

Commentary on Riitta Hoffren-Larsson's *From Touching to Supportive Caring – Results from Two Studies on Rosen Method Bodywork*

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From 1974 to 1992 I worked as a Registered Nurse and Midwife in West Africa. Most of my experience as a nurse was during these years, and later included five years of working as a Hospice Nurse in California. My nursing work relates to Hoffren-Larsson's research with two different health care systems and is relevant to the background of her research.

In the two countries where I worked, Ghana and Nigeria, the people were primarily provided health care through a Western-style conventional medical health care system. This system corresponds to the conventional health care system (CHC) where Hoffren-Larsson did her research.

Unfortunately, none of the three hospitals where I worked had an outreach program to the neighboring villages. There the people sought help from their own traditional healers who were using healing practices that people relied upon according to their various customs and beliefs. My experience with this complementary and alternative medical (CAM) System in West Africa was that, unlike Sweden, the care was less expensive and often unsafe. Many of our patients came to us with complications from having been treated by traditional healers.

As with Hoffren-Larsson's population, there was no coordination of care between these two systems. In fact, as she described in her article, there was no understanding or knowledge of how each system worked, sometimes putting patients who were using both systems at risk.

From the beginning of my work in rural West Africa, I was keenly aware of the gap between what we could offer in our hospital-based services versus what could have been offered *via* preventive health care services to people in the villages where religious and cultural beliefs were vastly different from ours. Too many of our resources and time were spent on curative health care. Too many lives were lost, especially among children, from diseases that could have been prevented. Clearly there was an urgent need for primary/preventive health care, and an integration of the two health care systems, CHC which was hospital-based, and CAM which was community-based.

In 1983 I took the opportunity to return to Dublin, Ireland where I studied community-based Public Health Nursing. A year later I participated in a UNICEF program that was based on the World Health Organization and Alma Ata agreements for Primary Health Care. These guidelines focused on community-based programs that empowered people to make their own decisions about health and stressing the importance of preventive care; training of village health workers chosen by their own people; programs for traditional healers; mother-child care, and use of simple basic technology.

Back in Nigeria I set about to establish a Primary Health Care program modeled on the recommendations cited above. In order to identify the most urgent problems and needs of the people in a very remote, isolated area, a native Nigerian woman and I began with a "Listening Survey." We went around from village to village holding community meetings, listening to the people's stories, and documenting their problems and concerns.

At the top of their long list of problems was their deep anguish about the number of children, infants, and toddlers especially, dying from gastroenteritis. Over the next several months as we worked in the villages, we integrated education on how to prevent gastroenteritis alongside demonstrations on how to make home-made oral rehydration fluid, which we called "salt and sugar water."

The elders of the communities were hoping to receive from us a CHC style health care program. During several meetings in which we described our preventive care intervention and the importance of it in relation to their immediate health concerns, they continued to complain about us not building them a hospital or giving them employment.

A year or so later, disheartened by their continuing complaints I asked: "Did anything good happen since we came to work with you?" There was a silence that seemed at the time to last for several minutes. Then out of this silence the oldest elder among them spoke the following words: "We notice that we are not being wakened at night by mothers' crying/wailing because their children have died." In the midst of confusion and uncertainty, we were being reassured by the people themselves that the action we had taken from the results of our Listening Survey was proving to be effective.

Less and less did mothers need to go long distances to a hospital and more and more of them were being empowered with knowledge and skills to take care of themselves and their children.

We continued with this evidence-based practice of health care for the people. Our goal was to create trusting interpersonal relationships between ourselves and the people and between the traditional CAM doctors and the distant hospital CHC service where we referred people when necessary, eliminating unsafe health care practices within the community, and supporting the people to choose methods of health care that had the best outcome.

In later years I would hear Marion Rosen, during her teaching hours with us students, speak about her belief in people's inherent competence and capacity to solve problems. Through this health care approach in West Africa I had come to know and to experience this truth.

As Hoffren-Larsson reports in her article, the increased use of CAM health care services plays a significant role in increasing people's motivation to take care of their health. As stated above, we were incorporating into our work the guidelines of WHO and the Alma-Ata agreement on Primary Health care, which, as we can see here, share some of the caring concepts in the nursing theoretical framework that was used in Study 2. One of its main theoretical concepts is "human view" where the human being is described as an active and responsible person who always acts in a goal oriented way. We were working with the people who were in a continuous relationship with their physical, emotional, social and cultural environment.

From the time I came to California in 1992, I have been aware that the journey I began here with my training in Rosen Method Bodywork, and other personal-growth promoting opportunities, mirrored and balanced the journey I made in West Africa. My outward journey to Africa was now to be made inward, to

find and visit the 'africa,' that vast and unknown territory, inside myself.

The first words I read about RM before I began my training was a quote by Marion Rosen about moving "... from the person I think I am to the person I really am." I realized there was some distance between my actual self, and my ideal self - the person I want to be. I knew I wanted to bring these two poles closer together. An important part of my Rosen journey has been finding out who I really am and integrating these two poles, coming to a more realistic self-perception – a strengthened self-relation, which is one of the most important theoretical concepts in the SAUC Care Model.

This care model, specific to Nursing and used in Study 2, gives me an opportunity to reflect on the care I have given as a nurse and RM practitioner, and on my experience of receiving RM bodywork over the years. Through the caring presence of RM practitioners and teachers, I have received support and confirmatory guidance that has made it possible for me to move into my own personal power in order to live my life from a different place; to handle life's challenges, and to make better and more realistic choices for myself.

This care has been very empowering. In RM sessions I have felt safety and trust, created by the attuned listening and caring presence of practitioners. This has allowed me to become vulnerable, open, and present to myself moment-by-moment during sessions. The practitioner's touch, verbal mirroring, guidance and observations have allowed me to balance my inward state of anxiety and confusion. Through this caring presence of someone I trust and feel safe with I have developed increasing ability to be with my inward state in living my life and in my ability to self-regulate my nervous system in stressful life situations.

In the results of Hoffren-Larsson's Study 2, the most important finding is that "caring," as defined by the theoretical framework used in this study, existed in RM bodywork treatments and the quality of caring influenced the outcome of such treatments. My experience of receiving RMB as described above bears this out. Also my own experience supports Scenario 1 that emerged from the conclusion of the two studies, that there are at least two integrated major components, touch and supportive guidance caring, which are necessary complements to each other and contribute to the experienced benefits.

Because of my experience as a receiver of RMB I have in turn been able to give listening, and "supportive touch and care," as Hoffren-Larsson described above, to my clients. I am more present to myself, to clients, and able to be with "what is" without judgment or agenda.

I would now like to give the following examples from my work with clients to illustrate how Hoffren-Larsson's primary findings play out and support the scenarios 1 and 2 which she presents in the conclusion of her paper.

Example One

A Psychoanalyst came to me for a RMB session after he heard about my work from a mutual client, and he was curious about the work. During the first session with him he spoke about his childhood, how as a young teen he had belonged to a gang and was always fighting. At the age of 17 he was thrown through a shop window and his buttocks were cut very badly. He was left lying helpless in a pool of blood as his brother looked on without giving him any intervention or assistance.

From the beginning of the session I noticed widespread muscle tension in the upper torso area. His muscles were tense to my touch, especially in the upper back, shoulders and neck. I noticed and felt also a

rigidity of movement in the expansion and recoil of the thoracic cavity as he breathed in shallow breaths and spoke about his long-term breathing difficulties. There was very little mobility to my touch in his hips, and his hamstring muscles and calf muscles were indeed very tight.

With my hands on his hips the memory of being thrown through a shop window at the age of 17 came to him. As he described this event I kept my hands on his hips with enough pressure to meet the tension I felt under my hands. I waited and watched carefully for a small “opening” in his narrative, when there might be a connection between his words and a change in his body state, for example in the breath or in the tissues under my hands.

With my hands still on his outer hips I began to notice a change in his breath pattern. There began to be slightly longer inhalations followed by slightly deeper breaths, and a sigh now and again. Also, I began to notice a softening in his tissues under my hands. I asked him then if he noticed anything happening inside his body. He said he was beginning to feel more relaxed and I asked, “where in your body are you feeling this?” He replied that he was feeling it in his legs more than any other place. I invited him to stay with this feeling of relaxation and any other feeling that might arise.

To bring his awareness more into his body, I asked, when I noticed an opening, “Did you notice that change in your breathing?” At first he did not seem to notice. And then waiting for another opening, “There it is again. I notice that it happens as you feel the feelings in your body right now.” During this session, I checked several times on my own body awareness to make sure my hands were soft and receptive and that I stayed connected to his body allowing his words and body responses to guide me.

As the session progressed he became increasingly more vulnerable and more aware of his body feeling all the abuse he had given it in his early adult life. With the release of emotions and muscle tension his body softened. With this also came the surprised realization that despite all of his thirteen years of psychoanalytic treatment, he had never considered his body in the healing process. As he stated, “It just didn’t come up.” Also, although he had forgiven his brother he had never asked for forgiveness from his body for the abuse he had given it.

This is an example of a session during which touch greatly enhanced the value of a long-standing psychoanalytic therapy where touch was not used. It reflects Hoffren-Larsson’s Scenario 1 where the two components, touch and supportive caring, complemented each other and contributed to the beneficial outcome of the session. This scenario seems to be optimal, as stated by Hoffren-Larsson in the results of her study, for clients who had experienced psychological problems in the past that are related to physical problems. With this client both muscle tension and breathing problems were reported and observed during the session.

Example Two

A woman came to see me several times for personal growth. On one particular visit, she settled into the session and into her own experience. There was a long silence and I noticed her body quite held. I asked her, “What is happening?” She responded, “I’m in a bad mood.” I assured her that it is all right for her to be so and invited her to feel her feelings. With my hands on her upper back, her body continued to be held. After another silence, she told me that she knew what it was about and I invited her to talk about it. She reported that she was observing her mind, her delusions, and her belief systems, and that in meditation it was not just about coming back to the breath and her body. This was followed by a strong statement saying that we have

to get to know the mind, understand it and how it works, and to break through our fear. With my hands still on her upper body connecting with the muscle tension under my hands there was still no shift in her body as she spoke these words.

In an effort to bring her into body awareness from her conceptual thinking I maintained my contact with her deep muscle tension. Here I waited for an opening, a change in her body state. There was no response and her body continued to be held and very still. With my hands now on her diaphragm, I invited her into her body, to perhaps feel it on the table, or to notice her breath, or my hands on her body. She said she could feel my hands, that they were warm and supportive. There was still no response in her body as she spoke these words.

I then began to ask her about the fear she spoke about earlier in the session. She told me that she very often experiences fear and anxiety in her life, and during meditation, and that she did not often know where it was coming from. I asked her if she were willing to explore any fear she might be feeling at that moment. She became very quiet and after some moments she said that she was feeling fear and that it was not in any one particular place inside her body.

As I continued to feel no response in her body from the words she spoke I asked her what was on the other side of her fear? Without having to think about it she responded, "Love and compassion." As she spoke these words there began to be a change in her body, a softening, and tears began to pass gently down the sides of her face. She began to breathe more deeply and to experience her own words in her body.

This session reflects Hoffren-Larsson's Scenario 2 where there is no real physical problem or previous traumatic experience. Rather the client needs supportive guidance, understanding, acceptance, and an opportunity to explore her internal reality. I feel that the supportive caring and interpersonal interaction was the most important component in this session and that touch, though important, played a less obvious role.

Finally, I would like to thank Hoffren-Larsson for her two detailed and thoroughly researched studies on Rosen Method Bodywork. From the onset, this article engaged my curiosity because it is written by someone who is not a RM practitioner, who has a Nursing background, and also because it is the first of its kind to appear in the Rosen Journal. Her in-depth research, her richly detailed and clearly written article can help us, as RM Bodywork teachers, practitioners, and trainees, to appreciate the importance of research today as we find ways to make this special kind of body therapy more known and better understood by all groups of people in the communities we serve.

As we read through the results of her two studies in the article, there is nothing new for us to learn about the benefits of RM Bodywork. However, as the author states, we are working in an era of evidence-based practice. If our goal is to be seen as an evidence-based practice, we need to pay attention to what this research is inviting and study our work from different perspectives. People ask me all the time, "What are the benefits of your work?" "Is there any research done?" "And where can I find it?" I am delighted to have these two research studies now available in our International Journal for people to read and to have our work validated in such a public way.