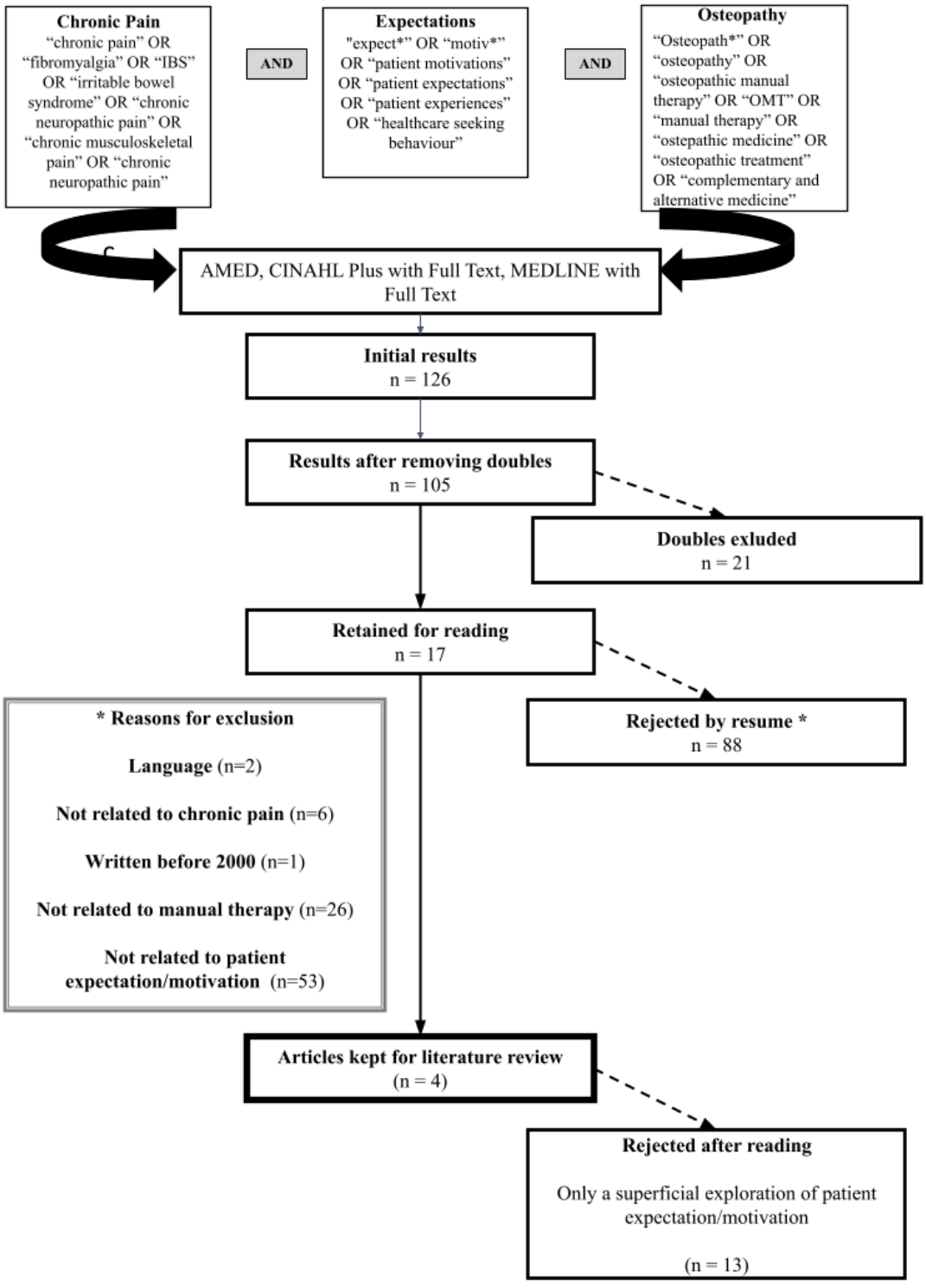


Figure 1. Prisma Diagram

Selection of Studies

The choice of keywords in the 'Chronic Pain' category was made based on the most prevalent reasons for consultations related to chronic pain. (Robert J. Romanelli et al., 2017) Neuropathic pain, fibromyalgia, and musculoskeletal issues encompass the majority of consultations for chronic pain and irritable bowel syndrome is a primary comorbidity of fibromyalgia. After completing research using the concepts determined and expressed in the PRISMA diagram, the results were transferred to ZOTERO. The initial number of results (n=126) was immediately reduced to 105 due to duplicates. The remaining 105 articles were assessed both based on title and the content of their resumes and 17 were kept. Papers that were discarded included: those that specifically weren't related to one of seven categories of chronic pain (n=6), those not written in English (n=2), those written before 2000 (n=1), those not related to osteopathy or manual therapy (n=26), and those not relating to patient motivations or expectations (n=53). The 17 remaining papers were read and after completing the readings 13 were rejected as they didn't focus specifically on patients' motivations and expectations for pursuing manual therapy. The final 4 papers that were kept were read and will be analyzed below.

Key Concepts

This section, in the form of a thematic review, will elaborate on how concepts intersected or diverged in the research articles chosen. A table compiling the results from these research articles is seen below. Based on the results of the research articles that were kept, there were 3 primary categories that emerged which researchers used to develop their theories. They included the dynamic nature of patient expectations around CAM, the intersection of motivations with hope, identity, and meaning, and the importance of qualitative approaches to uncover the subjective experiences of patients.

Table 1. Compiling Results From Literature Review Studies

Authors (year)	Design	Participants	Data collection	Key Procedures	Limitations /Biais	Main findings
Qualitative studies						
Hsu C et al, (2014)	Unspecified	64	Semi-structured qualitative interviews based on a conceptual model of patient expectations elaborated by the authors	Temporal interviews before, during, after receiving CAM treatments for chronic low back pain	Sampling bias due to online advertising in two geographic areas.	Participants focused on incremental improvements and interrelatedness in outcomes on pain, function, physical health and mood, quality of life, and well-being. Concepts of expectations and hopes overlapped.
Eaves et al. (2015)	Unspecified	64	Semi-structued qualitative interviews	Interviews to examine how expectations change over the course of CAM treatment for chronic back pain over 3 months	Sampling bias due to 75% women and predominantly caucasian participants	Patient expectations started as cure focused and evolved into an awareness of the importance of self-management and awareness strategies.
Eaves et al. (2014)	Qualitative study embedded in RCT trial	44	3 to 5 semi-structred open ended interviews conducted over 1 year.	A "Modes of Hoping" framework	Sampling bias: Predominantly white and female.	Consider hope as exercising a multifaceted and dynamic influence on participants' reporting of expectations and their experience and evaluation of treatment.

Randomized controlled trial						
Authors (year)	**Comparator**	**Participants**	**Primary outcomes**	**Key Procedures**	**Limitations /Biais**	**Main findings**
Kasimis et al. (2024)	Manual therapy, pain neuroscience education (PNE), motivational interviewing (MI).	60	Pain Low Back Pain Disability Pressure Pain Threshold Kinesiophobia Catastrophizing	Over 6 months, Randomized into 3 groups: manual therapy (n=20), manual therapy + PNE (n=20), manual therapy + PNE + MI (n=20)	Conceptual bias: limited to outcome focused measures	Combined intervention group showed significant improvements in pain, disability, and psychological factors

Theme 1: Expectations Are Not Static

Across the literature, a key theme is that patient expectations are not fixed at the outset of treatment. Instead, they shift over time in response to bodily experiences, interpersonal dynamics with practitioners, and perceived changes in their health and lives. In "A qualitative study of changes in expectations over time among patients with chronic low back pain seeking four CAM therapies," (Eaves et al., 2015) found that expectations evolved from initial pragmatic hopes (e.g., relief from pain) to deeper goals such as self-awareness and lifestyle change. Similarly in "New perspectives on patient expectations of treatment outcomes," (Hsu C et al., 2014) emphasized how expectations are reshaped through patient-practitioner dialogues and changing self-perceptions over time. In spite of the increase in self-awareness and lifestyle modifications that emerged from evolving expectations, these changes weren't always perceived as positive by the participants. This points to a reality for some that sovereignty over health isn't necessarily a responsibility patients are prepared to accept.

Theme 2: Expectation/Motivation beyond symptom relief

The literature extrapolates that patient motivation cannot be simplified to the pure pursuit of symptom relief. Instead, patient motivation is impacted by identity, personal purpose, and the nature of the therapeutic relationship. In "Modes of Hoping," (Eaves et al., 2014) introduced concepts of hope that range from wishful thinking to transformative spiritual hope, showing how these affect patient engagement and their interpretation of treatments. Similarly, Kasimis et al. (2024), in their clinical trial combining manual therapy with motivational interviewing and pain neuroscience education, showed that motivation increased when patients' awareness of their internal goals were acknowledged as central to the treatment process. Finally in "New Perspectives on Patient Expectations" (Hsu C et al., 2014) observed that patients would interchangeably use 'hope' and 'expect' in describing expectations from treatment but could make distinctions between the two concepts when asked directly. Many studies still treat motivation as synonymous with treatment adherence or goal orientation, overlooking its emotional and existential dimensions. This results in conceptual oversimplification and limits the ability to support truly personalized and meaningful care.

Theme 3: Importance of qualitative approach

Qualitative methods are vital for exploring the nuanced experiences of patients, especially as they relate to expectation and motivation. Eaves et al. (2015) and Hsu et al. (2014) used semi-structured interviews to capture evolving perspectives over time, revealing how patients interpret their healing journeys. These interview methods highlight that healing is not merely a physical outcome but a transformation of perspective about health, of personal responsibility and control, and even of greater purpose.

Limitations

Sampling Bias

Hsu et al. (2014), Eaves et al. (2014 & 2015) were all qualitative studies that relied on small and narrow participant pools. This narrow demographic representation could limit cultural and contextual insight into a more generalized population of patients. Kasimis et al. (2024) also had a rather narrow participant demographic, further limiting how diversity impacts motivations and expectations.

Conceptual Bias

Although Eaves et al. (2014) addressed the concept of hope, motivation and expectation as impactful in fostering identity and meaning, there was an absence of it in research from Kasimis et al. (2023). Kasimis was more focused on determining how to increase treatment adherence and didn't explore the concepts of identity, meaning-making, or the spiritual dimensions of motivation. Hsu et al. (2014) fell in the middle as they touched on reshaping patient expectations but were less interested in the development of identity and meaning as it relates to patient motivations.

Critical Summary: Relevance of Current Study

This literature review supports a more layered, dynamic understanding of patient motivations and expectations. It shows that expectations evolve and are embedded in personal context and shaped by relational dynamics and existential enquiry. This challenges more reductive models (ex. pain vs. no pain) and supports research grounded in the lived experience of chronic pain patients. Of particular pertinence to this study is that osteopathy specific research relating to chronic pain patient motivations and expectations is absent in the well established research databases.

This positions the current study as necessary and timely. It will use qualitative design with repeated interviews to capture how expectations and motivations develop over time, allowing osteopaths to better support patients in understanding their personal healing narratives. Furthermore, it aims to explore how the therapeutic relationship can serve as a framework for fostering patient sovereignty and meaningful, lasting goal-setting.

METHODOLOGY

Research Objectives

Primary Objective

- Understanding how osteopaths can support the evolution of motivations and expectations in patients with chronic pain.

Secondary Objectives

- Helping patients understand and clarify their own personal healing narratives beyond the primary goal of relief from pain.

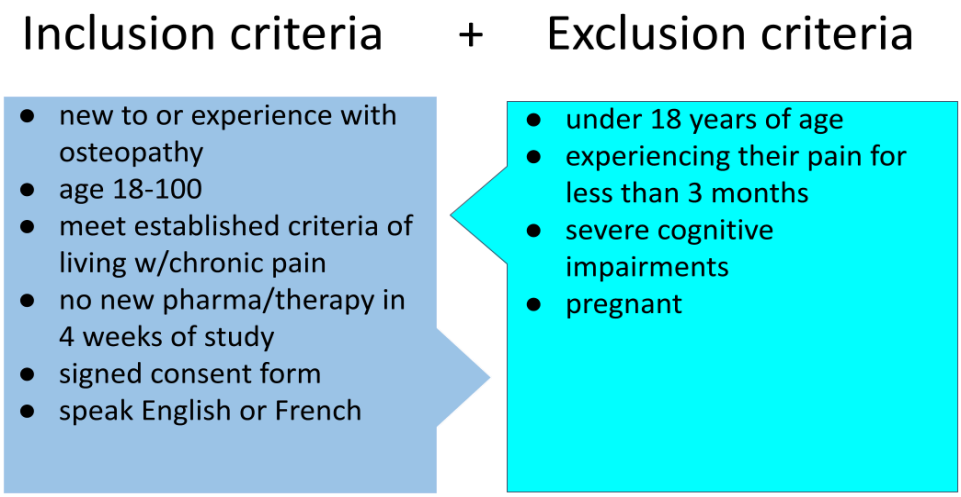
- Explore how the therapeutic relationship between osteopaths and chronic pain patients might serve to foster patient sovereignty and meaningful, long-lasting goal setting aligned with their healing narratives.

Research Methodology

With the intention of this study being qualitative, an interpretive descriptive design approach was chosen (Thorne, 2016). Interpretive descriptive design was chosen as it is a flexible research approach that is ideal for generating applicable knowledge in a clinical context. It's well suited for observing patterns and establishing meaning in real-world practice. Under the interpretive descriptive design semi-structured interviews were used. Semi-structured interviews were chosen because they are well-suited for exploring the meaning and perceptions of participants as well as generating hypotheses (Dicicco-Bloom & Crabtree, 2006). The goal of the research was to create open ended questions which allow the interviewee to freely explore their experience. This data was then interpreted to extract meaning for clinical use and contribute to the body of research on the subject.

Population (sample size, recruitment)

The sample size with patients and recruitment was done through the various clinics where I work with osteopathy clients. Eligible clients were recruited via direct email communication. The eligibility questionnaire can be seen in Annex 2. Patients solicited were current clients of mine. Approval was received from the clinic management to contact patients and only patients that met the eligibility criteria were contacted. Invitations to participate were sent to clients explaining the intention of the study as well as the structure of the research. Participation was voluntary with no financial compensation provided to the patients involved. The desired number of participants was 4 which was chosen as an appropriate number for achieving data saturation. The goal of 4 was not achieved and there were 2 participants in the end.



Eligibility Criteria

Inclusion

Both people new to osteopathy as well as patients with experience receiving osteopathic treatments were eligible. Adult populations between 18-100 were solicited. Patients that met the established criteria as living with one of the seven categories of chronic pain (chronic primary pain, chronic cancer-related pain, chronic post-surgical or post traumatic pain, chronic neuropathic pain, chronic secondary headache or orofacial pain, chronic secondary visceral pain, chronic secondary musculoskeletal pain (Treede et al., 2015) were solicited. Additionally, accepted participants were required to sign the informed consent form which can be seen in Annex 3. Patients also had to be able to communicate in English or French.

Exclusion

Exclusion criteria included patients under 18 years old. Participants who were only experiencing acute pain (under 3 months duration) were also excluded. Patients with severe

cognitive impairments that might impair their ability to reflect and share about motivations and expectations from osteo would be excluded**.** Although the inclusion of pregnant women in qualitative studies is of vital importance, pregnant women were excluded from participation in this study. The choice not to include them here was based on the need to diminish the possibility of unscheduled attrition that may result from the sudden onset of childbirth or a pregnancy related medical emergency. Patients could not be planning to start any new pharmacological or manual treatment protocols in the month of the trial.

Data Collection

The interviews were spread out over 4 weeks between November 1st and Nov 30th, 2025 and included a day 1 baseline interview, an osteo treatment according to the expressed needs of the participant, and an end point interview to capture the evolution of the participants' experience. Interview questions are in annex 4. Three weeks was established as a minimum timeline for the establishment of reeducation of movements and beliefs (O'Sullivan et al., 2018). Interviews were done via video conference (Microsoft Teams) so as to encourage a comfortable, safe, and familiar setting for the participant as well as to simplify the logistics of meeting up. Microsoft Teams was chosen in order to access the automatic transcription feature in the software. The interviews took between 30-45 minutes to conduct. During the interview process, patient information was collected regarding their sociodemographics as well as specific clinical details regarding their chronic pain.

Analysis

Qualitative data analysis method (Miles et al., 2014) was used for the analysis of the data. The approach was chosen as it is appropriate for qualitative research and allows for patterns of meaning to emerge from the lived experiences shared by the participants. The open-ended nature of the questions expanded on the richness of the experience being communicated by participants. Additionally, the subjective nature of this research meant this was an appropriate tool that honoured the voices of the participants in the results. Analysis was done following the interviews. The verbatim transcripts were taken from TEAMS and analyzed using a quantitative data analysis coding spreadsheet. The coding

strategy, category organization, and matrix display format were informed by the procedures outlined in Miles and Huberman's *Qualitative Data Analysis: A Methods Sourcebook*, particularly the chapters on coding fundamentals and matrix-based data displays. They were all input into a google sheets spreadsheet for analysis and clarity, again as outlined in Miles and Huberman's above mentioned book. Two coding cycles were conducted: initial open coding followed by focused coding to refine categories into themes. Themes were generated inductively. Since the goal of this research was exploratory, the inductive approach was considered the appropriate in order to discover new insights vs testing existing ones. The data was approached with menial preconceived notions in order to allow patterns to emerge organically. Transcripts were checked for accuracy and editing for clarity.

Methodological integrity

Credibility

Although a formal researcher's journal was not kept, reflection was integral throughout the research process. I looked out for personal assumptions during data collection and analysis, particularly given my prior clinical experience in osteopathy. Critical self-examination was encouraged through repeated analysis of interview transcripts and note-taking during the coding process. This was to ensure interpretations remained focused on participants' accounts rather than my expectations as the researcher.

Transferability

Transferability was supported through the specific descriptions of participants' sociodemographic and clinical characteristics. This allows readers to assess if these findings are relevant in other clinical or research contexts**.**

Reliability

To support reliability, data analysis was based on direct participant quotations. Themes were not developed in advance but emerged from the data. Interpretations were revisited multiple times to ensure consistency across transcripts. Participants were informally asked whether the themes reflected their experience, and they confirmed alignment.

Audit trail/Credibility

Initial codes such as “fear of non-recovery,” “discouragement,” and “hope” were first treated as separate emotional states. Moving back and forth between pre- and post-interviews, these were grouped under the category “pain experience”, reflecting a shift in outlook over time. This contributed to the development of the theme “Evolution of Motivations and Expectations”, which captures how participants’ perspectives changed over time rather than remaining fixed. In my role as the researcher it was important for me to interpret the data to create the themes rather than just finding them in existing literature.

Ethical Considerations

The primary ethical consideration was informed consent of the participants to be part of the study. Informing them of their right to stop participating at any given time was also a fundamental ethical consideration. The consent form informed them of all the steps of the study. Additional ethical considerations included informing the participants that their responses would be used for the purposes of improving the experience of patients as well as optimizing the delivery of osteopathy services. They were also informed that their names would not be used in the final thesis. It was important to discuss the previous standing patient-therapist relationship so as to ensure the participants didn’t feel coerced to participate due to their relationship with me as their osteopath. This was critically important as the participants' experience of freedom to access treatment that works for them could not be compromised by their choice to participate in or complete the study.

This research complied with the Tri-Council Policy Statement 2 (TCPS2) (Government of Canada, 2023) on ethical conduct. To reduce perceived pressure, participants were

informed in writing that care would continue regardless of participation. No video was recorded and transcript data was stored on a password-protected computer and will be deleted after two years.

Timeline

Upon approval of the protocol the emails were sent out to clients in late September of 2025. The first interviews and treatments were conducted at the beginning of November 2025 and follow up interviews were held at the end of November 2025. Analysis was completed in Dec 2025.

RESULTS

Results were based on the responses from two participants that took part in the project. They included a male between the ages of 45-55 years of age and a female between the ages of 30-40 years of age. Both participants had prior experience with osteopathy and met the established criteria of living with chronic pain. They completed both interviews during Nov 2025 and they each received an osteopathic treatment between the two interviews. In using qualitative data analysis methods three wider themes emerged from the initial coding of the raw data captured in the interviews.

Table 2. Sociodemographic and Clinical Characteristics of Participants

Characteristic	Participant 1	Participant 2
Age	46	34
Sex	M	F
Education	University	University
Pain Duration	10+ years	4+ years
Chronic pain type/location	Chronic neuropathic pain (neck)	Chronic primary pain (r hip)
Prior osteopathy	yes	yes
Other prior care	yes	yes

Table 3: Theme Matrix

Theme	Category	Change Over Time	Participant 1 Evolution	Participant 2 Evolution
Evolution of Motivations & Expectations	Pain experience	Chronic pain burden, fear of non-recovery shifts toward hope	**High distress shifting to optimism:** **"***My expectation now is that my healing will only continue as I'm just super motivated to heal."*	**Discouragement shifting to hopeful:** *"I don't think I'm necessarily more in control of my body but hopefully I'm in a better space to look for solutions."*
Evolution of Motivations & Expectations	Self & agency	Strong agency; Persistence-behavioural/ mindset shifts	**Action-taking increases:** *"It* (interview and treatment) *opened me up to take action.*"	**Mindset shifts:** *"My expectations aren't really much different, but there's a little bit of a different context around them."*
Evolution of Motivations & Expectations	Physical change	Body confirms progress	**Increased activity:** *"Since the start (of this process) I've started training with my friend Max which is more fun and community."*	**Subtle bodily changes:** *"I mean, It's only been a day, but I can, I can feel a difference in how my body feels."*
Healing Narratives Beyond Pain Relief	Meaning-making	Deeper understanding of role of pain in their lives, New perspective	**Pain reframed:** *" I saw that I had accepted the normalcy of my condition as the truth."*	**Pain linked to emotions:** *"I would say the interview was key and that centering around agency kind of brought that sense of empowerment to light."*
Therapeutic Relationship & Sovereignty	Therapeutic role	Trust; Collaboration, evolving to partnership w/ therapist	**Feels prioritized:** *"The osteopathic process itself puts me first."*	**Feels more involved:** *"I guess previously my context has been a little bit more like 'show up, tell the expert your issue, let them do their job' instead of centering myself in the process."*
Therapeutic Relationship & Sovereignty	Self & agency	Self-advocacy: Personal agency accelerates after interviews	**Self-advocacy increases:** *"My role now is the action taker in my healing process."*	**Coordinator role emerges:** *"I'm kind of maybe stepping more into the role of the coordinator rather than just the patient."*

Theme 1: Evolution of Motivations and Expectations

Consistent across both participants in both of their interviews was a shift in how they understood their healing process and what they expected from their healing. Two areas emerged inside of this theme and included changes in their experience of pain, and of particular interest, their experience of self-agency. Both of these results had an impact on their expressed confidence.

Pain Experience

Both participants entered the study with a heavy emotional burden tied to the chronic nature of their symptoms. Participant 1 described living with pain for almost two decades, noting its "major impact on my well-being," while Participant 2 spoke of the discouragement that came with daily symptoms, saying the pain created "a sense of resignation." These early descriptions highlight a picture of fear, discouragement, and resignation.

Participant 1:

Exemplar*: "I get scared it will never resolve."*- (code) fear of non recovery - (category) pain experience - (theme) Evolution of Motivations and Expectations

Participant 2:

> *"It's definitely discouraging. There's a sense of resignation and of a loss of knowing what to do."*

By the second interview both participants reported notable yet unique shifts in their motivations and expectations.

Participant 1:

"*My expectation is that my healing will only continue as I'm super motivated."*

Participant 2 experienced subtler early changes in their experience of their body, sharing:

"I mean, it's only been a day, but I can feel a difference in how my body feels."

"The motivation is probably still the same but the context is different."

These examples show a progression from disempowerment and heaviness toward a sense of renewed or discovered optimism, even if small.

Growth of Self-Agency

One of the clearest findings from the results was an observed increase in self-agency in both participants with self-agency being defined as a perceived sense of control and responsibility for their lives, the actions they take, and the outcomes. During the first interviews there was a sense of loneliness, skepticism, and frustration of the impossibility of change from the first participant:

Participant 1 said:

> *"My current experience with chronic pain is one of real frustrations."*

> *"It's a lonely process and I become skeptical that anything will help as time marches on."*

There were however glimmers of agency emerging even in participant one's first interview:

> *"If I don't show up as the leader for my health I disempower myself."*

Participant 2 echoed uncertainty in their responsibility around their health in the first interview even while showing an awareness that their role, or agency, was fundamental to their wellness:

> *"I think my role in my own process is key. It's not always obvious to know what to do for oneself though."*

By the second interviews, the sense of agency appeared to have become more firmly rooted for both participants.

Participant 1 showed a measurable jump in self-agency in the second interview:

> *"My role is as the action taker in my healing process. I'm the analyst that consults others, I'm the one responsible for figuring out what drives my soul which drives my body. I think before I was in a disempowerment loop regarding my role in my health which I spoke about in the first interview*."

> *"My role now is to keep taking steps that allow me to be that little boy who ran freely with his friends. Now in life that means getting in waaaaay better shape and just taking the steps to be active now and build my life so the activities I love are readily available*."

Participant 2 described a fundamental role-shift for themselves in the second interview. The emergence of responsibility and agency was very clear:

> *Exemplar (excerpt) "I'm stepping more into the role of the coordinator rather than just the patient."- (code) coordinator identity- (category) Self and Agency - (theme) Evolution of Motivations and Expectations*
>
> *"The word agent makes a lot of sense to me. If we're talking about agency, or if you have an agent for something, they're the ones who say 'let me make the calls and figure it out.' They're not mired in the process but are focused on arriving at an outcome. So, it's about finding a bit more of that for myself."*
>
> *"The feeling was of being a bit more dependent and I guess I feel less dependent now."*

Both participants described moving from passive or uncertain roles toward more active, motivated, and self-directed involvement in their healing journeys.

Theme 2 Healing Narratives Beyond Pain Relief

In both participants they described their healing as involving more than simply reducing symptoms. It included shifts in how they understood their pain, their bodies, and the meaning behind their experiences.

Reframing the Meaning of Pain

Both participants naturally used meaning-making to interpret their pain. Participant 1 expressed pain as purposeful and as a source of information:

> *"We're told not to feel, to trust the doctor and make the pain go away. I mean, c'mon, pain is there for a reason*."

In their first interview participant 2 described pain as likely emotionally protective and part of a perceived mind-body connection where information is there to be interpreted:

> *" The book that I listened to recently from John Sarno on back pain and healing back pain would say that the pain is there to kind of mask other emotional things that you maybe don't want to deal with. So I think for myself that's probably part of what's at play. Maybe that's the way my body shows up to protect my mind from certain stressors. There's clearly a relationship, like a body-mind relationship in my case.*"

In the second interviews, both participants expressed the development of deeper insight around the perceived meaning of pain.

Participant 1 reflected on long-standing patterns that had become anchored as truths. The awareness that their state of health around pain had been limiting was both shocking and eye opening for them:

> Exemplar (excerpt) *"I saw that I had accepted the normalcy of my condition as the truth and yet I was faced with the sadness and shock that there was a time long ago that I felt free in my body. Such as when I remember being and feeling really care free as a little kid running and playing wildly. I longed for it*." - (code) Limiting Beliefs - (category) meaning-making - (theme) Healing Narratives Beyond Pain Relief

Participant 2 shared how local tension connected to broader patterns:

> *"I don't think I realized how much there's one knot of tension in the side of my body. It's like really radiating out in many directions. That kind of connects the dots. I'm not quite sure what to do with it on a personal level, but there's definitely something there that's been discovered."*

This theme suggests that participants were making sense of their symptoms, not just trying to eliminate them.

Purpose, Empowerment, and Identity Through Healing

Participant 1 described a strong expression of purpose emerging through the healing process. They described a vivid reconnection with activities that once made them feel alive as well as greater purpose around their life that becomes possible through healing and maintaining a more powerful context:

> Exemplar: (excerpt) "*Its opened me up to take action as I was tired of living in this experience of myself in my body. I have seen myself allowing myself to get excited about back country skiing and I even went out and bought back country skis which was just a thing I talked about for a long time*. *They allow me to be free, to be in nature, to trust myself that I will get strong enough to do this activity, and to be with friends*." - (code) New Perspective - (category) Meaning-Making - (theme) Healing Narrative Beyond Pain Relief
>
> *"I have discovered a reason to train, a reason to exercise, a reason to get in amazing shape. My expectation is that my healing will only continue as I'm just super motivated to heal. I see it as possible even though I'm not out of the weeds*."

Participant 2 did not describe a similar concrete purpose-driven shift but showed cognitive meaning-making through reflection.

Empowerment as a Mindset

Both participants used reflection to strengthen an empowering mindset. The narrative suggests that the interviews themselves served as catalysts:

> Participant 1:

“Doing the work, whatever it looks like, to maintain an empowering context around my health, one that is fun, and that speaks to me, that sparks me up, that has me getting into action.”

Participant 2:

"I would say the interview was key and that centering around agency kind of brought that (sense of empowerment) to light."

In both cases, the verbal processing of their experiences helped reinforce a forward-moving mindset, giving them clarity, confidence, and emotional grounding.

Theme 3: Therapeutic Relationship & Patient Sovereignty

Both participants experienced shifts in how they viewed the practitioner-patient relationship, moving from dependence toward collaboration and shared responsibility.

Feeling Supported and Understood

In the first interview the first participant placed significant value on feeling heard.

Participant 1 spoke about the importance of support:

“It’s good to get support and build faith that things could be better.”

Participant 2 spoke about what they expected from their visits to practitioners such as osteopaths:

> "*I think that osteopathy is a very holistic approach and it gets at systems in ways that massage wouldn't necessarily be able to access. Relieving tension. I think that's like putting things back into alignment when it comes to the structures of the body."*

By the second interview participants described a relational shift about what they expected from osteopathy (and other health care professionals) as well as their own roles in their health became clearer.

Participant 1 reflected on the osteopathic process as it relates to the human in front of them:

> *"The osteopathic process itself puts me first. It trusts that my body, and me as its custodian, knows what's up and knows what it needs. Part of the process is listening to what the patient (in this case, me) is learning and bringing to the treatments.*"

They also showed reflection in their own responsibility in the healing process:

> "*Let's trust the process being presented and also take the actions I know that will complement or supplement the work.* "

Participant 2 described hearing the invitation to do follow up treatments in a new way:

> Exemplar: (excerpt) *"I heard your invitation differently after the first interview. Rather than it being that I come back again because the pain didn't go away or something bland like that the invitation landed like a 'Oh yes, I'll consider how this has impacted my body and then ask for more or different based on that,' it just brought a bit of a different awareness to me."* - (code) New Perspective - (category) Care Experience - (theme) Therapeutic Relationship and Patient Sovereignty

Participant 2 also emphasized how being asked reflective questions changed their experience of care:

> *"Yeah, and I think the questions that you asked last time kind of centered me into the larger context of things*."

Both participants began to see the therapeutic relationship as a shared space rather than a hierarchical one.

Increased Sense of Partnership

This shift from healer as solution provider to healer as provider was especially strong for Participant 2, who said:

> *"I guess previously my context has been a little bit more like 'show up, tell the expert your issue, let them do their job' instead of centering myself in the process. It's not necessarily just about getting myself to the appointment."*

Participant 1 expressed a similar trajectory:

> "*It becomes easier as I'm in charge but open to support.*"

Together, these excerpts show both participants moving from a dependent role to a co-leadership role, where their own insight and actions are central. The most notable relational finding from these limited examples is that agency increased when patients felt like partners in the process.

Participant 1 demonstrated this through clear action:

> ***"*** *I also brought my realizations and discoveries from one therapist to the next so it could be integrated. I advocated for myself and my process*."

Participant 2 describes the same shift cognitively:

Exemplar: (excerpt) "*I'm stepping into the coordinator role.*" - (code) Coordinator Identity - (category) Self and Agency - (theme) Therapeutic Relationship and Patient Sovereignty

In both cases, the interviews accelerated this shift. Reflection gave participants language and structure to better understand their role, and their actions naturally followed.

DISCUSSION

This qualitative study explored how patients living with chronic pain experienced changes in motivation, expectations, and self-agency during a short phase of osteopathic care that included reflective interviews. The findings may support how the experience of healing of participants extended beyond their desire for a change in symptoms and involved shifts in identity, personal responsibility, and the perceived role of the therapeutic relationship. These results are in alignment with and an extension of existing qualitative research on patient expectations in complementary and manual therapies.

Interpretation of Findings

Expectations and motivations are dynamic, not fixed

A central finding of this study is that participant expectations may not be static and might evolve through experience, reflection, and relational context. Relational context as it pertains to the patient-practicioner relationship involves the building of trust and respect, the perceived experience of compassion and empathy, the building of continuity in care over time, and importantly mutual participation where the patient plays an active role in their health and healing journey. Both participants entered care with symptom-focused expectations shaped by months or years of chronic pain, frustration, and uncertainty. Over

the course of the study their expectations appeared to broaden to include increased self-awareness, agency, and engagement in meaningful life activities.

These results closely align with findings from (Eaves et al., 2014), who demonstrated that patients seeking CAM therapies for chronic low back pain often begin treatment hoping primarily for pain relief, but gradually shift toward longer-term perspectives emphasizing self-management, awareness, and quality of life. Similarly, (Hsu C et al., 2014) observed that patient expectations are nuanced and interrelated, often blending hopes, beliefs, and cautious optimism rather than clear outcomes.

In the current study, this evolution was particularly evident between the first and second interviews. Participant 1 expressed a noticeable shift from resignation to motivation and action, while Participant 2 showed a more subtle and meaningful change in how they perceived responsibility and engagement around their health. These findings reinforce the idea that expectations are shaped and evolve during the therapeutic process rather than being fully established at the outset.

Growth of agency as a central process

Across both cases, increased self-agency emerged as one of the most consistent and impactful changes. Initially, both participants described uncertainty, dependency, or confusion regarding their role in healing but by the second interview, both articulated clearer ownership of their process, although they expressed it in different ways.

This progression reflects the “modes of hoping” described by (Eaves et al., 2014), where patients move from passive or externally focused hope toward more active, embodied, and responsibility-based forms of engagement around their health. The Eaves study also supports the idea that agency does not necessarily require the experience of control over a patient’s symptoms. Participant 2 reflected this in their distinction between control and agency, describing a commitment to engaging around their well-being even in the absence of certainty or immediate relief.

This distinction of control vs agency parallels findings in (Hsu C et al., 2014), who noted that patients often hesitate to express strong expectations of improvement, preferring instead to remain open, realistic, or cautiously hopeful. This study's findings suggest that osteopathic care, when combined with reflective dialogue, may support patients in developing agency without requiring unrealistic certainty or optimism.

Meaning-making as part of healing

Both participants engaged in meaning-making around their pain, viewing symptoms not only as problems to be eliminated but as messages, patterns, or experiences to be understood. This process appears to have deepened between interviews, particularly as participants reflected on long-standing beliefs about their bodies and health.

Such meaning-making aligns with qualitative CAM research showing that patients often value changes in understanding, awareness, and self-perception as much as, or more than, symptom reduction (Eaves et al., 2014). Participant experiences from this study support the idea that healing can involve redefining one's relationship with pain, rather than simply reducing it.

Participant 1's reconnection with physical activity and purpose illustrates how meaning-making can extend into identity and life direction. While Participant 2 did not experience a similar purpose-driven shift their reflective insight and increased bodily awareness still points to meaningful change.

Empowerment as a mindset rather than an outcome

Empowerment in this study wasn't tied to specific healing outcomes but more to the participants discovering an ongoing empowered healing mindset. Both participants described the interviews themselves as fundamental in helping them clarify responsibility (theirs and others), reframe their expectations, and determine what support meant to them. This supports the qualitative literature which elaborates that empowerment often arises through relational interactions and the sharing of lived experiences rather than through direct interventions alone (Eaves et al., 2015).

Importantly, this study appears to suggest that empowerment does not require immediate symptom improvement. The experience of living with chronic pain can be one that requires patience and the experience of many deceptions along the way. The ability to foster an empowered mindset throughout the ebbs and flows of the chronic pain journey allows for a more enriching experience that isn't dependent on fixed results. As an example, participant 2 experienced increased agency despite expressing a sense of limited physical control regarding their health at that moment. This challenges the concept that success in healthcare must be outcome-driven and supports a broader understanding of patient progress.

Therapeutic Relationship and Patient Sovereignty

Both participants described a shift in how they related to practitioners, moving from a passive, expert-dependent model toward a more collaborative relationship. Feeling heard, respected, and invited into the process appeared to support increased agency and engagement and saw a shift occur from one of dependence on practitioners to one of partnerships with them.

This parallels findings from Hsu et al. (2014), where patient-practitioner dialogue played a significant role in shaping expectations and engagement. It also aligns with Eaves et al. (2015), whose work highlighted that therapeutic interactions can either reinforce dependency or encourage empowerment depending on how expectations are managed.

Reflexive interviewing as an active ingredient

In this study, reflective interviews appeared to accelerate this shift by giving patients language, structure, and permission to participate actively in their care. It is important to note that the reflective interviews themselves may have contributed to changes in participants' perceptions. This process functioned similarly to motivational interviewing or reflective counselling, where dialogue supports agency and meaning-making.

With this in mind future research could explore the different impacts of osteopathy alone vs reflective dialogue vs a combination of both. The aim would be to see how the different approaches impact the evolution of chronic pain patient's motivations and expectations around their condition.

Strengths and Limitations

A key strength of this study is the integration of reflective inquiry and therapeutic care. The unique lens of focusing on a chronic pain population under osteopathic care was particularly valuable as there is little to no current research exploring qualitative experiences for these cohorts. The inclusion of reflective interviews added to the value of the research as it brought an experiential lens for these patients. The experiential lens fits neatly into the biopsychosocial model which has become a cornerstone of the holistic practice of osteopathy and gives further depth to the application of the methodology. A further strength is the use of a data analysis process (Miles et al., 2014) which is highly recognized in the field of health sciences. It has led to the creation of a matrix of themes that provides a better understanding of the nuances of the subject under study.

Limitations included the very small sample size and demographic diversity of participants which limits the ability to generalize the results for a wider public. There were also limitations in that the research conducted did not achieve data saturation. This was mainly determined by the fact that there were very few examples for each established theme. This lack of data saturation results in the risk that the findings are incomplete or superficial in scope (Ahmed, 2025). The absence of tools to support patients in their ongoing experience of chronic pain beyond the therapeutic relationship was another limiting factor. A tool such

as a personal journal would both support patients in tracking the evolution of their experience of well-being and increase the validity and credibility of the findings via more robust data triangulation. The impacts from the interventions delivered during the study clearly stand to last far beyond the scope of the treatment window, and yet we've learned that empowerment is an ongoing and evolutionary process that requires maintenance and nurturing. This ties into another limitation of the study which was its short scope of time. The length was limited to 1 month which was established as appropriate for the reeducation of movements and beliefs, but, this timeline is too limited should we want to observe episodes of relapse, stabilization, or reorientation of expectations that are often found in chronic pain patients. As this research project was done alone and not enhanced by a co-researcher, the objectivity of the data analysis process could not be ensured. Selection bias must also be noted as recruitment was based solely on the researcher's existing clientele. Impacts of this bias include the risk that participants agree with the researcher in order to maintain the cohesiveness of the therapeutic relationship. Participants might already hold a level of bias towards the therapist and respond based on this pre-existing alignment. Finally, limits were observed in regards to the socioeconomic data that was collected. There was an absence of details regarding participants socioeconomic status, any preexisting treatments they might have been continuing during the study, or medications they might have been using.

Impacts of the study

Impacts on clinical practice

For osteopathic practice, these findings suggest several practical implications that warrant inclusion in clinical settings. As explored in this and related research, patient expectations should be explored as dynamic and evolving, not assessed only once at intake. Additionally, we observed that reflective dialogue may be as therapeutically influential as osteopathic manual therapy in treating patients and integrating it in the clinical process would prove a valuable addition.

Impacts on Research

An avenue of research to explore involves examining how the evolution of patient motivations and expectations over time could shape the methods osteopaths use in support of these key factors. Additional avenues of research that warrant exploration include a comparison of effectiveness between reflective dialogue alone versus classical osteopathy versus a combination of both. The emerging importance of agency for chronic pain patients points to further avenues for research. This study highlighted the diminished importance of specific outcomes for patients and casts a light on the importance of meaning making for their well being. Research around methods to help chronic pain patients develop and evolve in their own empowerment agency with the support of osteopaths would be well served.

To bring richer depth to the results further studies would be well served by including a larger participant population. This would lead to a wider diversity of perspectives and provide more credibility to the findings. While this study brought forth interesting perspectives from the participants through the semi-structured interview process, the use of other data collection methods would help to understand the phenomenon being studied and enhance the research credibility. Additional data collection methods to consider include focus groups, participant observation, case studies, as well as diaries or patient journals.

CONCLUSION

Overall, this study supports a view of osteopathic care as a partnership in which patients with chronic pain may redefine their relationship to pain, responsibility, and healing. By fostering reflection, collaboration, and agency, osteopaths may play a meaningful role in supporting patients with chronic pain beyond symptom reduction alone. Supporting agency does not require eliminating pain, but fostering responsibility, understanding, and engagement. The use of reflective dialogue is one tool which can help patients develop insight and understanding of their evolving motivations and expectations and may be as therapeutically influential as manual intervention.

In care settings, osteopaths should consider exploring patient expectations as dynamic and evolving, not solely assessed at intake. By helping patients in this exploration osteopaths may act as facilitators of meaning and self-leadership and not simply as symptom managers.

Further research exploring the impacts of reflective dialogue over a longer time period would be of great benefit in seeing how patient agency can be fostered.

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ANNEXES

Annex 1: Email invitation

(FRENCH BELOW)

Subject: Invitation to Participate in Osteopathy & Chronic Pain Research

Hello [Name],

I am conducting a study to better understand how osteopathy can support the evolving motivations, expectations, and experiences of people living with chronic pain *(Chronic pain is defined as pain signals that continue to fire after the bodily threat is removed or resolved or if there is no threat at all. When those signals persist or recur beyond 3-6 months, largely considered to be the timeframe required for healing, we consider the pain to be chronic)*.

This research aims to explore how people's sense of empowerment around their wellness may shift over time and create new approaches for osteopaths to better understand and support their patients in this regard. Beyond the intention of the research, my intention is that this process be beneficial for you personally in terms of expanding your empowerment around your health.

Participation entails all the following items:

• Complete a short eligibility screening (link below)
• If eligible:

- Sign a consent form
- Participate in two interviews and 2 osteopathy sessions:
  - Interviews will be 30/45 minutes long followed by an osteopathy treatment
  - Interviews will be minimum of 3 weeks apart
  - Note that there is no remuneration for participation in the study

Your participation is voluntary, and your responses will be confidential.

If you're interested, please complete the eligibility screening (link below) and I will contact you with an answer about your eligibility. Note that this study will have a limited number of participants:
https://docs.google.com/forms/d/e/1FAIpQLSdFJrTMhIcc1TAUdP6yoy3-tN8QlkZdOMpftJvmA_5EqjywgQ/viewform?usp=sharing&ouid=102030267082742348931

Thank you for considering this opportunity to share your experience.

Sincerely,
David Keane
Osteopath I.O.
David@Keaneosteo.com

514 804-4957

Objet : Invitation à participer à une étude sur l'ostéopathie et la douleur chronique

Bonjour [Nom],

Je mène actuellement une étude visant à mieux comprendre comment l'ostéopathie peut aider les personnes souffrant de douleur chronique à gérer leurs motivations, leurs attentes et leurs expériences en constante évolution. Cette recherche a pour objectif d'explorer comment le sentiment d'autonomie des personnes vis-à-vis de leur bien-être peut évoluer au fil du temps et de créer de nouvelles approches permettant aux ostéopathes de mieux comprendre et soutenir leurs patients à cet égard.

La participation implique les éléments suivants :

• Remplir un court questionnaire d'éligibilité

• Si vous êtes éligible :

- Signer un formulaire de consentement
- Participer à deux entretiens et à deux séances d'ostéopathie :
    - Les entretiens dureront 30/45 minutes et seront immédiatement suivis d'un traitement ostéopathique.
    - Les entretiens auront lieu à au moins trois semaines d'intervalle.
    - Veuillez noter que le traitement est gratuit et que la participation à l'étude n'est pas rémunérée.

Votre participation est volontaire et vos réponses resteront confidentielles.

Si vous êtes intéressé(e), veuillez remplir le questionnaire d'éligibilité (lien ci-dessous) et je vous contacterai pour vous informer de votre éligibilité. Veuillez noter que cette étude aura un nombre limité de participants :
https://docs.google.com/forms/d/e/1FAIpQLSdFJrTMhIcc1TAUdP6yoy3-tN8QlkZdOMpftJvmA_5EqjywgQ/viewform?usp=sharing&ouid=102030267082742348931

Nous vous remercions d'envisager cette opportunité de partager votre expérience.

Cordialement,

David Keane

Ostéopathe I.O.

David@Keaneosteo.com

514 804-4957

Annex 2: Eligibility Questionnaire

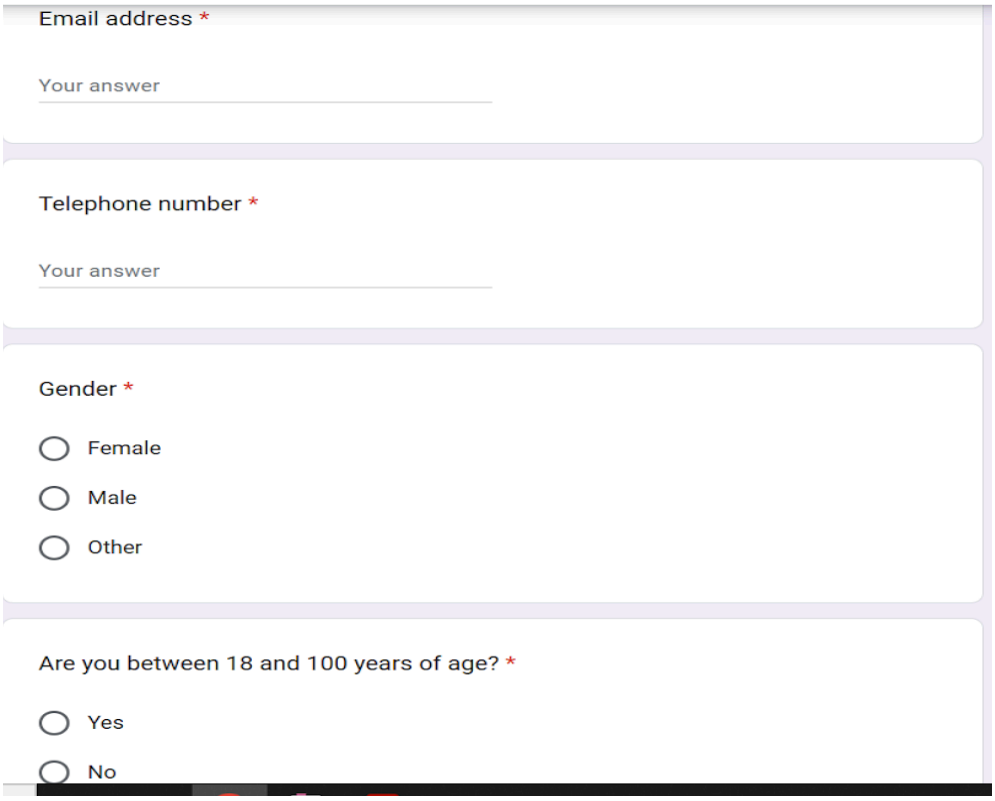
Eligibility questionnaire for research study exploring the evolution of motivations and expectations of patients with chronic pain who consult osteopathically

In filling out this eligibilty questionnaire you agree to divulge your information with the researchers involved in this project. All your personal information will be protected. You accept to participate in a study over 3 months that will be composed of 3 interviews of 30 - 45 minutes. You agree to receive osteopathy treatments at a reduced rate on at least 2 occasions during the 3 months. You accept the risks inherently related to osteopathy such as nausea, headaches, aches, fatiuge, etc. You understand you have the right to remove yourself from the study at any given time without giving reason. Thank you for your interest in participating in this project.

* Indicates required question

Full name *

Your answer


Email address *
Your answer
Telephone number *
Your answer
Gender *
Female
Male
Other
Are you between 18 and 100 years of age? *
Yes
No

Are you pregnant? *

- ◯ Yes
- ◯ No

Do you have a chronic pain diagnosis from your doctor? *

- ◯ Yes
- ◯ No

Will you be available for 3 interviews and 2 osteopathy sessions over the course of the study from October to December 2025? *

- ◯ Yes
- ◯ No

Are you comfortable speaking in English or French? *

- ◯ Yes
- ◯ No

Annex 3: Consent Form

Consent Form

Project Title: *Exploring the evolution of motivations and expectations of patients with chronic pain in Osteopathy treatment. A qualitative approach*

Presentation of the researcher

This research is carried out as part of the study project of David Keane, directed by Diego Legrand (scientific director) and Camila Durand (thesis supervisor) at ENOSI. It is the final component in the completion of the osteopathy program that results in a D.O. (diploma of osteopathy) designation.

Before agreeing to participate in this research project, please take the time to read and understand the following information. This document explains the purpose of this research project, its procedures, advantages, risks, and disadvantages. We encourage you to ask any questions you deem useful to the person presenting this document to you.

Nature of the study

The research aims to understand the evolving motivations of chronic pain patients over time as they participate in osteopathic care.

How participation works

Your participation in this research consists of participating in 2 interviews of 30 minutes (?) over the course of 1 months (?) with David Keane. They will be conducted either in person or via video call based on your preference. The interviews will cover the following elements:

- To establish a foundational understanding of each participant's motivations, expectations, and pain context upon beginning osteopathic care.
- To assess how the patient's motivations and expectations are evolving through the therapeutic process.
- To reflect on the overall therapeutic arc, capture evolved expectations, and gain insight into how the patient now views themselves, their pain, and the meaning of their journey.

Possible benefits, risks or disadvantages of your participation

Participating in this research offers you an opportunity to reflect and discuss, in complete confidentiality, your own evolving motivations and expectations in seeking osteopathic care regarding your chronic pain.

Recounting your experience may trigger emotional or unpleasant thoughts or memories. If this happens, please do not hesitate to discuss it with the person conducting the interview. In addition, you will find attached a list of resources that can help you, if necessary.

Voluntary participation and right of withdrawal

You are free to participate in this research project. You may also terminate your participation without negative consequences or harm and without having to justify your decision. If you decide to terminate your participation, it is important to notify the researcher whose contact information is included in this document. All personal information about you will then be destroyed unless you authorize the researcher to retain it; it will be retained according to the measures described below.

Confidentiality and data management
Researchers are required to ensure confidentiality of participants. In this regard, the following measures will be applied in this research:

- the names of participants will not appear in any report;
- the various research documents will be codified and only the researcher will have access to the list of names and codes;
- individual results of participants will never be communicated;
- research materials, including data and recordings, will be kept (e.g., location, locked equipment, or data on a password-protected computer). They will be destroyed two years after the end of the research, or in January 2028;
- The research will be published in scientific journals, and no participant will be identified.

Acknowledgments

Your collaboration is invaluable in enabling us to carry out this study and we thank you for participating.

Signatures

I, the undersigned _____, freely consent to participate in the research entitled: “Exploring the evolution of motivations and expectations of patients with chronic pain in Osteopathy treatment. A qualitative approach". I have read the form and understood the purpose, nature, advantages, risks and disadvantages of the research project. I am satisfied with the explanations, clarifications and answers that the researcher has provided me, if applicable, regarding my participation in this project.

_____

_____
Signature of the participant, of the participant Date

A summary of the research results will be sent to participants who request it, indicating the address where they would like to receive the document.**Results will not be available until __June 2026____. If this address changes by this date, you are asked to inform the researcher of the new address where you would like to receive this document.**

The address (electronic or postal) to which I wish to receive a summary of the research results is as follows:

_____
_____
_____

I explained the purpose, nature, benefits, risks, and disadvantages of the research project to the participant. I answered the questions to the best of my knowledge and checked the participant's understanding.

_____ _____

Researcher's signature Date

Additional information

If you have any questions about the research, the implications of your participation, or if you wish to withdraw from the research, please contact David Keane, research lead_____, at the following telephone number: (514) 804-4957_____, or at the following email address: ___david@keaneosteo.com_____. You can also contact the scientific director of ENOSI (Diego LEGRAND) at any time at the following address:recherche@enosi.caor at (514) 430-4966.

Complaints or criticisms

Any complaints or criticisms regarding this research project may be addressed to the ENOSI research department:recherche@enosi.ca

Participant's copy

Annex 4: Semi-Structured Interview Question

Semi-Structured Interview Question

Intentions:

- Explore initial motivations and expectations
- Introduce and sense-check the idea of empowerment in healing
- Track changes over time

Interview 1: Before First Treatment

(Goal: establish baseline motivations, expectations, relationship to pain, sense of control)

1. "Can you describe your current experience with chronic pain? Physical and emotional?"
2. "What led you to seek osteopathic care for your condition? At this point in your healing journey?"
3. "What are your main expectations from osteopathy in general?"
4. "How do you see your role in your own healing process?"
5. "In your own words, what does "feeling empowered" in your health journey mean to you?"
6. "What changes: physical, emotional, or otherwise, would help you feel that you are making progress? They could be a change in the experience of self and ability.
7. "Have you experienced moments at any time in the past when you felt more in control of your health? What contributed to that feeling? To the best of your abilities can you vividly describe the time and setting at that moment?"

Interview 2 : After Second Treatment

(Goal: assess change in perceptions, sense of empowerment, and alignment with earlier expectations)

1. “Since starting this phase of osteopathic care, have you noticed any changes in your pain, mobility, or overall well-being?”

2. “Have your motivations or expectations for healing changed since our first conversation? If yes, how?”

3. “How would you describe your role in your own healing process now compared to before starting this inquiry/process one month ago?”

4. “Can you share an example from the last few weeks where you felt more in control of your health or your pain?”

5. “How has the osteopathic process, including the interviews, influenced your sense of empowerment, if at all?”

6. “Looking ahead, what role do you see yourself playing in your ongoing healing?”

7. “Is there anything you’ve learned about yourself or your condition that you didn’t expect?”