

# Research on Rosen Method: A Summary of Recently Published Studies, and How You Can Contribute<sup>1</sup>

Alan Fogel, Editor

Rosen Method International Journal and Rosen Method Bodywork Practitioner  
Salt Lake City, UT, USA  
alan.fogel@psych.utah.edu

## Abstract

A research study on the effects of Rosen Method Bodywork was recently published in the *Journal of Alternative and Complementary Medicine*, by Riita Hoffren-Larsson, Barbro Gustafsson, and Torkel Falkenberg of the Karolinska Institute, Huddinge, Sweden. The following article is an interpretation and summary of their findings, accompanied by an interview with lead author, Hoffren-Larsson. I also discuss the role of research in clinical practice, the concept of evidence based practice (EBP), and use the Hoffren-Larsson et al. study to illustrate ways to understand what research may mean for Rosen Method practitioners.

The practice of Rosen Method is poised to become a more professional and accepted Complementary and Alternative Medical (CAM) approach. Part of that professionalization is the re-organization of the world-wide Rosen Method community and the setting of common standards for training and governance (Wright, 2008). Another part of professionalization of any CAM treatment approach is the growth of research on the practice and its effectiveness. Licensing boards, insurance providers, those who make referrals, and even clients themselves tend to prefer treatment approaches that are supported by evidence. In a world where clients seeking treatment have an expanding number of CAM choices, and where people increasingly consult the internet to support their choices for health care, practices that are evidence-based are more likely to thrive and grow.

Few practitioners in any field will take on the task of supporting and carrying out research studies, nor is this necessary. It is important, on the other hand, for practitioners to at least be research

literate. **Research literacy** is the ability to read and understand a research study in your own area of practice and to know what the strengths and limitations of that research may be for your work. Research literacy also includes the ability to explain the pros and cons of research on your practice to clients and other health care professionals, both in person and in your written materials (brochures, flyers, and web sites).

This article is written to help Rosen Method practitioners understand the findings and implications of recently published studies on Rosen work. I would like it to be understandable to all readers. Research literacy, like any kind of literacy, requires learning some minimal vocabulary and learning to become increasingly fluent in the use of that language. Don't give up if some of what you read here is challenging to your understanding. Put it aside for a while and come back to it another time when your mind is fresh. You can't learn a new language in one day.

In the field of health care, for both traditional medical and CAM health care, there is an increased demand for what is called **evidence-based practices** (EBP). EBP requires a strategy of obtaining data that involves (Peile, 2004):

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1. Editorial Board member and Rosen Method Bodywork Practitioner Annabelle Apsion served as acting editor for this article.

1. a questioning approach to practice leading to scientific study,
2. conducting detailed observations, and
3. recording and cataloguing the evidence for later study, analysis, and interpretation.

Evidence may be collected in a variety of ways including by direct observation, interviews, and patient self-reports. The data collection may be done by practitioners themselves or by an independent team of researchers.

These sources of evidence must then be organized, recorded, transformed and coded, and thus made available for inspection and analysis. The reason for this documentary process is to allow the research team (which may include the practitioners and the clients) to study the evidence in order to arrive at an interpretation that is colored neither by personal biases nor by the inaccuracies of memory. This definition of EBT is very liberal in terms of the type of research that can be used. This could be everything from the so-called "gold standard" of randomized treatment and control groups on the one hand, to case studies based on notes made by practitioners on the other. *The key criteria are the systematic recording and cataloguing of data and the later study and analysis of these data with a questioning perspective.*

In the early stages of research in any clinical discipline, case reports and questionnaires or interviews with clients are common sources of evidence. Even at this early stage of description, it is essential for the authors/practitioners to have made documentary records of their sessions and to record interviews for later study. Such evidence is crucial in building a record of what the work can and cannot do under a variety of circumstances. *This type of documentation usually grows out of a natural curiosity and enthusiasm to describe the work to others.* Rosen Method practitioners are likely to be especially adept at curiosity and enthusiasm.

Why is this information useful? The detailed level of description of such reports is helpful for non-practitioners to understand what may actually occur in a treatment session or over the course of treatment. It also helps practitioners to develop a

common language and shared understanding of their practice. A good example of this in the Rosen Method literature is the concept of **resonance** introduced by Sandra Wooten (1995). This concept is now in common usage in writings and discussions of Rosen Method, including in the article by Hrossowyc in this issue of the *Rosen Method International Journal*. Hrossowyc expands on the concept of resonance, links it with neuroscience research, and goes on to introduce some original concepts of her own: **regulation** and **revison**. As other people writing about Rosen work continue to use similar concepts, the meaning of those concepts deepens and becomes more specific. A language is developed in which anyone familiar with Rosen method can immediately share a common understanding.

Another benefit of building a common conceptual language is the possibility of sharing insights with practitioners in other fields. Don Hanlon Johnson, a recognized leader in integrating concepts and methods across different types of body-based treatment practices – and who has included a chapter on Rosen Method in one of his books (Johnson, 1995) – has written about what he calls **intricate tactile sensitivity** (ITS), which "creates a unique kind of intricate bodily connection between therapist and patient" (Johnson, 2000, p. 480). Johnson uses the concept of ITS, which in fact is the same as the concept of **resonance**, to distinguish two types of treatment practices using touch: work such as Rosen, Rolfing, Feldenkrais, Bodymind Centering, craniosacral therapy, Alexander Method, and Rubenfeld Synergy are different from more "manipulative" treatments using touch including physical therapy, Swedish massage, and chiropractic which may not use ITS. He also makes a case that ITS helps to distinguish what happens in the former group of practices as compared to psychotherapy, which may also contain elements of a sensitive contact between patient and therapist but which does not use the element of touch (Johnson, 2000).

Contrary to popular notions about scientific objectivity, practitioners are actually one of the best sources of evidence in early phases of research on a clinical practice. As so-called **participant observers**, practitioners know the work better than anyone else and each practitioner brings their own perspective

and approach to the work as they record and write about it (Moustakas, 1994). Multiple case reports from different practitioners begin to create a larger body of evidence from which further interpretations can be made and new research can be designed. I have written a detailed guide for keeping case notes on treatment sessions (Fogel, 2007) and in my editorials for this journal, I have appealed to bodywork practitioners and movement teachers to take on the task of documenting their work.

An excellent example of an EBP case study on Rosen Method Bodywork was published in the previous issue of this journal. The author, Bodywork Practitioner Teresa da Silva from Copenhagen, Denmark, presents a case report that describes the progress of treatment of a single client with chronic pain. In addition to having written detailed descriptions of individual bodywork sessions, da Silva also presents quantitative (numerical and graphical) data on her clients own self-report of pain intensity and also provides client records of actual dosages of pain medication (da Silva, 2009). While these numerical accompaniments to detailed case descriptions are not required in the early stages of EBT, they provide additional evidence supporting the effectiveness of the practice. As da Silva shows, qualitative changes in the client's self-awareness during the sessions corresponded with statistically significant quantitative reductions in perceived pain and medication dosage. This study is limited because it is only a single case but it does reveal that for this client, Rosen Method was effective in a way that no other treatment had been.

Another approach that is helpful in early stages of creating EBP is the use of interviews, questionnaires, and other available measures in addition to or separate from case notes. A good example of this approach was also published in the previous issue of this journal. Bodywork practitioner Sylvia Nobleman, in collaboration with co-worker Marcie Wilson, a clinical exercise specialist, collected data on a pilot study of executives enrolled in a wellness program of which Rosen Method bodywork was a part. Wilson and Nobleman (2009) enhanced their case descriptions of bodywork clients with self-report measures as well as physiological measures obtained as part of

the exercise and health component of the program. Many of the physiological indices of health showed statistically significant improvements as a result of the program. Because Rosen Method bodywork was only one part of a comprehensive package of program components, however, we cannot say that Rosen Method was the cause of the participant's improvement. The authors speculate that increased self-awareness of the body, learned as part of their Rosen treatments, may have contributed to the outcomes.

If you read these two articles, you can ask yourself if they fit the definition of EBP. Did the authors have a "questioning approach" to their clinical practice? Did the authors do detailed observations? Did they record and report those observations in their articles? Did they inform their readers about how they collected, recorded, analyzed the data and interpreted it? I think you will find that the answer is "yes" to all these criteria of EBP.

#### *The Swedish Research Study*

Another example of an early stage EBP research study on the effects of Rosen Method bodywork was recently published in the *Journal of Alternative and Complementary Medicine*, by Riita Hoffren-Larsson, Barbro Gustafsson, and Torkel Falkenberg of the Karolinska Institute, Huddinge, Sweden (Hoffren-Larsson et al., 2009). Unlike the studies by da Silva and by Wilson and Nobleman, the Swedish authors were not Rosen practitioners. Here, I provide a short summary of their article, followed by an interview with lead author, Riita Hoffren-Larsson. This will be followed by a discussion of how this work fits the definition of EBT. I will also say what we can safely conclude about Rosen Method from this study, and also what we cannot say, what we still do not know, what has not yet been confirmed by evidence.

With the intention of discovering why clients come to RMB (Rosen Method Bodywork), and how they perceived the possible benefits of this work, the authors of this study recruited 53 Swedish RMB clients and gave each of them a questionnaire. There were 45 women and 8 men, with an average age of 46 years (range: 27 – 67 years), and 65%

had a university education. At the time of being interviewed by the researchers, the clients had received an average of 29 Rosen Bodywork sessions (range: 1 – 140 sessions). Another notable fact about this sample of clients who volunteered to be interviewed was that on average, they used 5 different complementary and alternative medicine (CAM) therapies in addition to RMB. About one-third of the sample had seen a conventional physician for their problem prior to coming to Rosen treatments, and this group expressed that they were only moderately satisfied with the medical approach to their problem. The clients were not paid for their participation and they paid for their own Rosen treatments.

According to the research article, the “first group of questions covered sociodemographic variables such as education and age, reasons for using the therapy method, and contacts with conventional health care. . . . A second group of questions related to attitudes toward RMB and CAM in general, perceived everyday problems they were experiencing and that may have brought them to this therapy method, as well as their assessment of any perceived benefits from RMB. . . . Finally, the questionnaire contained three open questions with space for the clients to describe perceived benefits, reactions to the treatment in their own words, and to provide additional comments regarding the therapy method” (Hoffren-Larsson et al., 2009, p. 2).

The authors did a detailed analysis of the questionnaire data. “The data were analyzed by two of the authors (RH-L and BG) on the basis of qualitative content analysis, pursuing the following steps. First, both authors separately read through the transcripts. This first reading provided some overall ideas of how to categorize responses on the issue of perceived help or benefits from the treatment. The second step included several additional readings to mark sentences and words that seemed to match the first tentative categories. The third step included a comparison between the authors’ categorizations. The tentative categories were then revised until full agreement about the categories and their subcategories was reached. The categories were labeled by describing themes, and then supporting quotations were chosen from the text. Finally, additional read-

ings and analyses were made until the whole variation of the material was accounted for by the categories and their contents” (Hoffren-Larsson et al., 2009, p. 3).

In their results, the authors first reported the reasons why people sought Rosen treatments. These included *physical health problems* (such as muscle tension, pain, and diseases), *psychological problems* (stress and burnout, anxiety, depression, and a desire for improved well-being), and finally *personal growth* reasons including a desire to understand themselves better and to find new strategies for living.

With regard to the client’s perceived benefits of the Rosen treatment, only one client reported that the treatment had no benefits and none reported negative effects. This means that almost all the clients felt they received a positive benefit from the work. The benefits reported by the clients included enhanced *psychological health* (reported by almost all the clients; increases in happiness, harmony, well-being and self-confidence and reduction in depression, anxiety, suicidal thoughts, and stress), enhanced *physical health* (reported by most of the clients; reduction in pain, tension, and increase in the ability to breathe and enhanced digestive function, increased awareness of *mind-body connection* (26 clients; awareness of how body tension and emotion link to daily life and prior symptoms), *support for personal growth* (24 clients; awareness of previously repressed problems and memories and the ability to move beyond them), and finally *self-initiated life changes* (18 clients; resetting priorities making choices that are self-affirming).

More details about the study and its background were obtained during an interview by Alan Fogel with lead author Riitta Hoffren-Larsson. The interview transcript is presented here in its entirety.

**AF.** Please describe your background and training, and your current position at the Karolinska Institute.

**RHL:** I am a registered nurse with approximately 15 years’ experience of nursing. I have a MSc in psychology (behavioral sciences) and a university degree in Education. I have also taken several doctoral courses in research methodology. My current position at Karolinska Institute is teacher in advanced nursing at

the division of nursing. I work as a teacher with lecturing and training of nursing students.

**AF:** I think that K. Uvnäs-Moberg did some of her research on oxytocin at the Karolinska Institute. Is that correct? Do you have contact with her?

**RHL:** Yes that is correct. I had contact with her through my study. As our study was supported financially by Axelson's Gymnastiska Institute in Sweden and since Axelson's Gymnastiska Institute offers training courses for Rosen therapists we decided, in order to avoid any financial competing interests, to have a scientific referee board including three professors in medicine and one in health care sciences. The purpose was to ensure objectivity and transparency during the different steps of the study. Kerstin Uvnäs-Moberg was one of the persons in our referee board representing medicine. I have declared this fact in my article. I have no contact with her today.

**AF:** Since you are not a Rosen practitioner, what motivated you to do research on RMB?

**RHL:** I have been interested in CAM (complementary and alternative medicine) as a phenomenon since I was a student. I have some competence in practicing zonotherapy, massage, and auriculoacupuncture. I have published one study of zonotherapy earlier and I have been responsible for courses on integrative care at the university level for nurses and medical students. It is true that I have no experience of RMB. Marion Rosen asked the same question when we met in Stockholm 2006. I answered that I was "curious" and she accepted my answers and meant that curiosity is an excellent starting point. What I mean is that my lack of experience might be a positive factor when investigating a therapy method. I could ask the "silly" questions and observe the phenomena without any "taken for granted" standpoints or wishful thinking that sometimes makes experienced practitioners "blind" for new aspects of the therapy. But there are also some negative aspects. My observations are probably influenced by my background and scientific schooling as a nurse. In short, I was interested in CAM and I got the opportunity to study

RMB. The encouragement from Marion Rosen was also important.

**AF:** Have you ever experienced RMB and if so, did you receive any benefits from the work? Were the benefits you experienced similar to those reported by the clients in your study?

**RHL:** I have received one RMB treatment. It is very easy for me to go into deep relaxation. During the therapy session I experienced a condition of total happiness. This experience was positive and nice. But I experienced also some unconscious and traumatic events from my childhood which became conscious and I was somewhat confused afterwards. I have also observed a therapy session given by Marion Rosen. I put my hands on hers and followed her movements when she treated a person. What I experienced through her (or from her) was a total engagement and that she had a presence I had never experienced before (or afterward). She demonstrated (non-verbally) one of the core concepts of RMB, I think. The concept of presence is very important and highlighted in some nursing theories as an elementary factor as well as by the clients in my studies.

**AF:** How did you find the RMB clients who were the subjects of your study? What was the length of time that they had been receiving RMB?

**RHL:** RMB therapists do not register their clients in Sweden. So we had nothing to depart from as a way to describe RMB clients or their reasons to use the therapy. And as I understand it, this is the first study, so I got no help from earlier studies. The only way to sample RMB clients was through therapists. 17 Swedish therapists from different surroundings helped me to find a sample. So the sample is not random but based on a criterion. The time they received the therapy varied from 1 session to receiving sessions regularly for several years.

**AF:** Did you test whether time in RMB (or number of bodywork sessions) was a factor in their responses?

**RHL:** No. We had a focus on benefits and reasons to use the therapy only.

**AF:** I know you did qualitative analyses. If these were based on interviews, perhaps you could share any informal observations about the subjects' experience that did not get reported in the article.

**RHL:** I used a questionnaire collecting qualitative and quantitative data. The three last questions were open, asking the clients to describe with their own words what kind of help (benefits) they had experienced from the therapy method, but also their general experiences. These reports were interpreted qualitatively. But I have also interviewed clients (semi-structured interview) and I made observations when I visited some therapists. These last mentioned data will build up my forthcoming article (very premature yet). So this data is not reported in the article that you have seen on-line.

**AF:** In relation to the spectrum of CAM approaches, what do you think are the unique aspects of RMB that make it different from, for example, massage, yoga, acupuncture, etc.?

**RHL:** One unique aspect is the RMB therapist's attitude when she/he meets and treats clients. They really put the client in center, and they also have a very allowing caring approach which heals people.

**AF:** Which particular types of people or symptoms would be best treated by RMB as opposed to other CAM approaches?

**RHL:** I do not have enough knowledge to answer this question. The clients reported so many different reasons to use RMB and they were in different ages and sexes. I must do more research before answering this question. I think you have more knowledge yourself about this?

**AF:** Following from the previous question, could RMB be combined with particular other approaches to best meet the needs of particular clients? Give some examples.

**RHL:** I think an existing and respectful cooperation between RMB practitioners and psychologists and/or physicians (or other conventional care providers

"CCP") should be a very fruitful combination. Many clients in my study had chronic health problems and they had contact with CCP (but they never told the CCP provider that they used RMB). There are some risks with a parallel use of different therapies/treatments. Combining the services from conventional care and RMB (integrative approach) should be in some cases the very best help for some clients. But as this example illustrates, there are also some risks: sometimes the therapist may make a decision to treat a client who has a fragile self (or has many unconscious traumatic events so deeply buried inside which due to the RMB therapy become conscious). My experience was that RMB is a very potent therapy method. Many RMB therapists say that they have no obligation to take care of a client who gets psychological problems due to the therapy. The therapists can observe that a particular client has problems but they are not able to help them due to lack of psychological knowledge (or medical knowledge). This was the therapists' own descriptions. It should be nice if they could in such cases cooperate with a psychologist or physician and send their clients who need other kind of help to conventional care providers (or vice versa).

**AF:** In your response about integrating RMB with conventional approaches, you mentioned physicians and psychotherapists. I'm wondering, since you are a nurse, how RMB might interface with nursing practice?

**RHL:** Maybe I was a little unclear before pushing forward other health care providers (HCP). My professional opinion is that RMB should be a very fruitful method for nurses to integrate in nursing. I think AHNA (American Holistic Nurses' Association) should be very interested in RMB (they speak for holistic nursing and give body, mind and spirit equal importance in healing/caring processes). But there are some problems. In Sweden, we have still a barrier between the conventional health care system and CAM therapy methods. Our legal aspects defining the basic responsibilities of health care personnel can create a barrier. Certified health care personnel are (including nurses) generally prohibited to practice CAM therapies themselves if the method lacks evidence

and documentation. Nobody knows clearly where the line for “enough evidence” goes. (Anyway, HCP can receive CAM therapy methods and nurses and other HCPs were the largest group of RMB clients in my study sample). So it is not easy to integrate CAM methods like RMB in nursing but it depends on laws and informal rules in hospitals among HCP. Maybe the situation is better in other countries.

**AF:** There are now, as far as I know, four studies of Rosen Method, including yours. Two of these appeared in the Spring Issue of the Rosen Method International Journal ([www.rosenjournal.org](http://www.rosenjournal.org)) and these are preliminary or case studies. There is also a study of RMB’s listening touch that was adapted for an intervention with married couples who showed increases in oxytocin and decreases in stress hormones after just a week of taking a few minutes for daily listening touch with each other: <http://www.psychosomaticmedicine.org/cgi/content/abstract/70/9/976?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=couples&searchid=1&FIRSTINDEX=0&volume=70&issue=9&resourcetype=HWCIT>

**RHL:** I and our library personnel had some difficulties to find these studies when we made the literary survey. I am grateful getting information about them.

**AF:** So, what do you think of having nurses or other care providers getting a brief training in RMB listening touch to improve their contact with patients, and also to help their patients relax (reducing fear and stress)? Would you or your colleagues be interested in doing a study on this in the future?

**RHL:** Absolutely. In my next study I will look at RMB therapy method from a nursing theoretical viewpoint.

**AF:** Finally, your findings suggest a wide range of reasons that people seek RMB treatments and also a wide range of outcomes. Can you offer any advice for Rosen practitioners in terms of being open to different types of presenting problems and client outcomes?

**RHL:** I feel I am not comfortable trying to answer this question yet. But the outcomes of our study should stimulate the scientific community to find

more explanations for this phenomenon. My conclusions are that we must do more research. My study was qualitative describing something on scientific language from the “black box” of RMB and the findings illuminated a diversity of reasons and outcomes experienced by the people using RMB. We must do some other type of studies and apply other perspectives on RMB before answering. We must know more about the cases in which the therapy has not been helpful. The only advice I can think is the following: RMB practitioners have a great knowledge about body and mind responses to touch based on practice and many of them have a wide and long experience treating people with different types of problems. The knowledge is very important. There should be more formal or informal discussions with (for example) HC personnel like nurses. Nurses have some other type of theoretical and practical knowledge about people with different types of health problems. The discussions should help both groups to be better caregivers.

### *Conclusions*

The above review of the Hoffren-Larsson et al. study, as well as the interview, make clear that this study fits all the criteria of EBP. There was a systematic approach to the collection of data in which questionnaire responses were catalogued. The open-ended questions were studied in detail by two of the authors leading to the creation of a way to categorize responses that seemed to be an unbiased representation of the client’s views. The data were analyzed both using quantitative statistics and qualitative interpretation. The authors had a questioning attitude toward their data and also toward the effectiveness of RMB. The final answer by Hoffren-Larsson in the interview, above, reflects her caution in drawing conclusions that may not be warranted by the data, another sign of having a questioning attitude.

Rosen Method practitioners should be very familiar with this questioning attitude. Marion Rosen has taught that the practitioner’s stance, in addition to presence, is one of “not knowing” (Rosen, 2003). If practitioners think they know what a client needs, those practitioners are stepping out of the present moment and making a judgment that may not be right for the client. As practitioners in the present

moment, we may say words that the client has not yet spoken or has not yet articulated for themselves. These words may come out of what the practitioner feels in the moment as a non-verbal resonance with the client's feelings. Yet, we always need to be ready to be proven wrong. Our words may not deepen the client's experience, may not bring a deeper breath, and may even set up a defensive response in the client. *This openness to being wrong and to admitting that we don't have all the answers is at the heart of a questioning attitude that practitioners of both clinical methods and research bring to their work.*

In this sense, clinical practitioners in any discipline who have been trained in focusing on the client's perspective and not promoting their own views are particularly well suited to be participant observers in their own work. Practitioners can serve as essential players in the process of building a body of knowledge for EBP. When we write up our cases we must be accurate observers, admit to our own feelings and failings in the moment, and share our uncertainties and fears in the process of doing the work. And when we interpret our "findings," we must be hyper-alert to reaching too far beyond the evidence. We have to be clear about saying what we do know and also what we do not know. Using this approach, we can turn a questioning eye on the results of the Hoffren-Larsson et al. research.

*What do we know now about RMB from the Hoffren-Larsson et al. study that we did not know before?* Typically, in the **Discussion** section of a research report, authors can interpret the significance of their findings. Here is what they say about the results of their study: "Most clients reported several reasons for using RMB, and a majority of them were very bothered by these problems. Forty-eight (48) of 53 clients had experienced help from RMB. An analysis of the data found five separate categories of perceived benefits. Most of the benefits seem not to be related exclusively to the physical touching, but to a combination of physical touching and client-therapist interaction. This interaction has been discussed as being a significant factor for the outcomes of many CAM therapies. . . Our conclusion is that the interaction between client and therapist in RMB plays a very important role in the overall treatment satisfaction and outcome" (Hoffren-Larsson et al., 2009, p. 5).

Evidence for the conclusion regarding the importance of the client-therapist relationship is obtained from what clients said in the interview and was classified by the researchers into the outcome category, *support for personal growth*. Here is an illustrative quote from an open-ended response of one of the clients who participated in the research. "In the safe and respectful environment, I have gained the courage and support to experience things that I never before dared to "know" that I experienced. It is a great support that someone can stand to be there when I react to feelings that have been forbidden to me" (Hoffren-Larsson et al., 2009, p. 4).

*What do we **not know** about RMB from the Hoffren-Larsson et al. study?* Note that the authors do not conclude that RMB is an effective treatment. Why not? Didn't the vast majority of the clients (48 out of 53) report that they benefitted from the treatment? Yes, in fact, most of them benefitted. But because the clients were already in Rosen treatment and most of them were using other CAM approaches, we don't know if the benefits they reported are due to something specific about Rosen Method, or because, as the authors suggest, the benefits might have come from having a trusting and open relationship with their Rosen practitioner or because this was a group of people who were already invested in self-improvement and who would have improved no matter what practice they chose.

Given that type of client-therapist relationship, perhaps any practice in which there was a trusting relationship might have worked for them. The only way to attribute the effects directly to RMB would be to randomly assign some clients to RMB, and some to related types of treatment in which there is a long-term practitioner-therapist relationship, like Feldenkrais Functional Integration or psychotherapy. This type of study would give us more information about the specific effectiveness and clinical use of RMB in comparison to other clinical approaches in which there is an ongoing relationship with the client involving regular treatment sessions. Comparing RMB to Feldenkrais (which uses touch) and also to psychotherapy (which typically does not use touch) may also help to sort out the specific effects of touch.

Studies comparing conventional massage therapy with psychotherapy, for example, have

found that *massage is equally effective in alleviating symptoms of anxiety and depression as psychotherapy* (Moyer, Rounds, & Hannum, 2004). Perhaps the same could be said of RMB? We already know from the Hoffren-Larsson et al. study that a significant proportion of clients reported reductions in depression and anxiety and increased well-being. Is this from the touch element of RMB, as in massage? But RMB uses intricate tactile sensitivity (ITS) so what effect does that have? Or is the depressive symptom reduction effect unrelated to touch?

And it can work the other way around. Perhaps psychotherapy clients show reductions in muscle tension and physical pain in much the same way as Rosen clients do. If this were true, it would lead to further questions about what causes these effects. They could, for example, be due to being heard and unconditionally accepted by another person and the resulting relaxation and sense of safety that ensues from such an interpersonal relationship. This kind of investigation will tell us whether there is something more specific about each of these practices that may help to better match treatments to clients' needs.

In this context, Hoffren-Larsson's points in the interview about the relationship of RMB to other CAM treatments and to psychotherapy are also worthy of discussion. From an EBP research perspective, we do not yet know what RMB offers that is unique in comparison to other treatment approaches. This will take many years to sort out properly. We can, however, do more in terms of training and continuing education for RMB practitioners. *Because RMB may open new and unfamiliar gateways of experience for clients, practitioners need to be educated about their scope of practice, about other forms of treatment that might serve the needs of their clients that cannot be met with RMB, and about how to create a referral network to other types of practitioners in their area.* Having a referral network also benefits RMB practitioners who can thus inform their colleagues in other clinical fields about Rosen work, and who may in turn refer their clients to Rosen practitioners. A surprisingly large number of the RMB clients in the Hoffren-Larsson et al. study were already using other CAM practices, and Hoffren-Larsson suggests that clients be encouraged to let their other practitioners know that they are receiving Rosen treatments.

In my RMB practice, clients have shown similar improvements as those reported in the Hoffren-Larsson et al. study. I am able to help many clients find relief for a wide variety of symptoms and conditions that they reported in my intake questionnaire at the start of treatment. Since I have been keeping records for the past 7 years, I have noticed that there are two types of clients that do not consistently respond well to RMB, or to be more accurate, to my particular way of expressing and using Rosen work: those with bi-polar disorder and those with chronic fatigue syndrome (CFS).

In both of these conditions, I will not work with a client who is not concurrently seeing a psychiatrist or medical doctor for their condition. The people I have treated who have a medical diagnosis of bi-polar tend to love Rosen work because it opens up new experiences for them. On the other hand, this tends to promote recurrences for them of states of hypomania. In the 5 bi-polar cases I have worked with, all have stopped after several months of treatment, in consultation with their psychiatrist. Even with medication for bi-polar disorder, the heightened awareness engendered by Rosen work may have been too much for their impaired nervous systems to process safely and effectively.

In the cases with CFS, I have had mixed success. These individuals have a low tolerance for pain and are highly reactive to touch. They also have limited energy. Because Rosen work requires the client to fully participate, sessions are often experienced as relaxing at first but the after-effects may create excessive fatigue and days spent almost entirely without getting out of bed. In the normal course of Rosen treatment, the experience of pain may at first increase as the client becomes aware of it for the first time. This is usually followed over time by a decrease and even disappearance of the pain. CFS clients, however, are less likely to tolerate this initial increase in pain sensations because they are already flooded with pain. Slowing down, titrating awareness in each treatment session, has helped some of my CFS clients get far enough to experience some decreases in pain and a greater sense of ease, but others drop out before this happens.

In terms of scope of practice, I do not and cannot claim that RMB is a treatment for bi-polar

disorder, CFS, depression, anxiety, or any other diagnostic category. RMB uses resonant touch and talk to help people slow down and focus on their body sensations and feelings. That awareness in the present moment – without judgment or interpretation – seems to facilitate relaxation and self-acceptance across a wide range of symptoms and diagnoses. RMB does not cure any of these diagnoses but it may help people to develop ways to acknowledge their emotions and body sensations for the sake of better self-regulation and acceptance, thus reducing some of the symptoms associated with particular diagnoses. A key criterion for the effectiveness of any treatment approach – from the perspective of the client and EBP – is the alleviation of symptoms (Blatt & Zuroff, 2005). More research is essential, however, in the task of understanding how, why, when, and for whom Rosen work is best suited.

Another limitation of the Hoffren-Larsson et al. study is that only client self-reports were used. On the one hand, we learn a great deal from self-reports about how the work affects clients and their reasons for seeking treatment. On the other hand, there is no objective measure of improvement using self-report alone. In the da Silva study, for example, an objective measure is the amount of pain medication used daily by the client. In the Wilson and Nobleman study, heart rate, blood pressure, and other health indices were used. Those studies, however, were limited in other ways (small sample sizes, no control groups, etc.), as noted earlier. Self-report measures are extremely important as a way to hear the client's own voice, but eventually, we need a combination of self-report and more objective measures.

A related limitation of any self-report measure is what questions get asked of the client and what questions do not get asked. Perhaps there are questions you would have liked to see included in the Hoffren-Larsson et al. study that were not? Since the authors of the study appear to be interested in the role of client-practitioner relationships across different types of CAM approaches, in future studies they might want to include specific questions about the client-practitioner relationship as related to issues of teaching about the body, support for deepening self-awareness, or ways the practitioner created or did not create a sense of safety. Practitioners

might also have been interviewed or given questionnaires.

Another limitation is that the questionnaires were only given one time, after the client had experienced one or more treatments. A more objective approach is to use a so-called "longitudinal" (within subject over time) research, taking measurements before, during and after treatments. That way, researchers can compare what the client thought in each of these different periods over time. A one-time only questionnaire (a so called "cross-sectional" research approach) uses only the client's memories of the past (remembering back about why they entered treatment and summarizing the perceived benefits) which may already be colored and changed by their experiences in the treatment itself. The da Silva and Wilson and Nobleman studies used before, during and after approaches to data collection effectively.

The da Silva study used a particular sub-class of longitudinal methods called a **microgenetic research** design. Micro- (frequent observations) genetic (from the word genesis, or growth) research observes people on multiple occasions, ideally before, during, and after treatments, often including observations from every treatment session (Lavelli et al., 2004). This approach is particularly well-suited to EBP case studies. *Case studies cannot prove that a method is effective in the general population. They can, however, reveal how treatment and recovery unfolds over time to illuminate the actual process of change for particular individuals.*

These comments about limitations are not meant as a critique of the Hoffren-Larsson et al. study. Research is difficult to do, takes time, and often money: all limited resources. Any one research study can only contribute a small increment of knowledge and understanding. Rather, the goal of this discussion is to point out how much more we do not know and some new ways of thinking about what kinds of information we might want to collect in future EBP studies.

We can think of EBP as a process that goes through several developmental stages. These stages are comparable to the clinical trial phases required by the US National Institutes of Health for testing new drugs (<http://www.nlm.nih.gov/services/ct-phases.html>). The research stage we are in right now

for Rosen Method is the early stage in which studies such as the ones reviewed here are done: case studies, small sample studies, and interviews and questionnaires on groups of people who are already in treatment. We have a lot more to do in this stage and practitioners themselves can play an enormously important role by systematically documenting their own cases, whether those cases involve individual sessions or teaching larger classes.

The next stage is a continuation of the first, in which people organize and interpret evidence across previously published studies to see what might be common between them. This also leads to the creation of a set of measurement strategies that seem to yield consistent results across studies as well as to the development of the growth of a common language and shared set of concepts that guide both practice and research. Can a “fuzzy” concept such as “presence” be defined and measured, either qualitatively or quantitatively? Can we find the unique aspects of the client-therapist relationship that distinguish any one treatment approach from other approaches? Can we begin to catalogue which conditions are best treated by a particular clinical practice compared to or in conjunction with other practices. Which conditions are not readily treated by a particular clinical practice and to whom shall we refer such clients? Within any clinical discipline, we can also ask which types of practitioners are best for which types of clients.

A later stage is the use of randomized control group research which has become accepted as the most convincing type of evidence to support the effectiveness and potential counter-indications of a particular practice. Such studies, however, are useless in the absence of the grounded and detailed approach to evidence collection in the prior stages. Without case studies and without detailed interviews and questionnaires, we would not have a body of evidence that describes the work itself, evidence of the actual process of doing the work for all to see, understand, and even critique.

I would not say that randomized control groups are the best method. Rather, I would say that all these methods are equally important and need to be included in a comprehensive array of EBP procedures. Even neuroscience, a highly technical and

measurement based field, was founded upon case studies at a time when it was difficult or impossible to do brain scans and obtain more objective data. And today as neuroscience has reached a mature phase of its development, case studies of unique and special interest are still being published alongside quantitative studies involving brain chemistry, genetics, temperature and blood flow.

You don't need objective measures to make a contribution to an emerging or even an established clinical discipline. Write up your cases or your classes with care, session by session, and then sit down and read over your notes in a search for interpretations that seem consistent with the data you collected. You will learn a lot about yourself and about your clinical or educational practice in the process. You can also make audio or video recordings of your sessions or classes and study these to find ways to describe them. In RMB, there are a growing number of archival filmed records of entire bodywork sessions – many done by Marion Rosen herself – that can be studied in depth to look for where and why breakthroughs or changes in breathing or emotion or awareness may have occurred.

We can thank Riitta Hoffren-Larsson and her colleagues, not trained in Rosen Method, for being curious and energetic enough to study what we do. We cannot, however, sit back and wait for others to find us or to understand our work. Collecting documentary records and writing about our own work for EBP is as important in promoting Rosen Method as giving workshops and lectures and writing articles for the mass media.

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