From Touching to Supportive Caring – Results from Two Studies on Rosen Method Bodywork

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Abstract

This article presents my two studies on Rosen Method Bodywork (RMB) carried out from 2007-2013, and a tentative model of possible health-promoting components in RMB. This model arises from the results of two studies and focuses on reaching a better understanding of the possible health-promoting components in RMB. The two empirical studies and the results were published in two scientific journals in 2009 and 2013. In this article, I present the background to my studies, the study aims, methods, characteristics of the participants and briefly discuss the results. Because I used a theoretical frame for the analysis in Study 2, I will also present a short version of this theory for the readers who want to know more about it.

Introduction and Background

The importance of research on complementary care

In Sweden, where I carried out my research on RMB, the services that provide the population with health care are offered within several different systems. The main (formal) system is conventional (bio-medical) health care (CHC). In addition to CHC, complementary and alternative medicine (CAM) therapy methods are available in a parallel health-promoting system (market). RMB has been practiced as a CAM therapy method in Sweden since the 1980's. CAM therapies are generally not integrated within the Swedish CHC but many patients use them simultaneously.

The utilization of complementary and alternative medicine (CAM) therapies has grown rapidly in most countries. The increased use of CAM therapies may have positive effects on public health according to Hawk, Ndetan and Evans (2012). The authors argue that CAM consultations play a significant role as the consultations seem, for example, to increase people's motivation to take care of their health. Therefore, the authors claim that there is a need to engage CAM therapists in health promotion counseling and to improve the co-operation between CHC providers and CAM therapists.

The co-operation between CAM practitioners and CHC personnel is, however, still limited in Sweden, where the CHC providers' knowledge about CAM therapies is weak according to Bjerså, Victorin-Stener and Olsèn-Fagevik (2012). This may be a situation that is common in many other countries as well. The lack of knowledge about CAM therapies can be understood as a barrier for cooperation and communication

between CAM practitioners and CHC providers. This contains a risk for patient (client) safety as the parallel use of CAM and CHC treatments or pharmaceuticals is a common feature today and it might lead to adverse health effects or unwanted treatment interactions.

One further barrier between these two groups of health care providers is a lack of scientific evaluation concerning many CAM therapies. For this reason, several authors (e.g. Bodeker & Kronenberg, 2002; Harris, Finlay, Cook, Thomas, & Hood, 2003; Hanssen, Grimsgaard, Launso, Fonnebo, Falkenberg, & Rasmussen, 2005) declare that there is a great need for extended scientific knowledge about CAM. Other authors (e.g. Fönnebo et.al 2007; Verhoef, Vanderheyden & Fönnebo, 2008; Verhoef & Leis, 2008; Fönnebo & Launsö, 2009) argue that research on CAM needs to include new theoretical or methodological perspectives. Since many CAM practices are conceived to work holistically across multiple dimensions - e.g., mind and body - it is important to develop research strategies that combine qualitative and quantitative research designs in order to understand multiple aspects of CAM interventions. While quantitative methods can show the statistical magnitude of the effects of a particular kind of treatment, qualitative methods are descriptive and help to illustrate how a treatment may be integrated within the whole person in the context of the therapeutic relationship between client and practitioner.

In the CHC services there is a continued interest in building scientific evidence as well. The reason is that many treatments and/or interventions within these services are still based on experiential knowledge and not on scientific knowledge about the efficacy, effects or risks (Peile, 2004). Therefore, systematic documentation and scientific results are considered to be a useful tool for health care providers to decide what kind of treatments or interventions are the best evidence-based practice (EBP) (Polit & Beck, 2010). The goal is to eliminate unsafe, risky or ineffective methods and to choose methods that have the best outcomes. This goal concerns CHC treatments but should also be valid for CAM therapy methods.

Moreover, the Medical Research Council (MRC) (2006) has given recommendations for how a new or complex therapy method (or clinical practice) shall be evaluated. According to the Council, the evaluation should include different research methods and theoretical perspectives to identify potential important factors that may influence the therapy outcome. Once identified and defined, these factors can be examined to test the efficacy of a given intervention in clinical, randomized, and controlled trials. Furthermore, the MRC's recommendations point out that the qualitative experiences of the users and the clinicians who are familiar with the therapy must be included in the analysis when exploring potential explanations for the outcomes.

Peile (2004) put forward similar recommendations when discussing the research design of EBP. The initial (very first) stage in a scientific process of exploring new health promoting methods should be qualitative, in which users (clients) of a particular therapy method are asked about their experiences with the therapy method. Also, Brink and Wood (1998) state that a reasonable first methodological design concerning a new therapy method is descriptive or exploratory, including qualitative methods such as observation, interviews, patients' or clients' self-reports and questionnaires. Data obtained through such methods is important in building a foundational record that documents what a particular therapy method can and cannot do under a variety of circumstances. The results can then be used for forming hypotheses in subsequent studies or contributing to methodological or theoretical progress. The studies presented in this article are based on these recommendations.

The research project on Rosen Method Bodywork

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Rosen Method Bodywork (RMB) is still a relatively unevaluated therapy method. When I started my studies in 2006, scientific or systematic documentation about RMB was lacking regarding risks and benefits, harms, failed treatments, efficacy or therapeutic potential of the method for specific diagnoses. However, informal reports indicated that many RMB clients are satisfied with the treatments and/or experience improvements. Therefore, my overall aim was to obtain an initial qualitative picture of RMB concerning some of these aspects and to contribute to a better understanding of some possible health promoting aspects of RMB. The project was approved by the Regional Ethical Review Board in Stockholm, Sweden, and included several separate actions to achieve a solid ethical standard as detailed written and verbal information about the study to the participants. Furthermore, all participants received an informed consent form to be signed and were guaranteed confidentiality.

The overview, recruitment process and characteristics of the participants in Study 1 and Study 2

The project includes two separate studies: Study 1 (survey) and Study 2 (interviews). The questions and methodologies from both Study 1 and Study 2 are summarized in Table 1.

Table 1: *Overview of the study titles, questions, and methodologies*

	Study 1	**Study 2**
Title	Rosen Method Bodywork – An Explorative Study of an Uncharted Complementary Therapy	Caring as an essential component in Rosen Method Bodywork – Clients' experiences of interpersonal interaction from a nursing theoretical perspective
The study aims	To describe 1) why clients use Rosen Method Bodywork, and 2) what kind of help or benefit (if any) the clients perceive	To explore if caring is a part of the interpersonal interaction in RMB treatments by analyzing the RMB clients' experiences from a nursing theoretical framework
Design	Qualitative, exploratory and descriptive	Qualitative, exploratory and descriptive
Number of participants	53	11
Data collection method	Survey by using a study specific questionnaire with structured (fixed) and open-ended questions	Structured introductory questions from the questionnaire in Study 1 Semi-structured interviews beginning from four wide pre-formulated questions
Data analysis	Descriptive statistics and latent and manifest content analysis	Deductive content analysis of the participants' experiences utilizing the nursing theoretical framework, SAUC Care Model

Since the population who uses RMB was unknown, the best way to get in contact with clients was considered to be via practitioners. For both studies, the inclusion criterion for the participants was experience of RMB treatment, whether *positive* or *negative*. Seventeen certified practitioners from the Swedish Rosen Therapist Member Association member list (240 members year 2006-2007) were asked to assist in the research project. Their task was to inform their clients about the project and pass the name of interested clients to us. As the whole project was planned to include two studies (see Table 1) these clients were contacted by telephone and asked to take part either in Study 1 or the later Study 2. Sixty potential participants preferred participation in Study 1 (45 women and eight men) and 9 in Study 2 (six women and three men).

There is no accurate knowledge about the distribution of men and women among RMB users, but according to informal reports from the Swedish practitioners, men are a minority among RMB clients. Consequently, the distribution of men and women in the study group might mirror this information. All participants in Study 1 had only positive experiences from RMB and, in Study 2 there were only two clients who stated adverse experiences. Therefore, this lack of negative or adverse experiences led to a second recruitment of two additional participants for Study 2 who have had adverse experiences (upon recommendation from other participants). Improving representation of clients with negative experiences from RMB was considered important for the results.

Furthermore, two persons in Study 1 dropped out before the study commenced. Of the remaining 58 participants in Study 1, 53 returned the questionnaire (response rate was 88%). Since it is of interest to know why participants drop out, the participants who did not complete Study 1 were contacted and asked why they dropped out. Two of them stated lack of time as the reason for dropping out but the remaining participants indicated that they had *had negative experiences* from RMB. This means that the results from Study 1 must be considered as a testimony of successful RMB treatments and we must know more about the reasons why the treatments might fail. It also highlights the risk of underestimating negative effects or experiences when the study group is self-selected.

In addition to participants' experiences from RMB, my interest was also to reach a conclusion about the characteristics of clients who use RMB, as there was no previous data including this information. The participants' ages ranged from 31-67, they were *highly educated* and most of them belonged to the *upper income class* in Sweden. Their occupation was grouped into the following categories: office-based workers such as secretaries and administrators, participants with academic backgrounds such as associate professors or PhD students, managers (CEOs, production managers, and personnel managers), and engineers or consultants. In addition, over 20 % of the participants were CHC providers and staff working within municipal care services such as registered nurses, assistant nurses, social workers and psychologists. This is interesting since there is still a gap between CAM and CHC in Sweden, as I mentioned earlier. The majority of the participants had received multiple RMB sessions.

One additional interesting aspect was that many participants described actively searching for information about RMB *before* they contacted their practitioner (see the quotation below). They seemed to have made the choice based on an understanding of what RMB can do or not do and they were most likely motivated by self-exploration. Therefore, RMB users can be considered as *informed consumers* since they actively sought information about RMB and their decision to choose just RMB was not fortuitous but appeared to be based on need.

"[…] but I had read a lot about it [RMB] before the visit" [participant Study 2]

Study 1: Backgrounds, aims, methods and results

As the research on RMB was considered to be in the first stage, it was decided that the project design should be qualitative and descriptive. According to qualitative methodology, data from clients who already had some experience of RMB and the therapy process was determined to be the best way to gain initial understanding of the therapy method. Since RMB practitioners do not belong to CHC in Sweden where my studies were carried out, they have no formal obligation to register their clients or to document their work. For this reason, the knowledge about the population who uses RMB is limited, as well as knowledge about the reasons for RMB utilization and descriptions of what kind of benefits are experienced by clients. As a result, the first aim in Study 1 was to *describe reasons why clients* consult RMB, and the second aim was *what kind of help or benefit (if any) they perceive*. Because I wanted to obtain a larger amount of data about the participants and their experiences, a survey was the preferable data collection method in Study 1. One problem occurred when my project started: there was no validated questionnaire available from previous research concerning RMB. For this reason, I created a study-specific questionnaire based on modified questions from two questionnaires used in previous CAM research. The questions in the questionnaire were both fixed (structured) and open. They covered participants' social-demographic background, their CAM utilization, RMB and CHC utilization patterns. Furthermore, the questionnaire included ratings on a non-metric 7-point scale concerning participants' confidence in CAM therapies in general, their perceived difficulties related to the reason that brought the participant to RMB, including sick leave, expectations for RMB, and benefits from RMB and from CHC services (if used simultaneously). Finally, the questionnaire included three open-ended response alternatives requesting that the participants in Study 1 describe experienced benefits and reactions from the RMB treatments. This questionnaire was sent to 58 RMB clients.

Results and conclusions from Study 1

The analysis of reasons for using RMB was based on data from the structured (fixed) questions and from three open-ended questions included in the questionnaire. In many cases, the responses contained detailed information that expanded and exemplified the answer to the structured questions. The results illustrate that most participants reported not only one but several reasons for using RMB. However, the reasons could be sorted into three main categories: *physical health problems, psychological problems*, and *a need for personal growth.* Most participants rated the level of difficulty of the problem that brought them to RMB as *"very high"* or *"high"* in their lives, which prompted them to seek RMB. Table 2 shows the rated overall difficulty level for participants in Study 1.

Table 2: *Reported degree of perceived difficulties leading to seeking RMB*

Reported grade of the difficulty **Study 1**	**Number of participants reporting the difficulty** **n = 52**
7 Very high	21
6 High	12
5 Fairly high	14
4 Moderate	2
3 Some	1
2 Almost none	-
1 Not at all	2

The participants' responses to the open-ended questions included in the questionnaire pointed out that many of them suffered from chronic illnesses or pain. Accordingly, the participants in the study population reported that they experienced ill-health and/or had a lower life-quality quite often. Moreover, 14 participants reported that they had previously sought help from, or had parallel contact with, CHC providers (mainly physicians or psychologists) due to the same reasons for which they were consulting RMB. A majority of them also reported unsatisfying help from the CHC providers.

The second aim in Study 1 concerned benefits the recruited participants perceived from RMB. The rating on the 7-point scale gave quantified information about the level of experienced benefits. Most participants rated benefits from RMB as *very high* (7) or *high* (6) (See Table 3).

Table 3: *Rated level of perceived benefits in Study 1*

Perceived benefits from RMB	**Number of participants** **n = 52**
7 Very high	20
6 High	18
5 Fairly high	8
4 Moderate	5
3 Some	-
2 Almost none	-
1 Not at all	1

The three open-ended questions asking the clients to describe their perceived experiences of the treatments generated a rich amount of information. These data were analyzed on the basis of content analysis and generated five main categories of benefits. The first benefit category was *enhanced psychological health*, including sub-categories of *increased wellbeing, feelings of trust, happiness, and improved self-confidence*. The second benefit category of *enhanced physical health* included sub-categories of *reduced tension in muscles, improved capacity to breathe, improved intestinal function, increased physical energy*, and

relieved pain (such as headache, back pain and pain in the neck or the muscles). These types of reported improvements are often ascribed to neuro-physiological responses to the particular quality of "listening" or "supportive" touch found in RMB and other similar practices (Uvnäs-Moberg, 1998; IsHak, Kahloon & Fakhry, 2011; Lindgren, 2012; Fogel, 2013). In the third benefit category, *increased awareness of the body-mind connection,* the participants described how they have become conscious about how their behavior patterns influence their body but also how the ongoing processes in the mind also affects the body. The fourth and fifth benefit categories were *support for personal growth and self-initiated life-changes*. These categories show an interesting picture of learning, personal development and strengthened personal power for managing the life-situation. Moreover, the participants' responses included aspects such as establishing a secure environment, support, and learning about the causes of their health problems.

The results from Study 1 regarding reasons for seeking RMB are not extraordinary compared to previous results from research on CAM clients (Stewart, Weeks & Bent, 2001; Sirois & Gick, 2002). According to these authors, unsatisfying results from CHC is one reason why people consult CAM services. Moreover, the Study 1 participants reported, in many cases, severe illness which is a common feature among CAM clients (Mason, Tovey & Long, 2002; Cartwright & Torr, 2005; Bishop & Lewith, 2010). Moreover, the authors discuss that CAM therapies are regularly used by people who have chronic illnesses, have not responded to the CHC treatment, or who feel dissatisfied with the encounters to CHC staff. Additionally, the authors conclude that these people might have a specific need for care which CHC care providers have not satisfactorily provided. Furthermore, the results from Study 1 reveal that psychological problems were a frequent reason for seeking RMB. This result is also confirmed by a Finnish psychologist who has investigated dissimilarities between Finnish CAM clients (Svennevig, 2003). The author tested and interviewed clients who had chosen four different body-based CAM therapy modalities, including RMB. She found that clients who preferred RMB had psychological health problems to a greater extent than other CAM clients.

Study 2: Backgrounds, aims, theoretical frame, methods and results

During the formal data collection, the author observed and carried out discussions with practitioners in order to better understand the context of RMB. These observations and discussions, as well as some of the results (especially categories 4 and 5 from Study 1) raised curiosity about *how* the interaction between practitioners and clients was experienced by the clients. This led to an assumption that it might be important to further investigate interpersonal interactions between practitioner and client. Could the experienced benefits be a result of the unique qualities of RMB touching alone or could other factors be involved? It seemed to me that the participants' descriptions had many similarities with the concept of caring stated by a Swedish nursing theorist, Professor Barbro Gustafsson. According to her, good caring means *support that includes confirmatory guidance for assisting the patient to obtain a strengthened self-relation.* A strengthened self-relation (see below) is, according to the author, necessary for increased personal power and self-control to handle challenges (e.g. an illness) in a realistic way in order to maintain better health status or life-quality. Therefore, the aim of Study 2 was *to explore caring and interpersonal interactions in RMB by analyzing clients' experiences from a nursing theoretical framework*.

But, since this article is intended for RMB practitioners, nurses and non-nurses, the following section includes a short discussion of specific aspects in nursing and RMB that seem to be similar. RMB practitioners are not professional nurses but they may appreciate reflecting on their clients' experiences of *interpersonal interaction* and *caring* from a nursing perspective.

I would like to clarify how I chose this perspective. I am not a RMB practitioner and therefore am not

conscious about the deepest aspects of RMB. But for me, RMB treatment is a *care* situation where two people meet: the practitioner who has an intention to help (care) the client, and the client who is in need of care. The encounters between practitioner and client are interactive. Therefore, a further core question is if the kind of caring I defined in the text above exists in RMB and if so, can this caring satisfy the client's needs or benefit her/him? It is important to keep in mind that *caring* (though it may be defined in different ways by different people), it is also a universal personal human experience. It is not only experienced as the kind of care a professional nurse or caregiver offers (though for a long time it has been regarded as a core concept in the field of nursing theories) (see Alligood, & Tomey, (2010). The reason I used a specific nursing theory as a frame of reference in Study 2 is that the theoretical frame was a helpful support upon which to concretize aspects of the participants' experiences.

Furthermore, in my view, Marion Rosen's descriptions (2005) and the nursing discipline share at least some theoretical similarities, which is also an additional reason to choose a nursing perspective in Study 2. The similarities include: wholeness, respect toward the cared-for person and their capacities and the meaning of their interpersonal relations. The field of nursing considers the cared-for person (patient) as a whole, unique and irreducible unit. The wholeness is also eminent and nurses must consider physical, emotional and spiritual aspects in the patient's life-situation when planning care actions.

Nursing theorist Fawcett (2005) defines the patient as an active *bio-psycho-social-spiritual* human being who is in a continuous relationship with her or his physical, emotional, social and cultural environment. These aspects are seen as interrelated and interdependent, and a change in one aspect influences the others and contributes to the patient's symptoms, disease or illness. According to one important nursing theorist (Peplay, 1991) an essential intervention in all avenues of nursing is to create a trusting interpersonal relationship which is considered to have therapeutic characteristics. Another nursing theorist Meleis (2007) writes that good caring preserves the dignity of the cared-for person (patient).

Similar descriptions were found by Laine (2007), who is a Rosen practitioner, when she analyzed the content of Marion Rosen's book (2003). Laine believes that although RMB focuses on the body and bodily processes, emotional, social and spiritual aspects in the therapy situation are important to consider as they together form a wholeness in which all aspects play an important role in the client's recovery. Furthermore, Rosen expresses clearly in her book (2005) her belief in peoples' inherent competence and capacity to solve their problems. This view seems to influence Rosen's recommendations to RMB practitioners when she discusses practitioner´s main effort. According to Rosen (Rosen, 2005, pp 28-29 *Swedish translation*), Rosen Method Bodywork is not psychotherapy or physiotherapy; practitioners` task is to assist clients to be conscious about the body tension and give support whatever decisions their clients' make due to the experiences and insights they obtain in the therapy.

The theoretical framework in Study 2 - The SAUC Care Model

The theoretical frame used in Study 2 is specific to the nursing discipline (my discipline). I believe it is important to present some of the theoretical concepts in this article as they might help the reader better understand the results of Study 2. The nursing theoretical framework in Study 2 is the SAUC Care Model (SAUCCM) (*see the theoretical development in*; Gustafsson, 2000; Gustafsson & Andersson, 2001a,b; Gustafsson, 2002; Gustafsson, 2004; Gustafsson, 2007; Gustafsson et al., 2010:1). SAUC stands for **S***ympathy* (S), **A***cceptance* (A), **U***nderstanding* (U), and **C***ompetence* (C). It includes two parts: a theoretical conceptual basis and a practical Model. The theoretical part includes several abstract interrelated concepts which form the basis for the model. The model presents a practical guideline for the caring actions all caregivers offer in

care situations.

SAUCCM was, as mentioned earlier in the text, developed by late Professor Barbro Gustafsson (who also suffered from a chronic and severe illness) in collaboration with Professor emeritus Ingemar Pörn (previously active as a researcher at Oxford University) (see Gustafsson & Pörn, 1994). Their intention was to provide a deeper understanding of the problems that many patients suffer when experiencing services within CHC; namely, *feeling aggrieved and objectified, not feeling understood and supported as a person*. The theory is grounded in knowledge from empirical studies and theoretical knowledge from existential philosophy, which is primarily, based on Danish philosopher Sören Kierkegaard´s (1813-1855) texts.

One main concept in SAUCCM is *"human view"* where the human being ("she/her" in the text below) is described as an active and responsible person who always acts in a goal-orientated way. Some additional concepts are *self-relation, life-plan, repertoire* (which can be understood as behavior in particular situations), *internal* and *external environment*. The concept of *self-relation* is one of the most important concepts in the theory. Self-relation means how she perceives herself. It includes two poles (her actual-self), and the person she *wants to be* (her ideal-self). The concept life-plan is interrelated to self-relation. Life-plan includes her goals, desires and projects. Her actions (repertoire/behavior) arise from her *life-plan* including evaluations and decision-making. Therefore, it is important that there is a balance between the two poles in her self-relation.

If there is a balance, she has a realistic self-perception, which is essential for a realistic life-plan and actions. But if there is a large discrepancy between ideal-self and actual-self (e.g. non-realistic self-perception) it affects her assessments negatively, causing, for example, an unrealistic life-plan leading to unrealistic actions as her actions and projects are based on self-deception. Or she has a lack of courage to realize important goals. This is because her view of herself is not based on an honest assessment but rather an ideal picture that might be untrue. Moreover, the concept *internal environment* includes her emotions, motives to act, self-assessments, experiences of the physical body and her moral view. The *external environment* is described as the social context around her and its rules including significant people in her life.

The theory includes an additional interrelated concept, *confirmation*, which is described as verbal and/or non-verbal positive or negative reinforcement, especially from significant people in her external environment. The art of confirmation (positive or negative) influences her emotional and cognitive development, feelings of security and self-worth as a human being (e.g. internal environment), and has by this reason an impact on her self-relation either strengthening or weakening it. In addition, one more interrelated concept is *motivation*. It is linked to *self-relation* because the motivation for her actions or non-actions in different situations depends on her view of herself (self-perception). Finally, an important last concept is *health*. *Good health* is understood as a balance between the poles in self-relation (realistic self-perception), environmental factors and competence to act in an adequate and desired way. Good health can be evaluated as expressions of *wellbeing* related to positive (joyful) emotions, *happiness* (related to important personal relations) and *sense of life-meaning/purpose* (related to realization of important personal goals).

The Model (see Figure 2) is derived from the theoretical basis forming a pragmatic guideline for caring actions. It comprises three stages, each composed of four phases. In all phases the caring actions shall contain *support, guidance* and (positive) *confirmation*. All phases have a goal that makes it easy to evaluate if the practiced caring has been successful (for example through patient's expressions). The Model and its phases and stages including actions, reflections and goals are described in more detail in the previously

published article from Study 2 (see Hoffren-Larsson et al., 2013).

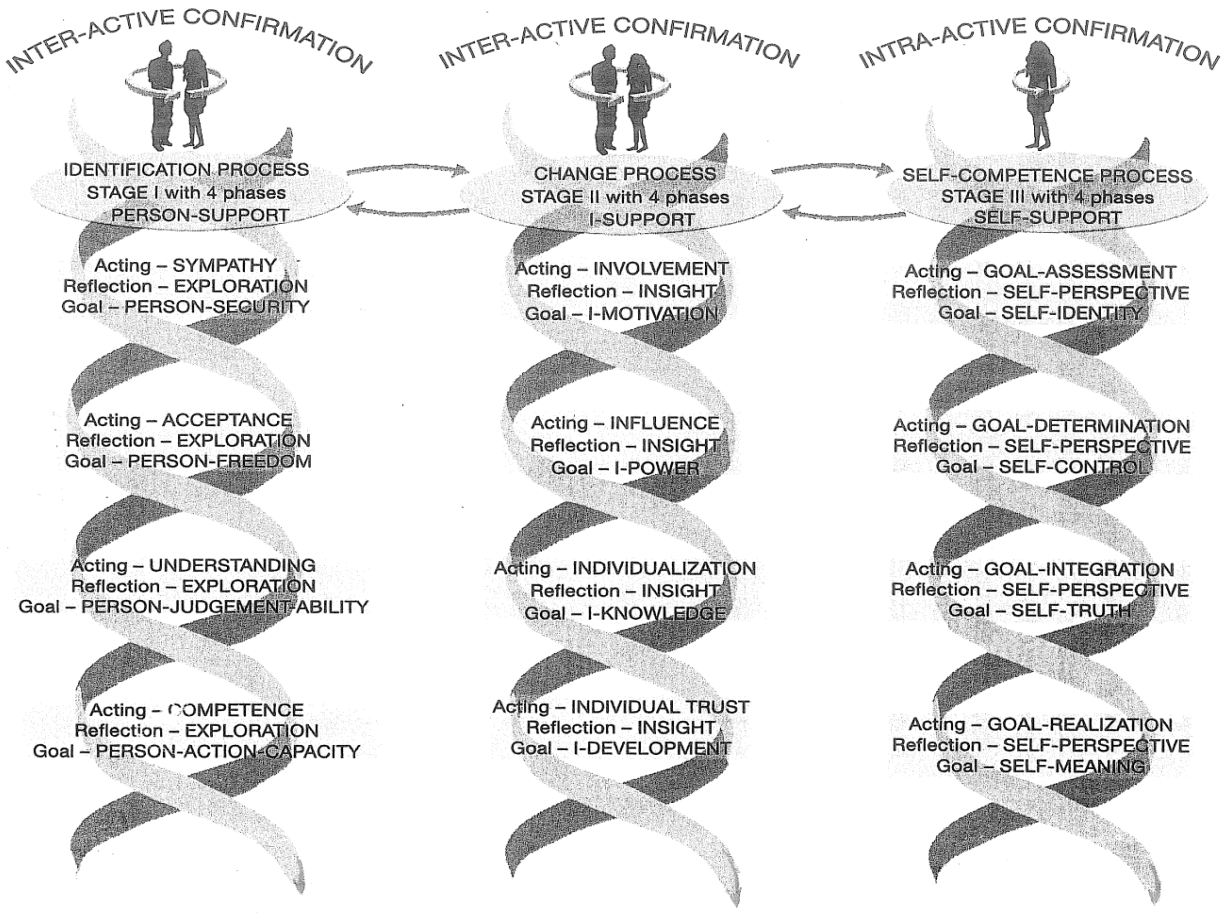

Figure 2: The SAUC Care Model. (Permission given by Professor Barbro Gustafsson, deceased).

The Study 2 method involved semi-structured interviews. Participants in this study began with structured introductory questions from the study-specific questionnaire used in Study 1. This was followed by the main interviews, including four wide pre-formulated thematic issues: (1) reasons for consulting RMB, (2) the therapy process as it was experienced by the participant, (3) perceived reactions and benefits from the therapy, and (4) perceived risks or harm. During the interviews, the participants were encouraged to elaborate on issues described vaguely or in a contradictory manner until a clear picture of the experience was reached.

The SAUC Care Model was then used as a frame of reference for the analysis of caring in the responses of RMB practitioners and participants' interaction in Study 2. The analysis was carried out in the following way: initially a matrix was constructed where the phases and stages of the Model formed the structure of categorization. The interviews were then read several times to reach an understanding of the experiences (positive or negative) concerning the interpersonal interaction, benefits (if any), and all kinds of intrapersonal processes (thoughts, insights, reflections, etc.) the participants connected to the RMB treatments and the interpersonal interaction. The experiences that were assessed to correspond to some of the Model's descriptions of the phases and stages were placed within the matrix that matched (or were opposite to) the descriptions. The text units were then condensed and grouped to state similar meanings

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to express their core content. The analysis revealed 144 experiences that corresponded to ten of the twelve stage/phase descriptions of the Model.

The results from Study 2

Similar to Study 1, most participants in Study 2 rated the *degree of perceived difficulties leading to seeking RMB* as *"very high"* or *"high"* (see Table 4), likewise the benefits (see Table 5). Two of the participants who were dissatisfied with RMB rated the experienced benefits as low.

Table 4: *Reported degree of perceived difficulties leading to seeking RMB*

Reported grade of the difficulty	**Number of participants reporting the difficulty**
Study 2	**n = 11**
7 Very high	5
6 High	2
5 Fairly high	3
4 Moderate	1
3 Some	-
2 Almost none	-
1 Not at all	-

Table 5: *Rated level of perceived benefits in Study 2*

Perceived benefits from RMB	Number of participants n = 11
7 Very high	4
6 High	4
5 Fairly high	1
4 Moderate	-
3 Some	-
2 Almost none	1
1 Not at all	1

Here I will provide a summary of the results from Study 2. A more detailed description and analysis can be found in Hoffren-Larsson et al. (2013).

Perhaps the most important finding is that caring -- defined by the theoretical framework -- existed in RMB treatments and the quality of caring influenced the outcome of the RMB treatment. In other words, the 9 participants who experienced better outcomes perceived more caring in the relationship while the 2

participants who discontinued RMB and reported poor outcomes reported less caring. Caring, therefore, was an important part of the interpersonal interaction in successful outcomes for RMB clients.

Caring is important because the client is vulnerable. One client describes physical and mental nakedness during RMB therapy session:

> *"You are in a very vulnerable situation [during the session] not only because you are physically naked but also mentally. You reveal more of yourself than you do, for example, with a blood test. It is not like when someone is listening to your heart with a stethoscope but giving someone access to your whole heart. To open up feels risky in all therapy situations as there is a possibility that someone uses it for her own purpose"* [Rosen Method treatment described by one participant in Study 2].

For this reason, a secure and trusting relationship is important. The experiences from the satisfied participants in Study 2 clarified that a trusting and supportive relationship was indeed established with their practitioners, making them feel secure and accepted regardless of the problems that brought them to RMB.

> *"[..]... X [name of the practitioner] is not only my therapist but also a human being. And [it is important] that there is mutual trust and respect. It means a lot."* (Participant C; Study 2)

Furthermore, their experiences indicate verbal but also non-verbal communication that lead to mutual understanding:

> *"[...] …my practitioner says that some words pop up in her mind. I pass these words to her in some way. I've been thinking about something and then she says a word that is exactly what I have been thinking about."* [Participant A; Study 2]

These circumstances seem to create an atmosphere where the client dares to take a step forward and grow. The supportive caring from the practitioner seems to lead to new knowledge and increased self-awareness that can be understood as a learning process leading to change.

> *"[During the discussions with my practitioner about the re-experienced memories] I realized that my illness was linked to betrayal. But I realized also that my [chronic] illness has to do with my genetic heritage [...]. And I was very pleased with all this knowledge of how things are related [...]."* [Participant E; Study 2]

Moreover, their experiences illuminate developmental progressions based on more appropriate self-assessments and changed behavior.

> *"[...] I have matured. It [to meet unpleasant people in my job] is not so threatening anymore"* [Participant I; Study 2]

The supportive and guidance caring offered by the practitioner seems to be important as it assisted the participants to discover new skills and made the processing of re-experienced memories and emotions easier to navigate (which were often frightening according to the descriptions by many participants). All but one satisfied participant's experiences covered a whole (therapeutic) progression from Identification (stage 1) to Self-Competence (stage 3). A progression from the first stage to the third is, according to the

theory, a very desirable outcome in all therapeutic caregiving, as it indicates a strengthened self-relation and development of more realistic self-perception. The cared-for person often expresses new competences which she or he can practice independently, but also shows more rational choices and new life goals. These developments were expressed by the satisfied participants. The quotations below describe the progression:

> *"[…] and I understood that I must leave or change [the things] that affect my health negatively."* [Participant B; in Study 2]
> *"[..] And then it's so that I [have begun to] understand what I mean and what I want instead of just running around."* [Participant D; in Study 2]

In contrast, the opposite experiences were found in the interviews with the participants who were dissatisfied with RMB (two of these participants chose afterwards a new practitioner and were satisfied with them and two completely discontinued RMB). The results indicate that if the interpersonal interaction did not comprise proper caring that met the participants' needs, the therapeutic progression was blocked during the Identification stage leading to dissatisfaction or lack of experienced benefits.

> *"[…] I felt that the therapist was not there [mentally] and did something that I felt was not coming genuinely from the therapist and the feeling in the treatment disappeared."* [Participant F; Study 2]
> *"My previous practitioner wanted me to respond to the treatments. As I understood it, the practitioner wanted to prove something and treated me without listening to me [...]. And I went out the door without saying anything."* [Participant G; Study 2]

Discussion: A tentative model of health promoting components in RMB

A conclusion that can be drawn from the results of these two studies is that there are at least *two* integrated major components that significantly contribute to the experienced benefits or client satisfaction with RMB; namely, the particular quality of RMB *touch* and *supportive*, *guidance*, *caring* in the interpersonal interaction. My assumption is that RMB touching alone is *not* enough to guarantee a successful therapy experience in RMB. RMB touch seems to lead to relaxation and release of unconscious memories and emotions that can be very painful to re-experience (according to formal and informal reports from many participants). My conclusion is that *supportive, guidance*, *caring* is a necessary additional component as an integrated part of the *interpersonal interaction* and very important in order to experience a successful RMB treatment. If the interpersonal interaction does not include this kind of caring, the therapeutic progress that comprises learning and growth through positive influence on the client's self-relation will be blocked. And vice versa, if the interpersonal interaction comprises this kind of caring, then it seems to lead to continued therapeutic progress that benefits the client by leading to strengthened self-relation, new self-awareness and progress toward new behaviors.

The results of Study 1 and Study 2 can be summarized as a tentative model on how the two components, *touching* and *supportive guidance, confirmative caring*, might interrelate and contribute to client satisfaction in RMB. The four scenarios in Figure 2 illustrate four different hypothetical combinations of these components. In scenario 1, the two components are a necessary complement to each other, forming a successful combination. This scenario corresponds to satisfied and/or benefitted participants whose experiences indicate progression to the *self-competence* component found in Study 2. The scenario seems to be optimal when the client has experienced psychological or other kinds of problems in the past that are related to physical problems such as tense muscles. The treatment seems to release suppressed emotions

and/or painful memories that are in many cases painful to experience. The interpersonal interaction that includes supportive guidance and caring provides a trusting, safe and non-judgmental atmosphere where the client dares to re-experience and process the released emotions or memories. The caring from the practitioner supports the client further to achieve new learning and self-awareness that strengthens the client's self-relation and makes it easier to make more appropriate self-assessments. Moreover, the support encourages the client to progress and to independently change the circumstances that threaten her or his health or wellbeing.

In scenario 2 there are no real physical or psychological problems, or previous traumatic experiences to be solved. Rather, the client needs support in her or his current life situation or life crisis. This scenario corresponds to the fourth category of benefits in Study 1 – *support for personal growth* (see Hoffren-Larsson et. al. 2009). Therefore, physical touching is probably of secondary importance and the supportive caring and interpersonal interaction is the most important component. Even though touching helps the client relax and experience wellness, it is likely that the supportive guidance and confirmative caring from the practitioner meets the client's needs and makes her or him satisfied with the treatment.

In scenario 3, the client consults the therapist for the same reasons as in scenario 1. The touching works well; the client relaxes and re-experiences demanding emotions or memories. But the interpersonal interaction does not include proper caring and fails to meet the client's needs around trust, safety and support. The treatment will most likely not be satisfying. This scenario corresponds to experiences from the dissatisfied participants in Study 2 who discontinued the therapy or changed practitioners.

In scenario 4, neither the touching nor the interpersonal interaction with integrated supportive caring met the client's needs and the client is likely to terminate the therapy. This scenario is not supported by actual cases in my research. The scenario is easily missed in this type of research study as the clients end the therapy rather soon and will not be included in a study group based on ongoing treatments but this situation can be considered as a probable scenario.

	Touching releasing emotions or memories **+**	**Inadequate touching or touching of secondary importance** **–**
Supportive caring in the interpersonal interaction **+**	**Scenario 1** *Satisfied client*	**Scenario 2** *Satisfied client*
Lack of caring in the interpersonal interaction **–**	**Scenario 3** *Dissatisfied client*	**Scenario 4** *Dissatisfied client*

Figure 2: Hypothetical illustration of the combination of the two treatment components in relation to client satisfaction or dissatisfaction with the treatments. The plus (+) symbol means that the component works well, and the minus (-) symbol means that the component has failed or has no major importance in the treatment.

The data was collected by using two different methods: survey and interviews, which are complementary to each other. The triangulation of two methods increases the possibility of including data that has been lost by using one method alone. Moreover, the entire sample consisted of conveniently sampled RMB users who were interested in participating and the majority of them were satisfied clients. Data concerning the number of received treatments indicate that a majority of them have had a good possibility to observe the interpersonal interaction and record benefits whose development probably is dependent on a long treatment period. The participants can be considered *"experts"* regarding reasons for RMB use, experienced benefits and interpersonal interaction, which increase the trustworthiness of the results.

My project has some limitations that the reader should be made aware of. The dropout control indicates that clients with negative experiences dropped out or were not reached, which might mean that scenario 4 in the tentative model above is underrepresented. The project participants can be considered to represent a particular share of the RMB population who utilize CAM therapies and experience benefits. Additional studies must be conducted to elucidate their representativeness for the whole RMB user population. For this reason, the results cannot be generalized to the whole RMB population.

According to some authors (Koitham, Bell, Niemeyar & Pincus, 2012) many CAM therapies are complex and include many mechanisms that cooperate, work independently, interfere with each other, or simply co-exist. My opinion after the project is that RMB is one of these complex therapy methods. I am sure that RMB comprises many important therapy components that have an impact on client satisfaction. I have focused on two of them but some informal data from the project indicates that there are other interesting components (for example existential and spiritual aspects) that might bear significance on the outcomes, although it is unclear in what way. Future studies may explore these aspects of RMB. My project resulted in a tentative model on how the two RMB therapy components, *touching* and *caring* cooperate, and what may happen when they do not. The model is based on data from clients who, in most cases, had used RMB for a lengthy period. Therefore, future studies may test the model to confirm its adequacy.

In theory, we may be able to separate out different components of RMB treatment, such as touch and caring. In practice, however, RMB – like all CAM approaches – is a holistic process. The quality of RMB touch, for example, contains within it some of the qualities of caring in the SAUC Care Model, since RMB touch as used by a skilled practitioner – even without words – communicates support, guidance, and confirmation. Nevertheless, by breaking down the process into components for the sake of research, we probably gain important understanding about how the treatment works and a better understanding of its potentials and limitations for particular clients.

Conclusions for further research on RMB

In the era of *evidence-based practice* (EBP), there is a need to study RMB from different perspectives. Further studies are essential to reach increased knowledge about the therapy efficacy, explanations of the outcomes, and a greater understanding of caring and other components of RMB that create benefits and client satisfaction. Moreover, there is a need for additional research about systematic documentation, risks, and reasons for failed treatments or whether and when RMB clients have been harmed by the treatment. The primary key to this kind of information will come from extensive documentation of experiences from practitioners and clients. This knowledge leads to new learning for the whole RMB community. Moreover, it is important to achieve cooperation with CHC providers as it can open the door for other kinds of studies if

the goal is to investigate the usability of RMB as a complement to CHC treatments. These kinds of projects should be prospective and based on patient and CHC staff measurements, assessments and observations about short- and long-term benefits, probable risks, adverse and favorable responses to treatments, and should include a health economics' perspective as the results also indicate that there might be a socio-economical aspect from successful treatments.

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