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An explorative study of a complementary therapy method - Rosen Method Bodywork

User´s reasons for therapy utilization, experienced benefits and existence
of caring in the treatment interaction

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Abstract

The utilization of complementary and alternative medicine (CAM) therapies is increasing and the users frequently report satisfaction and benefits from the treatments although scientific support for these self-reported experienced benefits are largely lacking. This thesis analyses users' experiences of Rosen Method Bodywork (RMB), a relatively unevaluated touch based CAM therapy method. The theory behind RMB suggests that bodily problems such as muscle tension are partly due to unresolved emotional problems or suppressed traumatic experiences. The treatment includes gentle touching on tense muscles with the purpose to detect and make the client aware of the tenseness. This project consists of two related studies and is innovative in studying a CAM therapy method from a nursing theoretical perspective. The study design is qualitative, exploratory and descriptive. The overall aim is to contribute to the understanding of possible health promoting aspects of RMB. The specific aims are; to describe why clients consult RMB, and what kind of benefits they perceive (study I), and; to explore if caring is a part of the interpersonal interaction in the treatments by analysing RMB clients experiences from a nursing theoretical framework (study II). The data was collected from a survey of 53 conveniently sampled Swedish RMB clients (study I) and through semi-structured interviews with 11 clients with both positive and negative experiences from RMB (study II). The data were analysed by content analysis and descriptive statistics in study I and the interviews were content analysed by using a nursing theory, the SAUC Care Model, as the theoretical framework for the analysis. The results show that RMB is consulted for three main reasons; that the experienced benefits include psychological and physiological health improvements but also a new awareness about the body, personal growth, and self-initiated life-changes. The results also indicate that treatments where participants reported satisfaction seem to include supportive caring as an integrated part in the interpersonal interaction. In contrast, the participants who were dissatisfied with the treatment described opposite experiences including lack of proper caring and failure to meet the client's needs. This findings add to previous knowledge, in showing that caring is an integrated and essential contextual component in RMB treatments. Based on the results a theoretical model of the components that might contribute to treatment satisfaction and experienced benefits is discussed. However, it is important to note the study limitations and that these qualitative studies were not designed to inform any conclusions about the efficacy of RMB.

Keywords: Rosen Method Bodywork; Complementary and Alternative Medicine; Benefits; Client satisfaction; Caring; Interpersonal interaction

List of publications

This licentiate thesis is based on following two papers.

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List of abbreviations

| Abbreviation | Definition |
|---------------------|---|
| CAM | Complementary and alternative medicine |
| CHC | Conventional health care |
| RMB | Rosen Method Bodywork |
| NCCAM | The National Centre of Complementary and Alternative Medicine |
| EBM | Evidence based medicine |
| EBN | Evidence based nursing |
| SAUC Care Model | <i>Sympathy (S), Acceptance (A), Understanding (U), and Competence (C) Care Model</i> |

1. Preface

The existence of Complementary and Alternative medicine (CAM) is not a new phenomenon. When I grew up in a little village on the Finnish countryside during the 1960s home-prepared herbal remedies, massage, Finnish copping (carried out in Sauna) provided by laymen were some of the health promoting activities the people in the neighbourhood often used as first option to relieve bodily, but probably even embodied mental health problems. I suppose the utilization of these traditional therapies sometimes relieved the illness, sometimes led to harm and sometimes did not work at all. Why or when the treatments worked, or did not work, were not scientifically known. The people did not bother about that. It was enough to get some relieve and they often expressed satisfaction with the treatments. If the layman provided therapy that did not work they chose in a pragmatic way to consult the provincial physician or district nurse but did not always inform them about their use of these unofficial treatments. When I became registered nurse in Sweden in the mid 1980s I again met the same utilization of these kinds of therapies among the people. I learned that the therapies had a name, Complementary and Alternative Medicine (CAM). Even now the CAM users I met were often satisfied with the treatments and in the same way as my previous experiences they seldom informed the conventional health care personnel about the use. Some years ago I got an opportunity to study Rosen Method Bodywork (RMB) which almost was a “*tabula rasa*” concerning scientific documentation. A natural point of departure for me was to start asking the therapy users, about their experiences with the therapy. Because I am registered nurse and teacher in psychiatric nursing my pre-understanding is based on a nursing perspective. In addition to the data collection, I have observed and carried out informal discussion with many RMB therapists and clients in order to understand the context of RMB. During the project, I met the RMB founder, Marion Rosen and she showed me very pragmatically (“*hands-on*”) something about the concept of “*presence*” in the therapist-client interaction and how to “*listen*” to a client with “*the hands*”. These encounters and observations raised my curiosity about how the clients experience the interaction with the therapist and what it means for the experienced outcome and satisfaction with the treatment.

2. Background

The interest in complementary and alternative medicine (CAM) has grown rapidly among populations in different high-income countries during the last two-three decades (Bodeker and Kronenberg, 2002; Harris, Finlay, Cook, Thomas and Hood, 2003; Hanssen, Grimsgaard, Launso, Fonnebo, Falkenberg, and Rasmussen, 2005; Barnes, Bloom and Nahin, 2008). The CAM utilization pattern can be seen in Sweden (Davidsson, Eriksson, and Östby, 1986; Eriksson, Davidsson and Davidsson, 1990; Eklöf, 1999; Nilsson, Trehn, and Asplund, 2001). But despite the increased utilization many CAM therapy methods are still relatively unevaluated. Therefore, for the sake of patient safety, it is important to increase the knowledge about different CAM therapies. This is one of the main motives behind this licentiate thesis. The CAM therapy method, studied in this project, Rosen Method Bodywork (RMB) is a popular therapy method that lacks scientific documentation and informal reports indicate that clients are satisfied with the treatments or experience improvements. Therefore, there is a need to obtain initial information about why people turn to this therapy method, what kind of benefits they experience, and what in the treatment might contribute to the experienced treatment satisfaction.

2.1 The Swedish health care

The services that provide the population with health care to cure or prevent illness, to improve wellness and life-quality are offered within several different systems in Sweden. The main (formal) health care system is conventional health care (CHC). Besides CHC complementary and alternative medicine (CAM) therapy methods are available in a parallel health-promoting system (market). The present definition of the concepts “complementary” and “alternative” medicine is according to the National Center of Complementary and Alternative Medicine (NCCAM) in the USA:

“The term “*Complementary*” generally refers to using a non-mainstream approach *together* with conventional medicine. The term “*Alternative*” refers to using a non-mainstream approach *in place of* conventional medicine” (www.nccam.nih.gov/health/whatiscom#definingcam, date: 2013-09-17).

CAM therapies are generally not integrated within the Swedish CHC service but many patients use them simultaneously to CHC service. This kind of use is similar in many other countries (Fonnebo and Launsö 2009). The Swedish CHC service is compensated by the Swedish Social Secure Health Care Insurance. This will guarantee that the health care service is available to the whole population regardless of income or social class. CAM therapies are not included in the insurance and the users must pay the entire therapy cost themselves. Some authors (Hawk, Nde-

tan and Evans 2012) claim that the increased use of CAM therapies is important because it plays a significant role in improving public health. Therefore, the authors state that co-operation should be essential between CHC providers and CAM therapists, and they argue that there is a need to engage CAM therapists in health promotion counseling. The role of CAM for public health is probably the same in Sweden. But the co-operation between CAM therapists and CHC personnel is still limited and the CHC personnel's knowledge about CAM is scarce as well according to Bjerså, Victorin-Stener and Olsèn-Fagevik (2012). This is problematic for patients who want to utilize CAM therapies as a complement to CHC treatments or have a need for professional advice about the therapies. The common simultaneous use is also problematic for CHC personnel because they probably lack knowledge about adverse therapy interactions and for this reason cannot assess risks properly.

One possible obstacle to providing professional information is the formulation in the “*Patient safety*” Act (Socialdepartementet SFS 2010:659) which regulates the Swedish CHC personnel's responsibilities, their professional competence and the treatments provided by CHC. The act states that treatments within CHC must be based on *experiential knowledge* and *scientific evidence*. The concept *scientific evidence* is defined as treatments that are supported by theoretical knowledge and/or the best available results of high-quality research. The concept *experiential knowledge* is intended to describe clinical treatments that are commonly accepted and practiced within CHC. Moreover, the same act defines CHC personnel who have certification and/or a protected health care occupation title (for example; physician, nurse, psychologist, and physiotherapist). This means that the specific title can be used only by persons with an educational and/or practical background approved by The Swedish Social and Health Welfare Board. Certified personnel must uphold their responsibilities in accordance with “*science and experiential knowledge*” inside and outside of their professional work. This means that they are in general prohibited from providing CAM therapies and cannot recommend such therapies or inform patients about their advantages and disadvantages if the therapies lack extensive scientific evaluation or the therapy is not practiced within CHC. However, this is changing and there is today “grey zones” between different legislations that regulate the CHC services and patient's rights. In case the patient initiates the request for a specific CAM therapy or when CHC service cannot provide a treatment to the patient, and there are no risks that are associated with the CAM therapy, certified CHC personnel can provide the therapy if they have adequate skills.

2.2 Research on CAM

The early research on CAM has been departed in general from a bio-medical perspective, which focuses on aspects of cure, the therapy effects and bio-medical explanations of the therapy outcomes. This research has often included a paradox - studies show ambiguous or ineffective results (Carpenter and Neal, 2005; Stevinson and Ernst, 2001) whereas many anecdotal reports from the CAM therapy users that often indicate improvements and satisfaction (Stewart, Weeks and Bent, 2001; Molassiotis et al. 2006; Hök, 2009; Arman, Hammarqvist and Kullberg, 2010). An explanation for the paradox may be that the previous research in many cases has ignored the importance of other aspects, such as, for example interpersonal interaction and social support, for the user's satisfaction or experienced benefits. As a consequence, knowledge about other components or mechanisms that might contribute to users' satisfaction or benefits is still relatively unevaluated. For this reason several leading authors in this field (see e.g. Fönnebo et.al 2007; Verhoef, Vanderheyden and Fönnebo, 2008; Verhoef and Leis, 2008) have claimed that there is a need for new theoretical or methodological perspectives on CAM and to develop new research strategies to evaluate CAM therapies.

2.3 The history of Rosen Method Bodywork

The founder of the therapy method studied in this project is physiotherapist Marion Rosen (1914-2012). The treatment is based on her empirical work and observations as a physiotherapist for more than 50 years. According to Mayland (1995) Rosen was influenced by the school of psychoanalysis in her youth. Before the Second World War and before becoming a physiotherapist she was introduced to the dancer and masseuse Lucy Heyer and her husband who was a psychoanalyst. The Heyer couple socialized with people from the early psychoanalytic school in Vienna and had started to combine psychoanalysis with body massage, breathing exercises and conversation. Marion Rosen worked for two years as a practitioner with the Heyers and during this time she was introduced to the idea of a body - mind connection. When the political climate changed before the Second World War Rosen was forced to leave Germany and moved to Sweden where she became a physiotherapist. After graduation she moved to the United States. After some years of work in local hospitals she started a private practice of physiotherapy. Influenced by the psychoanalytic school which focuses on unconscious processes she noticed that patients with psychosomatic disorder, bodily tensions or psychological or physiological traumatic experiences often started to talk about the incidents while she was touching their bodies. She noticed also that if the patients were treated with a combination of bodily touch and conversation their health improved faster than without the opportunity to converse. She included both touch and

conversation into her treatments and started to teach the therapy method, which she called RMB, to apprentices. She did not put her experiences extensively in print. Knowledge about RMB was instead passed on to her apprentices through practical work and workshops where she demonstrated RMB and by this formed the therapist's training program.

RMB has a connection to Sweden and the other Nordic countries. Marion Rosen has co-operated with Axelssons Gymnastiska Institut (AGI) in Stockholm and taught the therapy to Swedish therapists from the early 1980s until she died in 2012. There are no reliable sources on how widespread RMB use is among the Swedish population today but in one study (Stockholms läns landsting [Stockholm County Council], 2001) RMB was one among the ten most recognized CAM therapies in the Swedish capital area. It is possible that Rosen's co-operation with AGI in Stockholm is the reason for the reported high frequency in this region.

Rosen Method Bodywork is considered as a CAM therapy method in Sweden and has been classified as "body massage that is indented to create muscle relaxation and release of emotions" by Swedish Government Offices (SoU 1989:62). Several international definitions of CAM therapies could be used for classifying RMB. The National Center for Complementary and Alternative Medicine in the United States (www.nccam.nih.gov/health, date: 2013-02-15) has categorized CAM therapies. RMB is not mentioned in their classification but it could be placed in the group "Manipulative and Body Based Practice" because it is based on body touching with the purpose of dissolving muscle tensions. Tataryn (2002) has classified CAM therapies by dividing them into four hierarchically depended groups. RMB is not mentioned here but according to this author's definition it might be placed within the "body-mind paradigm" that describes dualistic therapies where the point of departure is that the mind and the physical body are intimately linked units. In this group, this dependability of the method is important to consider in illness and recovery processes.

2.4 The principles and the treatment

RMB treatments are based on conceptual and ideological viewpoints stated in some written documents (see Wooten, 1994; Mayland, 2001; Rosen, 2003) but also on Rosen's and RMB therapists' therapy experiences from several decades of therapy practices. RMB focuses on bodily problems (muscle tension) that are supposed to reflect (store) unresolved emotional problems, suppressed traumatic experiences or excessive social demands. Rosen (2003) means that the body stores as muscle tension the traumatic or significant experiences the client has experienced.

A treatment lasts approximately one hour and starts with a short conversation between client and therapist during which the therapist observes client's voice, way of moving, posture and breathing pattern. During the treatment the client lies on a massage table in her or his underwear covered by blankets. The therapist examines the client's body looking for tensions and irregularities in the muscles and observes the breathing pattern including diaphragm movements. Through these observations the therapist obtains a first picture of the client's problems. The treatment includes touching tense muscles. The touching is gentle and carried out with warm hand. The purpose of the touch is to "meet up" the muscle tension without manipulation of the muscle tissues. The touching and relaxation that follow the touching are supposed to open up the emotional sphere and make it possible for the client to re-experience emotions or memories from the previous traumatic incidences that lie behind the tension and connect them to the bodily condition or pain. The re-experienced emotions are the key to the recovery process according to Rosen (2003: pp, 14-15):

"Body tensions are expressions of our emotional attitudes. Rosen Method opens up patients to their unconscious directly accessed through the body. Other bodywork disciplines stay on the physical level. Rosen Method goes through the physical level to the emotional level. Rosen Method helps patients experience the felt meaning of previous emotional traumas. It can catalyse the transformation in behaviour that is needed to resolve them."

The breathing pattern and breast movements are important to observe according to Rosen (2003). They give the therapist essential information about whether the client responds to the touch and what processes are going-on in the client's mind. Moreover, during the treatment the therapist observes client's emotional and bodily responses and makes her or him aware of this through verbal exchange or by adjusting the bodily touch.

The written text from Rosen considers an extended view of what is needed for the healing processes. Laine (2007) who analysed the texts by Rosen (2003) found that even though RMB focuses on the body and bodily processes, emotional, social and spiritual aspects are contributing aspects that play an essential role in the recovery. Furthermore, Rosen (2003) believes that clients have their own capacity to master and solve their problems if they become aware of the psychological (emotional) hindrances behind the bodily tension. Her view on human beings' capacity can be understood as humanistic because she expresses clearly her belief in peoples' inherent competence. Moreover, Rosen (2003) discusses therapist's responsibility. She describes the therapist's responsibility "*assist the client to be conscious about the body tension and sup-*

porting whatever decisions the client make due to the experiences and insights they obtain in the therapy” (Rosen, 2003: pp, 14).

Furthermore, she means that it is important for the therapist to use all senses during the touching to be conscious about client’s state of mood and physical and psychological condition but she leaves the responsibility to work out the processes that occur during the treatment to the client and she compares therapist’s responsibilities with those of a midwife:

“Rosen Method Bodywork practitioners act as midwives to bring out what is within patients. Practitioners are not doing the work, patients are (Rosen, 2003: pp, 13).

2.5 RMB therapists’ training

The largest CAM therapist association in Sweden is The Swedish Association of Body Therapists (see: www.kroppsterapeuterna.se/rosenmetoden.html). The Swedish Rosen Therapist Member Association is organized within this association. Training recommendations for CAM therapists in Sweden are handled voluntarily by the Member Associations. They also register the therapists whose training meet up the recommendations. Rosen therapists’ training, ethical codes and therapy principles, however, are handled by the Rosen Institute in the United States (www.rosenmethod.org, date: 2013-06-01), the head organization for RMB development and training. Today there are at least 16 RMB centres in 14 countries that offer RMB workshops and training programs. Important in all training is to obtain increased self-knowledge and sensitivity to meet the client’s needs. The Rosen Institute in the United States presents this aspect as follows:

Rosen Method students are taught how to facilitate this process through learning to know themselves. This learning is a profound process that teaches self-awareness and the art and skill of listening touch, heart-felt presence, and the use of words that respond rather than fix or explain. Through this learning and intention, an environment of trust, caring and non-judgment is created. (The Rosen institute’s homepage: http://www.rmpa.net/html/training_pop.html. Date: 2013-08-25).

The centres in the different countries follow the recommendations from the Rosen Institute concerning the training program. In Sweden the program is carried out by Axelsons Gymnastiska Institut (AGI), Stockholm. The program (see www.rosenmetoden.se/Utbildning/Grundutbildning.html, date 2013-08-25) contains two steps. The first step includes a three day introduction course, seven intensive courses on seven days each and two weekend courses. Furthermore, this step includes demonstrations and supervision from certified teachers, theoretical studies in Rosen anatomy and in management skills. The first

step should be carried out during a minimum period of three years. Once the practitioner has proper theoretical skills she or he is allowed to start to practice RMB with own clients as an apprentice. During this period she or he have to practice 350 hours of client sessions with at least 45 hours tutoring from certified therapists, and must receive at least 25 of her or his own treatments. An additional important part of the training and learning process is “sharing”. A group of practitioners discuss with experienced therapists what they have experienced during the own treatments and client treatments. When the practitioner has passed all recommended levels the Rosen Institute in the United States will certify her or him.

2.6 Potential treatment risks

The increased use of CAM therapies raises questions about risks, harm and public safety. CAM therapists` training is not controlled by any authority in the same way as the CHC personnel`s. To some extent, RMB therapists` practice is regulated in Sweden by the “*Patient safety*” Act (Socialdepartementet SFS 2010:659), the same act that regulates CHC personnel`s working conditions. The act prohibits non-certified providers e.g. CAM therapists from using specific methods such as radiology and anaesthesia, or treating contagious diseases or diabetes, women who are pregnant or at delivery, cancer and other malignant tumours. Furthermore, CAM therapists are prohibited from treating children under the age of eight. No other laws or legislations regulate or control CAM therapists` practice in Sweden but the increased utilization has raised questions about CAM users` safety, and a Governmental investigation (SoU 2004:123) recommends a voluntary registering of CAM therapists.

The Swedish Rosen Therapist Association advertises RMB in the following way on their web page (<http://www.kroppsterapeuterna.se/rosenmetoden.html>: Date 2013-05-25): “Rosen Method is a gentle and empathic touch which has a purpose to solve bodily muscle tension. The treatment assists to deep relaxation and increased body awareness”. According to the same web page, “RMB can be useful for the following health problems: physical pain, muscle spasms or posture problems, insomnia or fatigue, relaxation problems due to stressful living, a wish to obtain greater body awareness, better well-being and increased self-awareness or for a physical or emotional change”.

Ernst (2008) states that CAM therapists are generally well trained and the treatments are safe. But the author outlines some potential risks that are connected in general to CAM treatments and CAM users` safety. One potential risk is an unqualified therapist who is not skilled enough to carry out the treatment, or ignores contraindications for the therapy. Moreover, if a CAM therapy

is the client's first choice in a severe illness there is a risk that it might contribute to delayed diagnosis of an illnesses where early diagnosis and bio-medical (CHC) treatments are important. An additional risk is the client's decision to terminate an effective conventional health care treatment and instead turn to CAM therapy. One more is economic; if the chosen CAM therapy lacks efficacy; the client has wasted her or his money. If the CAM therapy is used at the same time as CHC treatments or pharmaceuticals the utilization might contribute to adverse effects or unwanted interactions.

The official frequency of harmed clients from RMB treatments is unknown. There are no found formal reports on adverse treatment reactions, injuries or lawsuits. Certified RMB therapists are well trained but their training does not include extensive studies in psychiatry or psychology so far. The gentle touching in RMB includes a close body contact that stimulates different receptors in skin and muscle structure but the touching does not manipulate muscle tissues as for example, ordinary (Swedish) massage does. It almost certainly does not lead to skin, muscle or nerve tissue damage if the client is healthy in these areas. The touching often contributes to deep relaxation. During the treatment RMB clients seem to re-experience memories or emotions connected to previous traumas but they also experience other sensory sensations. In this project several participants in study I and II (but not all) described release of difficult emotions and memories, furthermore, a couple of them described sensations as smell, colours, muscle vibration and shaking as responses to the treatment. Several authors (Ehlers and Clark, 2000; Lindgren, 2012) who discuss massage techniques that apply gentle touch and confirm the re-experiences of emotions explaining that these therapy methods could diminish the cognitive control in the brain allowing feelings to rise and become conscious. Therefore, a potential risk connected to RMB treatment might be psychological rather than physiological. A possible risk is if the client has experienced severe traumatic incidents in the past and has not received adequate therapeutic treatment the therapy might activate post traumatic stress disorder (PTSD). Another potential risk is if the client suffers from severe mental illness where cognitive control is important, or is psychologically fragile; in such cases the treatments might contribute to a worsened psychological condition or mental disorder.

For the sake of preventing harm The Rosen Institute and The Swedish Rosen Therapist Association advise therapists to follow some recommendation before accepting a new client. The recommendation's purpose is to prevent harm but it is not known how and in what way RMB therapists apply the recommendations whether they fulfil its purpose. They are recommended to interview every new client about the client's overall health status and intake of pharmaceuticals.

They also are recommended to rejecting clients who abuse drugs or alcohol until they have been drug free for at least one year. The same recommendation concerns client who suffers from severe mental illness, has been hospitalized due to severe mental disorder, is prescribed psychotropic pharmaceuticals or is suicidal. The same recommendation concerns client who has recently lost a loved or significant person.

3. The study rationale and aims

The overall aim is to contribute to the understanding of possible health promoting processes in RMB by exploring the therapy users' reasons for consulting the therapy method, by them experienced benefits, but also the interpersonal interaction in the treatment. The study specific aims are:

Study I

To describe; 1) why clients consult RMB and; 2) what kind of help or benefit (if any) the clients perceive.

Study II

To explore if caring is a part of the interpersonal interaction in RMB treatments by analysing the RMB clients' experiences from a nursing theoretical framework.

The implications of the results from the two studies are discussed in a theoretical model concerning components that might contribute to the treatment satisfaction/dissatisfaction and experienced benefits.

4. Material and methods

RMB is an empirically practiced but scientifically relatively unevaluated therapy method and little is known about the population who use the treatments. It has been practiced since the 1980s in Sweden but RMB therapists have no formal obligations to register their clients or to document their work or the therapy outcomes. When this project started scientific documentation about RMB were almost non-existent concerning the therapy's efficacy, effects, risks, failed treatments, for what reasons they failed or whether the users had been harmed by the treatments. The sources that describe the therapy were a few texts written by practitioners and anecdotal reports.

The Medical Research Council (MRC) (2006) has stated recommendations for how an unknown or complex therapy method (or clinical practice) shall be evaluated. The recommendations concern CHC treatments, but the same interest and demands are valid for CAM therapy methods. According to the MRC, the evaluation should start, before defining independent/dependent variables for efficacy testing, by using different research methods and theoretical perspectives to portray aspects that may play a role in the therapy situation. Furthermore, the MRCs recommendations point out that the experiences from the users and the clinicians who are familiar with the therapy must be included in the analysis when exploring potential explanations that may play a role for future outcome studies (for example clinical trials or randomised, controlled trials (RCT) type of studies). The initial research therefore requires both quantitative and qualitative strategies to obtain empirical data from users who have primary experience with the therapy. Moreover, in the field of health promoting methods as medicine, psychology or nursing there is an increased interest in scientific evidence, evidence-based medicine (EBM) or evidence-based nursing (EBN). The reason for this is that many treatments and/or interventions within CHC are not based on scientific knowledge but on experiential knowledge without any scientific evaluation of the efficacy, effects or risks (Peile, 2004). The results of scientific studies or investigations builds the groundwork for evidence-based practice (EBP) which means that CHC providers like physicians and nurses should rate different treatments, therapy methods or interventions based on their scientific results and make decisions concerning care or treatments by identifying evidence that speak for the best practice (Polit and Beck, 2010). The goal of the decision making is to eliminate unsafe, risky or ineffective methods and choose methods that have the best outcomes. Peile (2004) has similar recommendations to those of the MRC when discussing the research design of EBP. According to the author a very first stage in a scientific process of exploring new (health promoting) methods is to ask the users for their experiences. The same approach is reasonable when the population is unknown. A first methodological design concerning a new

therapy method is descriptive or exploratory including qualitative methods such as observation, interviews, patients` self-reports and questionnaires (Brink & Wood, 1998; Peile, 2004). According to these authors, data obtained through such methods are important in building a record of what the therapy method can and cannot do under a variety of circumstances. The results can also build a base for new hypothesis in subsequent studies, or contribute to methodological or theoretical progress. Therefore, the RMB users` experiences with the benefits and therapy processes can be considered to be today`s best testimony of the therapy. This project has applied these recommendations and chosen a qualitative, exploratory and descriptive design. The studies (paper I and II) are based on the RMB user`s experiences.

Table 1: Overview of the title, study questions and methodology

| | Study I | Study II |
|-------------------------------|---|---|
| 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 analysing the RMB clients` experiences from a nursing theoretical framework. |
| Design | Qualitative, exploratory and descriptive | Qualitative, exploratory and descriptive |
| Participants | 45 female and eight male Swedish RMB clients | 7female and 4 male Swedish RMB clients |
| Data collection method | Survey by using a study specific questionnaire | Structured introductory questions from the questionnaire in study I. Semi-structured interviews departing from four wide pre-formulated questions |
| Data analysis | Descriptive statistics and latent and manifest content analysis | Deductive content analysis of the participants` experiences from the nursing theoretical framework, SAUC Care Model |

4.1 The sample and drop-out

The inclusion criteria were any experience of RMB treatment, whether *positive* or *negative*. The best way to get in contact with the clients was considered to be through the RMB therapists. As the variation of the therapists` background were assessed indirectly to increase the variation of the clients` experiences from the therapy the selection of therapists was based on broad criterias such as age, educational level, localization of practice, and length of experience as RMB therapist. Eighteen certified therapists who fulfilled the variation were selected from the Swedish Rosen Therapist Member Association list (240 members year 2006). They were contacted by telephone and asked to assist in the research project, and all but one accepted. The therapists` task was to provide their clients with written information about the study and to refer the names

and phone numbers of interested clients to the researchers. The total number of RMB clients from therapists was 69, from three different regions in Sweden. The clients were contacted per telephone and asked to participate in either study I (survey) or the later study II (interviews). Sixty preferred participation in study I (survey) and nine in study II (interviews). Two of the participants in study I declined participation before they were sent the questionnaire. The reported reason for the drop out was lack of time. The remaining 58 participants were sent the questionnaire and 53 returned it with complete answers. One participant returned an empty questionnaire. The four participants that did not complete questionnaire were sent a remainder but without response. After that they were contacted by telephone and this control indicated that they have had negative experiences from RMB or had not experienced benefits at all. In study II two of the nine participants had both positive and negative experiences. The lack of participants with negative or adverse experiences led to a second recruitment of two additional participants to study II through personal contacts (e.g. recommendation from other participants), hence representing clients with negative experiences from RMB (see Figure 1).

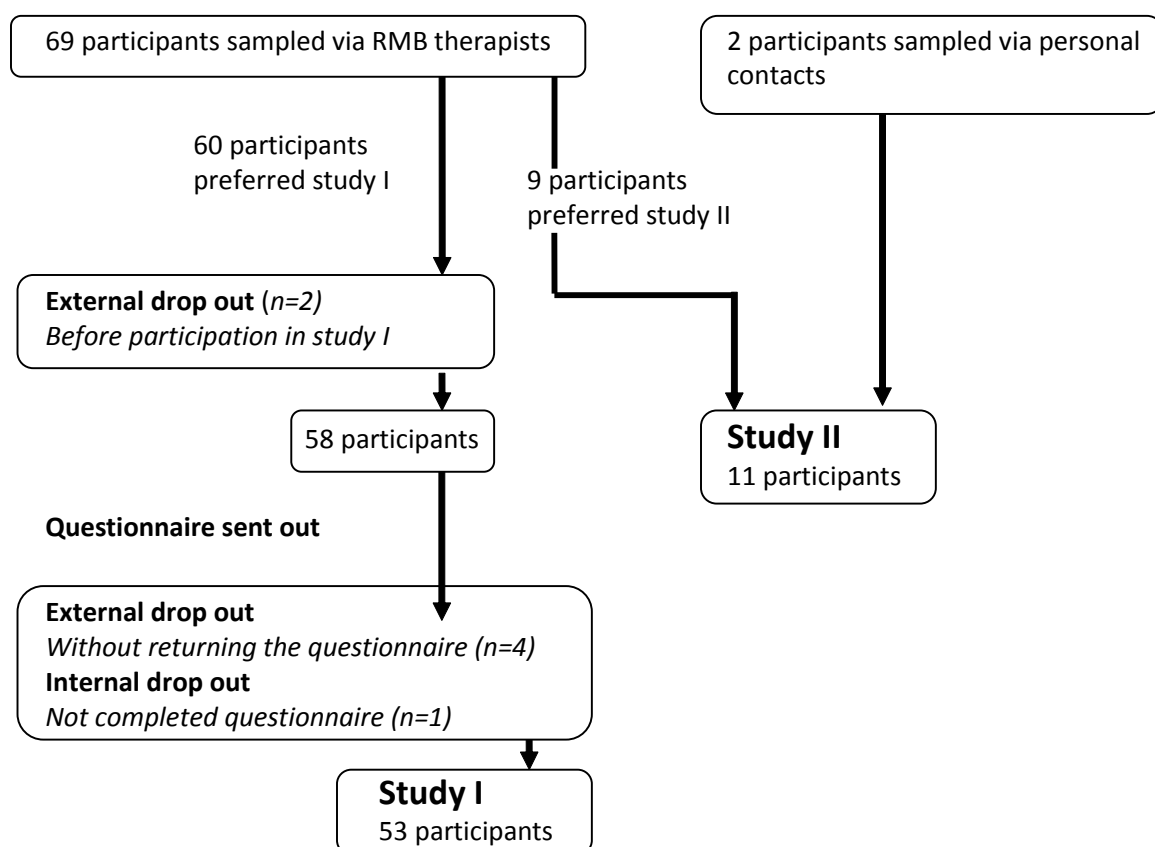


Figure 1: The sampling process and drop out

4.2 Method – Study I

In explorative studies where the information about the investigated subject is scarce a survey can be a first methodological option beside interviews (Brink & Wood, 1998; Polit & Beck, 2010). When this project was initiated there was no validated questionnaire available from previous research on RMB that focused on the study questions. For this reason, study-specific questionnaire was created based on questions from two questionnaires used as models. Beside the study questions variables covering the participants` social-demographic background, their CAM, RMB and CHC utilization pattern, confidence in CAM therapies in general, perceived everyday difficulties due to the reason that brought the participants to RMB including sick leave due to the reason, rating of expectations on RMB, rating of benefits from RMB and from CHC service (if used simultaneously); and descriptions of experienced benefits and reactions from the RMB treatments were assessed as informative (see Table 2).

Table 2: Variables and response alternatives in the study specific questionnaire

| Data of interest | Variables | Response alternatives |
|--|--|---|
| Socio-demographic data | Age | Open alternative |
| | Sex | Closed question with pre-formulated alternatives |
| | Educational level | Closed question with pre-formulated alternatives |
| | Social status | Closed question with pre-formulated alternatives |
| | Occupation | Open alternative |
| Information about CAM and RMB utilization, sick leave, CHC and RMB utilization | CAM utilization in general | Closed question with pre-formulated alternatives and one open alternative |
| | Rating of the expectations on CAM in general | Non-metric 7-point scale |
| | Sources of information about RMB | Closed question with pre-formulated alternatives and one open alternative |
| | Reason for RMB utilization | Closed questions with pre-formulated alternatives and one open alternative |
| | Rating of the confidence in CAM therapies in general | Non-metric 7-point scale |
| | Rating of the expectations on RMB | Non-metric 7-point scale |
| | Rating of the perceived everyday difficulties due to the reason (-s) that brought the participant to RMB | Non-metric 7-point scale |
| | Sick leave due to the same reason as for RMB utilization: | Dichotomous “Yes/no” alternative followed by several pre-formulated alternatives and one open alternative |

| | | |
|-------------------------------------|---|--|
| | Simultaneously CHC treatment due to the same reason that brought the participant to RMB. If yes: please state the profession of the caregiver | Dichotomous “Yes/no” alternative followed by pre-formulated alternatives describing different CHC professionals including one open alternative |
| | Number of RMB treatments | Open response alternative |
| Benefits from RMB | Rating of the perceived benefits from RMB | Non-metric 7-point scale |
| | Experiences of benefits | Open response alternative |
| Reactions related to RMB treatments | Question asking reactions related to the treatments | Dichotomous yes/no alternative |
| | If Yes: Experiences of reactions | Open response alternative to describe the reactions |
| Additional information about RMB | Possibility to give additional information | Open response alternative |

The first questionnaire (Sundberg et. al., 2010) was developed to evaluate integrative medicine provision in primary care. The questions included socio-demographic variables such as sex, age, educational level, occupation and sick leave. The second questionnaire was constructed to evaluate patient experiences of receiving Swedish Anthroposophic cancer care compared to CHC cancer care (Hamrin et. al. 1996). The latter questionnaire was pre-tested, validated and used in a five-year longitudinal project that resulted in several published articles (see Carlsson, Arman Backman, and Hamrin, 2001, 2005; Carlsson, Arman, Backman, Flatters, Hatschek, and Hamrin 2004, 2006). From the latter questionnaire the response alternatives on a non-metric 7-point scale were used as model for the questions concerning rating of expectations on CAM in general, confidence in CAM therapies in general, expectations on RMB, perceived everyday problems due to the reason that brought the participant to RMB and perceived benefits from RMB (see Table 3).

Table 3: One example of questions constructed from the original questionnaire by Hamrin et.al (1996). Permission given by Professor Marianne Carlsson, University of Uppsala

| Two examples of modified questions in the study specific questionnaire | One example of original questions by Hamrin et. al (1996) |
|--|--|
| <p>16. In what degree has Rosen Method benefitted (helped) You?</p> <p><input type="checkbox"/> In very high degree</p> <p><input type="checkbox"/> In high degree</p> <p><input type="checkbox"/> In fairly high degree</p> <p><input type="checkbox"/> In moderate degree</p> <p><input type="checkbox"/> In some degree</p> <p><input type="checkbox"/> Almost none degree</p> <p><input type="checkbox"/> Not at all</p> | <p>X. In what degree you have been bothered by:</p> <p>1. <i>Tiredness</i>?</p> <p><input type="checkbox"/> In a very high degree</p> <p><input type="checkbox"/> In a high degree</p> <p><input type="checkbox"/> In a fairly high degree</p> <p><input type="checkbox"/> In a moderate degree</p> <p><input type="checkbox"/> In some degree</p> <p><input type="checkbox"/> Almost none degree</p> <p><input type="checkbox"/> Not at all</p> |

The study specific questionnaire was tested for linguistic comprehension on ten people in different ages and educational backgrounds, and revised in accordance with their viewpoints.

4.3 The analysis – Study I

Data from questions covering socio-demographic variables, motives, attitudes, and assessments from the therapy were analysed by descriptive statistic. The written answers on open questions concerning reasons, experienced benefits and experiences from the treatments were rich and encompassed in total 7078 words. This data were analysed by qualitative content analysis which is a systematic method for identification of different variables in a written text (Patton 2002). Text units that included reasons for the therapy use were separated from the text, grouped in sub-categories expressing similar reasons and finally organized within three main categories of reasons. The same procedure was applied concerning experienced benefits, ending up with five main categories of benefits. A more detailed description of the analysis and coding process is found in the article from study I.

4.4 Method – Study II

Semi-structured interviews are a suitable method in explorative studies (Brink and Wood, 1998), and were assessed to be a valuable complement to the survey in study I. The participants decided on the place and time for the interviews. Most of them preferred to carry out the interviews in their own home or workplace. The interviews started with structured introductory questions (1-16) from the study specific questionnaire in study I. After that the main interview were carried out around four wide thematic issues; (1) reasons for consulting RMB, (2) the therapy process as

it was experienced, (3) reactions and benefits from the therapy and, (4) perceived risks or harm. During the interviews the participants were encouraged to elaborate on issue described vaguely or in contradictive manner until a clear picture of the experience was reached. Some examples on such encouraging questions were: “*Can you tell me more about what happened during the treatments?* Or, “*You said previously that you have benefitted from RMB, do you want to tell me more about what ways you have benefitted*” Or, “*Can you give me an example*”.

4.4.1 The theoretical perspective in study II

Nursing discipline defines, according to Fawcett (2005) the patient as an active, bio-psycho-social-spiritual human being, and 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 patient’s symptom, disease or illness (Montgomery Dossey et.al. 2005). This thesis uses the concept caring in study II. The concept and its significance are discussed intensively within the nursing discipline. According to Meleis (2007) who summarizes the concept, caring is a fundamental essence of nursing as it preserves the dignity of others and, therefore, caring is the base of all nursing interventions, assessments and activities. Another important aspect in nursing is according to a nursing theorist, Peplay (1991), to create a trustful interpersonal relation which she considers to have therapeutical characteristics. She considers the interpersonal relation as the base in all caring activities the nurse provides. One conclusion is that interpersonal relation is significant in a patient-nurse interaction, and that caring is an integrated part in this relation.

The interpersonal interaction between client - caregiver is the point of departure in study II. RMB therapists are not professional nurses but their clients’ experiences of interpersonal interaction and caring are possible to explore and describe by using a nursing theoretical framework to do so. The theoretical framework that forms the structure in the analysis is the SAUC Care Model (SAUCCM) (Gustafsson et al. 2010:1). SAUC stands for *Sympathy* (S), *Acceptance* (A), *Understanding* (U), and *Competence* (C). The SAUCCM is a slightly modified version of the original theory, SAUC Model (Gustafsson, 2004).

The theory was developed by Professor Barbro Gustafsson, who herself suffered from a chronic illness, in collaboration with the Finnish Professor Ingemar Pörn. Their intention was to provide a deeper understanding of the problems that many patients who suffer from illness often experienced within CHC service - namely feeling aggrieved and objectified, not understood and supported as a subject (a person) (Gustafsson and Pörn, 1994). The SAUC Model is grounded in knowledge from empirical studies and theoretical knowledge from existential philosophy, action

theory and confirmatory theory illustrating important aspects of human wellbeing, support, confirmation and health promoting factors (Gustafsson, 2000; 2002; 2007). The Model forms a basis for nursing actions concerning how the nurse shall interact in care situations in order to help patients dare to face the challenges of what an illness means for their life situation, and to obtain strategies to act in a way which positively strengthen the self-assessment, own control and power. The process is supposed to increase the patient's empowerment and wellbeing.

The theory focuses on support, confirmation and guidance in a patient - nurse relation. SAUCCM has several interrelated concepts that form the theoretical basis for the original and revised theory. The main concepts are "*Human view*", "*Health*", "*Environment*" and "*Nursing*". In the human view a person is described as an active and responsible person who acts in a goal-orientated way. Her life includes activities that follow a personal *life-plan*. The goal-orientated actions are influenced by her life-plan (goals, desires and projects), repertoire (evaluation and decision making abilities, competences), internal environment (e.g. emotions, motives to act, self-assessment, experiences of the physical body and moral view), and external environment (e.g. society context and its rules, significant people in her life). Her life-plan is influenced by her "*self-relation*" (how she perceives herself; her actual-self) and the person she wants to be (ideal-self). The balance between those two poles is essential for the competence to manage challenges (e.g. an illness) in a way that make it possible to live a good life. A discrepancy between the poles affects the self-assessment negatively causing e.g. lack of courage to realize important life-goals, or lead to self-deception. Another concept is *motivation*. It influences all personal actions. Motivation is linked to self-relation as the choice to act depends on the self perception. The concept *confirmation* can be described as verbal and/or non-verbal positive or negative reinforcement, especially from significant people. It is important for the emotional and cognitive development, and has an important impact on feelings of security and self-worth as a human being. Therefore, the art of confirmation (positive or negative) influences the self-relation. The concept *health* is understood as personal abilities (*repertoires*) to realize important life-goals. *Good health* is understood as a balance between personal goals, environmental factors and competence to act in an adequate and desired way. Good health can be evaluated as expressions of *wellbeing* (related to positive emotions), *happiness* (related to personal relations) and *sense of life-meaning* (related to important personal goals and life-plan). The last concept is *nursing*, which the theory clarifies as supportive and confirmatory guiding with the purpose to strengthen the cared person's self-relation. The goal of nursing is strengthened self-relation that is seen as a necessary component to reach an enhanced self-power and self-control when facing challenges

(e.g. an illness) in order to maintain better health status or life-quality. The different phases including their stages that form the structure on how to carry out the caring are described in more detail in the article from study II.

4.5 The analysis – Study II

The study purpose was to explore whether caring is a part of the interpersonal interaction in RMB treatments by analysing the RMB clients` experiences from a nursing theoretical framework, the SAUC Care Model. The method was deductive content analysis that is systematic techniques for structure, condense and categorize a large amount of text or number of words. This method was chosen by reason to describe the participants` experiences. The twelve theoretical stages of the revised theory (Gustafsson, 2010:1) formed the structure of categorization in study II. A more detailed account for the SAUC Care Model and the analysis is found in the study II article.

4.6 The study population

The entire sample consists of Swedish RMB clients. Most of them were women. There is no accurate source of the distribution of men and women among RMB users but according to informal reports from the Swedish RMB therapist`s men are a minority among RMB clients. The participants` socio-demographic background, RMB utilisation and sources for information about RMB are presented in Table 4 and 5.

Table 4: Socio-demographic data of the participants in study I

| Sex | Age | Education | Social status | Received treatments | Source of information about RMB |
|-------------------|--------------------------------|--|--|----------------------------|---|
| 45 women 8 men | Mean: 46 Min 27 – max 67 | 34 University degree 13 Upper secondary 6 Compulsory school or vocational training | 27 Married or cohabitant 23 Single 1 Widow | Min 1 - max 140 Mean 29 | Own network as friends, family members or fellow-workers (26 participants) Media reports (12 participants) Other sources as patient associations, workplace health care consultants or family physicians (8 participants) |

Table 5: Socio-demographic data of the participants in study II

| Sex | Age | Education | Social status | Received treatments | Source of information about RMB |
|---------|--------------------|-----------------------|--------------------------|---------------------|--|
| 7 Women | Mean 46 | 8 University | 6 Married/ cohabitant | Min 2 - max 50 | From own network of friends/ family members (7 participants) |
| 4 Men | Min 31 - max 65 | 3 Upper /secondary | 5 Single | Mean 15 | From media (1 participant) From other sources as Internet, book and workshops (3 participants) |

Most of the sampled participants' were highly educated and their occupation was grouped into several groups; official workers like a secretary and administrator; participants with academic backgrounds as associate professors or PhD students; managers (CEO, production manager, and personnel manager) and; engineers or consultants. The fifth group included participants who were CHC providers and staff within municipal care service, such as registered nurses, assistant nurses, social workers and psychologists. Twelve participants in study I and four participants in study II belonged to this group. The participants` in study I can be divided into two groups describing the utilization pattern. The first group had used the therapy once or twice a month up to 15 treatments during the year the study was conducted. A second group of participants reported utilizing more than 30 treatments. They had used RMB regularly for several years (once a month or second month) for support and wellbeing. In the extreme case of 140 treatments, the participant had used RMB once a month for 12 years for her own wellbeing. The participants in study II had received 1-50 treatments with a mean of 15.

4.7 Ethical considerations

The project was approved by the Regional Ethical Review Board in Stockholm (diary number 2005/1038-31/2). The project includes several separate actions to achieve a good ethical standard including detailed written and verbal information about the study to the participants in study I and II. Furthermore, all participants received an informed consent form to be signed (signed agreement) and were guaranteed confidentiality.

4.7.1 The research sovereignty

The project was partly funded by AGI which the Rosen Institute licenses to carry out the RMB therapists` training in several Nordic countries. For this reason there was a risk that the financial support could influence the results. In order to protect the research sovereignty a reference group was established before the project started that included two members from Karolinska Institutet

and two from AGI. The elected persons were all scientists with knowledge of research ethics; they represented the disciplines of biomedicine, nursing and CAM. The purpose of the group was to monitor the project and guarantee the researchers` independence but also to serve as an advisory group for ethical and scientific issues raised during the data collection and sampling.

5. Results

The first aim of study I was to describe why clients consult RMB and by them experienced benefits. The results from study I show three main categories of reasons for RMB utilization; physical health problems, psychological problems, and a need for personal growth. Most participants reported several reasons for using RMB. A variable of interest was the rating of perceived difficulties by the reason that brought the participant to RMB as it was assessed to give additional information about the experienced severity of the reason. This rating was carried out in both studies on the non-metric 7-point scale (see Table 6).

Table 6: Degree of perceived difficulties by the reasons for RMB utilization

| Perceived difficulties Study I | Number of participants n = 52 | Perceived difficulties Study II | Number of par- ticipants n = 11 |
|---|--|--|--|
| 7 Very high | 21 | 7 Very high | 5 |
| 6 High | 12 | 6 High | 2 |
| 5 Fairly high | 14 | 5 Fairly high | 3 |
| 4 Moderate | 2 | 4 Moderate | 1 |
| 3 Some | 1 | 3 Some | - |
| 2 Almost none | - | 2 Almost none | - |
| 1 Not at all | 2 | 1 Not at all | - |

The rating indicates that a majority experienced the problems as severe (rated the reason as high or very high). Furthermore, 14 participants in study I and five in study II reported also prior or simultaneously contact with CHC providers (mainly physicians or psychologist) for the same reason (or reasons) that brought them to RMB, and 15 participants in the entire sampling reported prior or present sick leave due to the reason or reasons. Moreover, in study II the participants were asked to describe the process that led them to RMB.

The second aim in study I concerned what kind of help or benefit the participants had perceived. They were initially asked to rate the grade of benefits from RMB. The rating shows that a majority in study I rated the benefits as very high (7) or high (6) on the non-metric 7-point scale. The same rating was performed in study II and the rating shows a similar pattern (see table7).

Table 7: Degree of perceived benefits in study I and II

| Perceived benefits from RMB Study I | Number of participants n = 52 | Perceived benefits from RMB Study II | Number of participants n = 11 |
|--|--------------------------------------|---|--------------------------------------|
| 7 Very high | 20 | 7 Very high | 4 |
| 6 High | 18 | 6 High | 4 |
| 5 Fairly high | 8 | 5 Fairly high | 1 |
| 4 Moderate | 5 | 4 Moderate | - |
| 3 Some | - | 3 Some | - |
| 2 Almost none | - | 2 Almost none | 1 |
| 1 Not at all | 1 | 1 Not at all | 1 |

The analysis identified five main categories of experienced benefits from the treatments. The first category was; “enhanced psychological health” including increased wellbeing and feeling of trust, happiness but also improved self-confidence. The second category enhanced physical health, included reduced tension in muscles, improved capacity to breathe, improved intestinal function and increased physical energy but also relieved pain such as headache, back pain and pain in the neck or the muscles. In the third benefit category “increased awareness of the body-mind connection” the participants described how they have become conscious about how their behaviour patterns influence their body but also how the on-going processes in the mind affects the body. The fourth and fifth categories of experienced benefits were support for personal growth and self-initiated life-changes.

Study II found that satisfied participants` experiences from interpersonal interaction corresponded to ten of the twelve stage descriptions of the nursing theoretical framework of the SAUC Care Model. Most identified experiences clarified how the participants experienced the relation with their therapist but also the therapy environment. In these cases, trustful and supportive interpersonal relations were reported that made the participants feel secure and accepted regardless of the problems that brought them to RMB. Furthermore, the satisfied participants` experiences indicate support and guidance from the therapists that resulted in deepened self-development obtained through new knowledge and insights. Their experiences illuminate progression and describe self-initiated life-changes based on more appropriate self-assessments. In contrast, the opposite experiences were found in the interviews with participants who were dissatisfied with RMB. These experiences show a lack of communication and experiences of objectification of the participant. In these cases, the interpersonal interaction seemed to fail to

provide a proper supportive caring that meets the participants' needs. Moreover, these experiences indicate that the failed caring blocked the therapeutic progress leading to dissatisfaction and a change of therapist or discontinuation of the therapy.

6. Discussion

Study I identified three main categories of reasons for RMB use; physical health problems, psychological problems, and a need for personal growth. These three categories of reasons seem to be valid also for the use of CAM therapies in general. According to Astin (1998) CAM users' have poorer psychological and/or physiological health status than non-users. Svennevig (2003) concludes that clients who consult RMB have psychological health problems in higher extent and a greater need for psychological support than clients who use other massage or manipulative body therapies. The results from study I and II show that psychological problems were a frequent reason for the use. Furthermore, the participants rated difficulties in daily life due to the reason that brought them to RMB as severe. Mason, Tovey and Long (2002) state that CAM therapies are regularly used by people who has chronic illness, who have not responded to the CHC treatment, or who feel unhappy, and by these reasons have a specific need for care. Several participants reported that they had previously sought help from, or had parallel contact with, CHC providers due to the same reason as they now consulted RMB, but a majority of them had not experienced satisfying help. In addition, the results indicate that many participants had chronic illnesses or pain. An unsatisfying help from CHC is according to several authors (see e.g. Sirois and Gick, 2002; Ernst and Stevison, 2008) one explanatory reason for CAM therapy use. The conclusion is that the sampled participants mirror the population that utilizes CAM therapy methods in many aspects and the identified reasons for RMB utilization in this project are not extraordinary compared to previous knowledge about reasons for CAM use in general.

Also like the CAM population in general, a majority of the participants reported "friends and family members" as the primary source of information about RMB. According to Bishop and Lewith (2008) do significant people influence users' decision to choose a specific CAM therapy. Moreover, the participants, at least in study II, can be considered as informed consumers as many of them reported that they had actively sought information about RMB before they entered the treatment. This indicates that their decision for choosing RMB was a conscious choice.

The results from study I concerning experienced benefits show five categories including experienced improved physical and psychological health. These kinds of improvements are discussed in several studies (Uvnäs-Moberg, 1998; IsHak, Kahloon and Fakhry, 2011; Lindgren, 2012) concerning other touch based massage therapies and the outcome has been ascribed to a neurophysiological response from the massage. The third category of benefits indicates new knowledge concerning how body and mind influence each other leading to new consciousness about

the connection. This consciousness seems to be supported by a learning process where the interpersonal interaction plays an important role. The new awareness leads to a changed view of the body and changed behaviour patterns. Furthermore, the results from study I show experienced support for personal growth (category four) and increased empowerment for self-initiated life changes (category five). These benefits - support for personal growth and self-initiated life-changes - have not been discussed extensively in previous studies of CAM. The results from study II might explain some of the reasons for these reported benefits. RMB seem to open up to emotions and memories, which several participants in study I and II link to previous difficult incidences in their lives. The re-experiences were reported to be psychologically challenging in this situation. The supportive caring in the interpersonal interaction is likely to be important as it seem to assist the participant to stand the emotions and as a result make it possible to gain new self-awareness and self-development. The contrasting experiences from the dissatisfied participants indicate interpersonal interaction where caring seems to fail and result in discontinued therapy or a change of therapist. Clearly, further investigations are needed to clarify such possible interactions in more detail.

According to Koitham, Bell, Niemeyar and Pincus (2012) are many CAM therapies complex and include mechanisms that can co-operate, work independently, interfere with each other, or simply co-exist. The two studies (I and II) indicate that there are at least two integrated major components that contribute significantly to the experienced therapy benefits or client satisfaction, namely touching and caring. Moreover, the assumption from study I is that the last two categories of benefits, support for personal growth and increased empowerment for self-initiated life changes seem not to be related exclusively to the physical touching, but to a combination of touching and interpersonal interaction. The touching alone seems not to be enough to guarantee a successful therapy progress in RMB. Supportive caring in the interpersonal interaction seems to be a necessary component as it contributes to a safe therapeutic environment and trustful relation where the client feels accepted, dare to re-experience and express difficult emotions without being judged. Therefore, the conclusion from study II is that caring is likely to be an integrated part of the interpersonal interaction that supports the client to process the responses and reactions that probably follows from touching, and leads to therapy satisfaction. This conclusion is supported by results from a study by Cartwright and Torr (2005). They mean that the interpersonal relation is an important CAM therapy component and it contributes to satisfaction irrespective of the therapy efficacy.

6.1 A tentative theoretical model

From the study results a tentative model can be hypothetically formulated that indicates how the two components - touching and supportive caring - interrelate in the treatments and contribute to client satisfaction (see figure 2). The four hypothetical scenarios in figure 2 illustrate four different combinations of the two treatment components.

In scenario 1 the two components are a necessary complement to each other. This scenario corresponds to satisfied participants whose experiences indicate progression to the phase Self-competence in study II. The scenario seems to be optimal when the client has experienced psychological problems in the past that are related to physical problems such as tense muscles. The treatment releases suppressed emotions and difficult memories. The supportive caring in the interpersonal interaction provides a trusting relationship and safe environment that assists the client in processing difficult experiences. This creates an opportunity to learn new self-awareness, which consequently leads to self-development. The therapy process encourages and empowers the client to change independently the circumstances that threatens her or his health or wellbeing. This situation includes a successful combination of the two components and will probably lead to client satisfaction and experienced benefits.

In scenario 2 there are no real physical or psychological problems, or previous traumatic experiences, to be solved. The client rather needs support in her or his current life situation or life crisis. This scenario corresponds to the fourth category of benefits in study I – support for personal growth. Therefore, the physical touching is probably of secondary importance and the supportive caring in the interpersonal interaction is the most important component. Even though the touching makes the client relax and experience wellness it is the supportive caring that 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 I. The touching works well; the client relaxes and re-experiences difficult emotions or memories. But the interpersonal interaction fails to meet the client`s needs concerning trust, safety and support. The treatment most likely will not be satisfying. This scenario corresponds to experiences from the dissatisfied participants in study II who discontinued the therapy or changed therapist.

In scenario 4 neither the touching nor the interpersonal interaction with integrated supportive caring meets the client`s needs and the client will probably discontinue the therapy rather soon with dissatisfaction. This scenario is not supported by the results but is considered as a probable scenario.

| | Touching + | Touching — |
|---|--|--|
| Supportive caring in the interpersonal interaction + | <i>Scenario 1</i> <i>Satisfied client</i> | <i>Scenario 2</i> <i>Satisfied client</i> |
| Supportive caring in the interpersonal interaction — | <i>Scenario 3</i> <i>Unsatisfied client</i> | <i>Scenario 4</i> <i>Unsatisfied client</i> |

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

6.2 Methodological considerations

The study's trustworthiness in qualitative research can be reflected through the concepts credibility, transferability and sampling adequacy (Polit and Beck, 2010). The credibility reflects the sampled population, methods to collect data and analysis procedures.

The credibility depends on how suitable the chosen methods to collect data are. A possible way to reach first information about an unknown subject from a larger population is through survey (Brink and Wood, 1998). This method was considered as an appropriate way to start the data collection. But the questionnaire was study specific and not validated which increases the risk for incorrectly formulated questions. One way to avoid a threat was to formulate the question concerning reasons for RMB use as a pre-formulated alternative with one open alternative. This allowed the participants to add information that was not covered of the pre-formulated alternatives. In addition, the participants had an opportunity to describe the reasons in the last open question, which many of them did. The question asking to describe the experienced benefits was an open response alternative. In several cases the participants had written extensive responses which gave a rich amount of information about the subject covering approximately 40 A4 sheets of written text. An additional potential threat for credibility is systematic (non-random) drop-out (not completed questions) which leads to underrepresentation of important data (Czaja and Blair,

1996). The control shows a minor number of not completed questions in a non-systematic (random) way concerning the reasons and benefits. The conclusion is that the formulation of the questions and the response pattern strengthen the creditability of the results. Furthermore, the chosen method in study II was semi-structured interviews. The methods in both studies can be considered as complementary and the combination increases the possibility to reach data that had been lost by using one method alone. The interviews provided additional information about the interpersonal interaction in the treatment, the reasons but also about the benefits and reasons for the use. The survey provided information about the interpersonal interaction as well.

The sampling adequacy is about demonstrating that the chosen ways of selecting informants (participants) are the best sources for information concerning the study aims (Polit and Beck, 2010). Moreover, according to Czaja and Blair (2005) the best way to obtain information about a specific subject is from a well defined population through random sample. This was not possible to do in this study. A rationale is to sample informants who have expert knowledge of the study questions (Polit and Beck, 2010). The data was collected from 64 conveniently sampled RMB users. Data concerning number of received treatments indicate that a majority of them have had a good possibility to observe the interpersonal interaction in the treatments and be conscious about benefits whose development probably is dependent on a long treatment period. The participants can be considered as experts concerning reasons for the therapy use, experienced benefits and interpersonal interaction, which increase the trustworthiness of the results. In study I the participants represent benefitted RMB users. In study II a majority represents positive RMB users who have gained benefits from the therapy and were satisfied. But four of them had mixed or negative experiences. They can be considered to have had the same opportunity to observe the interpersonal interaction during several encounters with their therapist, and in some cases, with several therapists. By this reason these dissatisfied participants' experiences illuminated other aspects in RMB treatments.

6.3 Study limitations

The study has, however, several limitations. It is exploratory and the participants were conveniently sampled through therapists without control of how this recruitment procedure was made. Hence, it is likely that mainly satisfied RMB users were included in giving reasons, experienced benefits and the interpersonal interaction. The participants' socio-demographic characteristics show likeness to CAM users in general. They also reported similar reasons for RMB use as CAM clients do in general. Therefore, the participants can be considered to represent a particular part of the population who utilize CAM therapies but additional studies must be conducted to elucidate their representativeness for the whole RMB user population. In addition, the results cannot be generalized to a target population or no conclusions about causality can be drawn. Further studies must be performed to confirm the results as well as to test the hypothetical model presented.

6.4 Considerations regarding the theoretical framework

Good nursing theory is according to Fawcett (2005) characterized by a unique focus, is grounded in and describes clearly the logical, empirical and ontological knowledge it is based on including a brief description of the theory development process. Moreover, a good theory clarifies clearly different problems in human interaction, describe the goal population and situations where the knowledge from the theory can be used (credibility and implementation) and if possible, the theory should be empirically tested. A testing in real nursing situations evaluate if the theoretical structure can be applied successfully in real situations and if the theory can be used as theoretical support for caring interventions in a way the theory describes. The theoretical framework, SAUCCM meets many of these demands. It is validated with reference to theory description, analysis, critique and support (Gustafsson and Andersson (2001a,b). One unclear condition is that the original or revised theory does not clearly state in what situations the theoretical knowledge is not applicable. Neither is the goal population clearly defined (Gustafsson, 2004; Gustafsson et.al. 2010:1). But the study results indicate that RMB clients might represent a population where the theoretical knowledge can be applied.

The theory was an important tool for structuring the participants' experiences in the data analysis and it contributed with a systematic and pragmatic structure for organizing data, a lens to find caring actions in the participants' experiences. The theory was also a useful tool for identifying experiences where the interpersonal interaction did not include proper caring. But one question is if a particular theory is good enough to illuminate all aspects of caring that might occur in the

interpersonal interaction? A theory can be defined as a “systematic abstraction of reality that serves some purpose” (Chinn and Kramer, 1991, pp. 20). But a theory is a “representation of reality and not reality itself” (ibid, pp. 20). In a theory specific concepts are weaved together to a system with the purpose to explain some aspects of the real world (Polit and Beck, 2010). This means that a theory or model in some concern might simplify the reality and the use of a theoretical model can mislead the researcher to miss important data as it does not fit within the model (Omery, Kasper and Page, 1995). This is a potential threat in this study. The results might in some extent mirror caring that are integrated in the interpersonal interaction fitting the used theoretical framework and other aspects of caring might be visible by using other theories. The informal observations and some experiences from the participants in study II indicate that the applied theoretical framework lacks some aspects that appeared important. One example is aspects of communication. Some participants in study II described a specific mental but wordless connection with the therapist that seems to be important for their growing self-awareness that can be interpreted as an aspect of support and guidance. The importance of this is not covered in this project but might be an area for future research.

6.5 Clinical implications and further research

The results indicate that supportive caring is as an integrated and essential contextual component in RMB treatments. Therefore, there is two possible ways to perform future research on RMB and probably on other similar CAM therapies. New studies should focus more systematically on the interpersonal interaction and caring. Another suggested future study is a clinical trial project that evaluates the usability of RMB as a complement to e.g. nursing care. RMB could be provided to CHC patients who wish to receive these treatments, e.g. patients who are in a need for support. The project should be prospective and based on patient and nursing staff measurements, assessments and observations about short-time/long-time benefits, probable risks, adverse and favourable responses to treatments, and it should include a health economy perspective.

7. Summary in Swedish – Sammanfattning

Användning av komplementär- och alternativmedicinska (KAM) terapier ökar och användarna rapporterar ofta tillfredsställelse med dessa terapiers resultat även om vetenskapligt stöd för effekten av många terapier fortfarande saknas. Denna licentiatavhandling fokuserar på en relativt outforskad psykologiskt orienterad KAM terapi – Rosenmetoden (RM). Man menar inom RM att muskelspänningar kan ha sin grund i olösta traumatiska upplevelser eller tidigare obearbetade stressituationer. Behandlingen består av lätt beröring med varm hand på spända muskler. Syftet med beröring är att göra klienten medveten om spända muskler och därmed möjliggöra att bakomliggande emotioner och minnen kan bearbetas.

Projektets design är kvalitativ, explorativ och beskrivande och undersöker klienternas självrapporterade erfarenheter från terapin. Studie är innovativ i sin målsättning att studera en KAM-terapi från ett omvårdnadsteoretiskt perspektiv. Syftet i studie I är att beskriva varför klienterna konsulterar RM, och vilken typ av hjälp eller nytta (om någon) klienterna uppfattar sig ha fått av terapin. Data från 53 svenska RM klienter samlades in med hjälp av ett studiespecifikt frågeformulär. Data analyserades med hjälp av latent och manifest innehållsanalys och deskriptiv statistik. I studie II undersöktes om omvårdnadsaspekter ingår i den mellanpersonliga interaktionen i RM och data samlades in med semistrukturerade intervjuer med 11 RM klienter med positiva och negativa erfarenheter från terapin. Data analyserades med deduktiv innehållsanalys där ett omvårdnadsteoretiskt ramverk, SAUK Care Modell utgjorde matrisen i analysen.

Resultaten från Studie I identifierar tre huvudkategorier till varför klienterna använde RM samt fem kategorier av fördelar/nytta. Resultaten från studie II visar att den mellanmänskliga interaktionen innefattar stödjande omvårdnad som en viktig del som bidrar till att klienten utvecklas och får ny styrka att initiera egna hälsofrämjande åtgärder. Deltagare som var missnöjda med behandlingen upplevde snarare att omvårdnaden hade misslyckats. Detta projekt bidrar till att lyfta fram omvårdnadsaspekten som väsentlig och aktiv kontextuell komponent i RM. Resultaten sammanfattas i en teoretisk modell som indikerar att beröring och den mellanpersonliga interaktionen där stödjande omvårdnad är en integrerad del, är nödvändiga komponenter i framgångsrika RM behandlingar. Studien har flera metodologiska begränsningar och den var inte upplagd för att besvara några generaliserbara frågeställningar som rör eventuella behandlingseffekter av RM.

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