GROUNDED THEORY OF ROSEN METHOD BODYWORK

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GROUNDING THEORY OF ROSEN METHOD BODYWORK

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ABSTRACT

Complementary approaches to health and wellness are widely used and research is needed to provide evidence of their utility. Rosen Method Bodywork (RMB) is a complementary approach with a small, but growing body of evidence. The purpose of this research study was to explore the processes of Rosen Method Bodywork to develop a theoretical framework about what occurs over the course of receiving sessions RMB, both within the recipient and between the recipient and the practitioner. In this grounded theory study, data from interviews of twenty participants was analyzed and a theoretical model of the overall process of RMB was constructed. The model consists of the five integrative phases through which these participants moved within the iterative RMB process from *Feeling Stuck and Disconnected* to *Feeling Connected*. Mindfulness is observed to be a central component of the RMB process which participants describe as helpful for trauma recovery. Implications of these findings for mental health care providers, including advanced practice mental health nurses, for Rosen Method Bodywork practitioners, and for future research are discussed.
DEDICATION

This study is dedicated to all those who recline upon the Rosen Method table to explore themselves and their relationship with the world, and to those who stand beside the table as caring witness.
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Chapter I: Background and Significance

The purpose of this study was to explore a complementary health care approach - Rosen Method Bodywork. Rosen Method Bodywork (RMB) is a hands-on mind-body modality that is not extensively studied. This initial chapter provides a general discussion of complementary health care approaches in order to put Rosen Method Bodywork in context. The significance of research on complementary approaches to the nursing discipline is presented. The chapter provides a brief description of Rosen Method Bodywork, followed by discussion of the significance of Rosen Method research to nursing. Lastly, the rationale for this study of RMB is presented.

Complementary Health Approaches

Complementary health approaches, sometimes referred to as CAM (complementary and alternative medicine) are approaches to health that originate outside of conventional Western medicine (National Center for Complementary and Integrative Health, NCCIH, 2015a). The NCCIH categorizes complementary health approaches in two large sub-types: natural products (such as supplements and herbs) and mind and body approaches which include touch interventions. Rosen Method Bodywork falls within the latter category.

In 1999, in response to public interest in and utilization of alternative health care practices, the National Institutes of Health (NIH) established the National Center for Complementary and Alternative Medicine (NCCAM) to research the efficacy and safety of CAM and to promote dissemination of CAM evidence to healthcare providers and the public. In 2014, the NCCAM was renamed the NCCIH to reflect the shift in usage of these interventions from alternative, implying use of an approach instead of traditional interventions, to complementary and integrative approaches to reflect how these approaches are most often used in combination
with mainstream medical care (NCCIH, 2014). Goals of the NCCAM, and now of the NCCIH, include providing evidence-based knowledge about these approaches to support the public in making informed health care decisions and supporting integration of safe, evidence-based complementary approaches within standard healthcare practices (NCCIH, 2015b). In the past decade, the agency funded over 2,500 CAM studies, and findings from these studies have been published in over 3,300 scientific, peer-reviewed articles (Briggs, 2010).

**Complementary Therapies Utilization**

Every five-years, the NCCIH summarizes data on the utilization of CAM in the United States. Data from each of the three five-year surveys suggests that more than 30% of the adult population used at least one complementary approach during a 12-month period (Clarke et al., 2015). While yoga was the most popular mind-body approach among adults, utilization of massage was also popular. In 2002, massage was used by 5.0 percent of adults. In 2007, 8.3 adults used massage, and in the 2012 survey, use of massage was at 6.9% (Clark et al.). According to the 2012 survey, the mind-body category of massage remains among the most common CAM approaches used by adults in the United States (Peregoy, Clarke, Stussman, & Nahin, 2014).

According to the NCCIH, mind-body practices include a spectrum of approaches many of which involve the assistance of a trained teacher or provider. (NCCIH, 2015a). Among the NCCIH objectives are the advancement of knowledge regarding mechanisms by which mind-body approaches influence health, particularly for pain, depression, and anxiety (NCCIH, 2016a).

People seek complementary therapies for varied reasons, regardless of evidence supporting the therapies (Clarke et al., 2015). Pain is the most common reason that people seek
CAM approaches (NCCIH, 2017). In addition, CAM therapies are often used to address psychological pain, such as anxiety and depression (Barnes, Bloom & Nahin, 2008). According to the Institutes of Medicine (2015), reasons people use CAM include chronic illnesses, conditions with poor prognosis or significant pain, side effects of standard treatment, and the improvement of general health and disease prevention. According to national statistics on the utilization of CAM, touch therapies were often used to treat physical pain, anxiety and depression (Barnes et al., 2008). Reasons women seek CAM include consistency with their beliefs about health and treatment, dissatisfaction with standard health care, costs of standard health care, and referrals from traditional doctors (Chao, Wade, Kronenberg, Kalmuss, & Cushman, 2006). According to a national 2012 survey, annual out-of-pocket payments for CAM were estimated at more than $30.2 billion, 14.7 billion of these funds were for visits to complementary practitioners (Briggs, 2010; NCCAM, 2013; NCCIH, 2016b).

Although not in the United States, a (2014) Queensland study survey of 1256 adults found that spirituality (not religion) positively predicted CAM use, and that openness to new ideas and experiences predicted CAM use (Thomson, Jones, Browne, & Leslie). The authors noted that these findings were consistent with their previous research.

**Importance of Research on CAM**

Certain complementary approaches, such as yoga, meditation, and acupuncture have undergone considerable exploration while other approaches have been studied much less (NCCAM, 2015). Further research on CAM is important to protect public health, coordinate care, improve standard treatment, and improve quality and access to health care. Research on the safety of and indications for CAM builds understanding between traditional healthcare and CAM providers, setting the stage for effective communication, profession alliances, coordination of
care, improved patient compliance and outcomes, and ultimately improved public health (Hawk, Ndetan & Evans, 2012; NCCIH 2016c; Schultz, Chao, & McGinnis, 2009). Recipients of CAM may have multiple health problems, including obesity, diabetes, and elevated cholesterol. CAM providers may be in an optimal position to recommend healthy lifestyle behaviors or refer to other providers who address specific health issues (Hawk et al., 2012). Conversely, informed traditional providers are better prepared to refer patients for appropriate CAM therapies (NCCIH, 2016c).

Mutual understanding among standard care and CAM providers can improve patient outcomes. People utilizing CAM often visit their CAM providers more frequently than their traditional care providers and do not necessarily inform their primary care providers of CAM use (Hawk, Ndetan & Evans, 2012; Institute of Medicine, 2015). A well-developed foundation of evidence from research on CAM would improve communication and continuity of care between traditional and CAM providers and would likely improve compliance with treatment (Hawk, Ndetan & Evans, 2012; NCCIH, 2016c). In addition, such communication would be essential to effectively manage adverse treatment reactions or interactions, and it would minimize gaps in care (Katz & Ali, 2009). With knowledge of the evidence, all practitioners are better positioned to support the public in making informed choices about health care.

Research on CAM approaches can enhance the quality of standard care. Standard healthcare may be evidence-based, but it might not be ideal. It can involve side-effects or contraindications for some individuals. Evidence-based practice includes individualization of treatment which requires clinicians who are knowledgeable about options. Well-researched CAM therapies can broaden the range of treatment alternatives from which standard health care providers and their patients can confidently choose.
Research on CAM identifies effective or harmful interventions and thereby can contribute to the evolution of standard therapeutic treatment and improved quality of care. For example, research on mindfulness led to the inclusion of mindfulness practices in standard psychiatric care (Segal, Williams, & Teasdale, 2013). Basic research on interventions can increase understanding of what occurs for people receiving a CAM approach and what processes are involved in the intervention. This knowledge contributes to understanding of the mechanisms involved and to theory development which can then be subjected to theory testing.

Access to evidence-based CAM is improved by research. Evidence supporting CAM usage would presumably stimulate interest in professional training in CAM approaches, thereby expanding the pool of available trained practitioners, including traditional practitioners who adopt CAM approaches as part of their treatment toolbox (Katz & Ali, 2009). A growing body of research on CAM ultimately influences reimbursement by third-party payers, increasing access to interventions previously categorized as CAM, requiring private, out-of-pocket payment (NCCAM, 2013). Improved access would bring CAM to currently under-served populations, such as low-income groups (IOM, 2015).

**Nursing and CAM**

Given the trend toward public interest in CAM and the basic goals of nursing that include provision of comfort, pain reduction and health promotion, it is understandable that nursing interest in CAM has also increased in recent decades. Nursing has traditionally cared for the whole person, body and mind (Kim, 2010). It makes sense to consider mind-body interventions in nursing practice.

Evidence of nurses’ interest in holism and complementary approaches is seen in the numbers of nurses identifying themselves as holistic and pursuing knowledge about CAM. As of
2015, 1441 nurses held national board certification as holistic nurses (Erickson, personal communication, May 11 2015). Another indicator of nurses' interest in CAM is the growth of the American Holistic Nurses Association (AHNA) from its pioneering inception in 1981 to its membership of more than 4,500 members (AHNA, 2015). This number does not represent nurses who are not AHNA members but who view the site and the journal as resources).

Another indicator of nursing interest in CAM is the availability of CAM continuing education offerings. For example, the AHNA is accredited by the American Nurses Credentialing Center to both approve and provide continuing nursing education for nurses (AHNA, 2015). Courses include a variety of mind-body approaches involving touch, such as Healing Touch, Reiki, Therapeutic Touch, and Quantum Touch. Rosen Method Bodywork training centers are located in two California cities (Berkeley and Monterey), Minnesota, and Utah, and these centers hold trainings in other locations in the U. S. Nursing continuing education is available for Rosen Method Bodywork trainings. (Rosen Method, n.d.).

Recognition of the significance of CAM approaches has motivated state nursing boards to publish position statements about CAM use by nurses. A 2001 survey of state nursing boards found that most boards had either adopted position statements on the use of CAM modalities in nursing practice, or were discussing this topic (Sparber, 2001). Those boards which had not yet explored the topic were not necessarily opposed to nursing utilization of CAM (Sparber, 2001). As of 2017, 18 states have statements referring to holistic nursing, complementary alternative or integrative modalities or holistic nursing or holism (Roberts, Schoenfeld, Schneider, Cohen, & Bergum, AHNA, Dec 2017). The Ohio Board of Nursing (OBN) states that nurses trained in complementary approaches may determine, based on their individual clinical judgment,
knowledge, and training, that a complementary intervention fits within the plan of care for an individual patient (OBN, 2009).

Responsible nursing care includes knowledge and skill in treatment options including evidence-based CAM approaches (California Board of Registered Nurses, 2000; Jackson, 2015). For example, given the extant evidence for certain CAM approaches in pain management and the role of nursing in pain management, it can be argued that nurses have the obligation to be educated to understand CAM approaches to either implement CAM approaches if qualified or refer their patients to appropriate providers (Trail-Mahan, Chia-Ling Mao, & Bawel-Brinkley, 2013; Van Sant-Smith, 2014).

Consumer demand for complementary approaches drives a movement toward integration of complementary approaches in hospitals and private practice settings (NCCAM, 2015). Many health care settings increasingly include CAM services to address public interest and maximize recipient satisfaction (Trail-Mahan et al., 2013). Within health care settings, knowledgeable nurses are well-positioned to encourage this movement and to seamlessly integrate CAM approaches with standard care during direct patient care. Informed nurses also advocate for patients when CAM approaches are indicated. According to data on CAM utilization in the United States, use of CAM among adults in the United States is influenced by education, socioeconomic status, and ability to pay out-of-pocket fees (Katz & Ali, 2009). Armed with adequate evidence, nurses can advocate for evidence-based CAM approaches be made available in hospital and clinical settings through third-party reimbursement to help reduce health care disparities.
Need for Nursing Research in CAM

Nurses who provide or recommend CAM approaches rely on an ever-increasing body of evidence to wisely determine the usefulness of specific CAM approaches for patient care, to refer their patients for CAM, and to advocate for the provision of CAM services for their patients. Responsible utilization of CAM approaches requires evidence of safety and efficacy. Anecdotal evidence, popularity, or tradition are insufficient reasons to broadly recommend a CAM treatment (Ernst, 2015). Nursing utilization of CAM approaches requires rigorous inquiry. Research is needed to build evidence and eventually identify causal relationships between approaches and outcomes.

Even when adequate evidence exists for CAM, translation of extant evidence takes time. Barriers to implementation of CAM in many standard health care settings prevent smooth integration of CAM with standard care (Trail-Mahan et al., 2013). Nursing leadership, informed by research evidence on CAM approaches, is obligated to improve the integration of substantiated CAM into standard care. If nurses have the professional obligation to promote CAM approaches that have been demonstrated to be helpful, and if nurse researchers are important contributors to the body of research evidence with expanding evidence, then it follows that the nurse researcher's role may include contributing to knowledge about CAM approaches.

Unique Utilization of CAM by Nurses

Nursing often employs interventions that are also used within other disciplines. For example, psychotherapy is utilized by advanced practice mental health nurses as well as other mental health disciplines. Complementary health approaches are used by a wide variety of practitioners with diverse backgrounds, so the question arises as to how CAM approaches are uniquely utilized within nursing practice? Professional nursing practice involves delivery of care
according to nursing theory and nursing processes. The provision of complementary approaches by nurses is distinguished from CAM provided by other disciplines by such nursing elements as the theoretical underpinnings of practice, use of the nursing process, and the utilization of nursing taxonomies (Frisch, 2001). Nursing is well-positioned to implement CAM approaches due to the nursing discipline’s unique, holistic, mind-body knowledge base and focus on interventions to benefit the wellness of the whole person (American Nurses Association, 2015).

**Rosen Method Bodywork**

The NCCIH describes the mind-body approach of "massage" as encompassing "many different techniques" in which "therapists press, rub, and otherwise manipulate the muscles and other soft tissues of the body" (NCCIH, 2015c). According to this definition, Rosen Method Bodywork falls within this sub-category of mind-body approaches. The goals of RMB are relaxation, awareness, and transformation (Rosen & Brenner, 2003). The body and mind are understood to be connected. Tension and relaxation of the physical body are believed to correspond with tension and relaxation of the mind (Rosen & Brenner, 2003). Rosen Method works with muscles and the breath. The ease or tension of the breath is viewed as an indicator of the ease or tension of the mind-body (Rosen & Brenner, 2003; Wooten, 1995). Rosen Method Bodywork involves “listening” touch to encourage awareness of the embodied experience of the recipient. (Fogel, 2009).

During a Rosen Method Bodywork (RMB) session, the recipient lies on a massage table and receives gentle touch applied to the body with particular attention to areas of muscular tension (Wooten, 1995). The recipient is guided by the practitioner's touch and sometimes by words, to mindfully attend to the mind-body experience of moment-by-moment physical sensations, thoughts, mental images, and emotions, as they occur. In the same way that physical
relaxation frees the body, allowing more flexibility and novel movement, relaxation of the mind is believed to awaken more novel and less habitual, unconscious ways of responding, enabling personal transformation (Rosen & Brenner, 2003; Wooten 1995).

Rosen Method Bodywork is taught and practiced in more than 15 countries including, Russia, Israel, Australia, Canada, and centers in European countries (Keller & Webb, 2011) with 14 training centers, worldwide (Rosen Institute web site accessed 1-3-18). Within the United States there are five training centers; Centers often provide trainings in other locations within the United States, upon demand (Rosen Institute, 2016). Certification in Rosen Method Bodywork involves several years of training with at least 262 classroom hours and an internship involving work with clients, supervision, personal sessions, and consultation (Rosen Method, 2016). Books and articles have been written on Rosen Method Bodywork and a Rosen Method International Journal was established in 2008 to publish peer-reviewed literature on RMB.

Research on RMB is new and growing, however relatively little has been formally studied about this intervention and its possible applications. From the somewhat small body of research on Rosen Method Bodywork, we know that recipients of RMB perceived benefits including improved psychological health, increased positive emotions, reduced anxiety and depression, and reduced suicidal ideation (Hoffren-Larsson, Gustafsson, & Falkenberg, 2009). Fogel (2013) found that chronic pain participants experienced reduced physical pain and improvements in mood over a series of RMB sessions. Bernard (2014) found that RMB facilitated healing from traumatic experiences and that the client-practitioner relationship is essential.
Need for Further Research on Rosen Method Bodywork

The theoretical literature on Rosen Method bodywork describes it as a type of mindfulness process and suggests that both practitioner and recipients have experiences that resemble mindfulness (Kushnir, 2008) such as embodied self-awareness (Fogel, 2009, Fogel, 2013). While, RMB appears to support mindfulness experiences in recipients, researchers have not yet examined in detail the experiences of recipients with regard to the processes occurring during and between sessions which may indicate mindfulness. Little has been studied about what recipients experience within sessions, between sessions, or how the relationship with the practitioner influences their experience, although one study found that the client's perception of the practitioner's caring influenced satisfaction with the RMB session (Hoffrén-Larsson, Löwstedt, Mattiasson, & Falkenberg, 2013). Evidence about how RMB works or what processes are involved is limited. Understanding what occurs for recipients will provide greater theoretical understanding of how this touch intervention works and how it may be helpful.

Knowledge about mechanisms involved in RMB would contribute to theory development. Building a theoretical understanding of this bodywork would provide a theoretical framework for future studies and hypotheses to be tested. For example, mindfulness may also be a dimension of the intrapersonal and interpersonal processes experienced by recipients of RMB. If RMB contains significant elements of mindfulness, then theoretically, mindfulness may contribute to the beneficial effects of this touch intervention on mood. To explore what occurs for recipients without biasing them with the researcher's assumptions, an inductive, qualitative approach is indicated to encourage recipients of RMB to describe their experiences. Research on RMB would help clarify the type of persons drawn to this bodywork and reasons they receive it. This understanding would be useful to standard health care providers of both physical and
psychological care to help identify patients who might respond well to the addition of RMB in their treatment regime.

**Rosen Method Research and Significance to Mental Health Nursing**

Providing Rosen Method Bodywork is consistent with what nurses do. Nurses promote relaxation, take action to reduce physical and emotional pain, and they individualize care to best meet the individual patient's needs. Touch therapies have been shown to improve not only physical comfort but to positively affect anxiety and depression in a wide variety of non-psychiatric patient populations, including people with cancer (Fulcher, Badger, Gunter, Marrs, & Reese, 2008; Jackson et al., 2008), chronic pain (Smith, Arnstein, Rosa, & Wells-Federman, 2002; Fogel, 2013) and the elderly (Richeson, Spross, Lutz, & Peng, 2010).

Although research has demonstrated improvements in psychological states with touch interventions, touch therapies are not usually employed in standard western psychotherapy. That said, the apparent benefit of touch interventions is indicated by the branch of psychotherapy identified as body-psychotherapy. Within body-psychotherapy there are multiple approaches which integrate touch with psychotherapy (European Association of Body Psychotherapy, n.d.; United States Association for Body Psychotherapy, 2015). Given the apparent benefits of touch interventions on mood, as well as the apparent usefulness of touch interventions in body-psychotherapy, further research on touch therapies, such as RMB, is warranted.

In mental health nursing, as in all specialties of nursing, knowledge about diverse evidence-based approaches to treatment allows for optimal individualization of patient care. It behooves nurses to have different approaches to address learning preferences and capabilities of different individuals. Within the specialty of mental health, common psychotherapy goals include educating patients about relaxation, regulation of mood and thoughts, and awareness of
patterns of behavior (Tusaie & Fitzpatrick, 2013). Nurses teach patients to self-soothe, recover from distress, and to gain insight from distress. Nurses teach self-awareness so that patients can learn to change patterns of behavior. If RMB indeed facilitates relaxation, comfort, pain reduction, and embodied awareness (Fogel, 2009, 2013), then provision of RMB is consistent and appropriate for mental health nursing, and RMB can provide yet another tool for assisting patients in the learning process.

Psychiatric mental health advanced practice nurses provide a variety of psychotherapy approaches many of which now include elements of mindfulness (Tusaie & Fitzpatrick, 2013). Some decades ago, mindfulness was considered a CAM approach, however it has since become integrated with several standard western psychotherapy methods (Segal, Williams, & Teasdale, 2013). This evolution of standard western psychotherapy was substantially influenced by the body of research which validated mindfulness interventions. Just as the once-foreign mindfulness practices have now joined standard psychotherapy practice, with sufficient research other CAM approaches may also be shown to hold value. If recipients of RMB indicate improvements in mindfulness over the course of RMB sessions, then RMB may be another tool for teaching mindfulness and thereby enhancing mental health.
CHAPTER II: LITERATURE REVIEW

This review of the literature presents the theoretical framework of Rosen Method Bodywork (RMB) within the general context of other complementary and alternative medicine (CAM) touch therapy theories. Parallels between RMB and the concept of mindfulness are found in the literature on RMB; therefore, the concept of mindfulness is presented, including its role in psychological treatment. The literature demonstrating beneficial psychological effects of touch therapies is presented as well as literature addressing the management of ethical concerns which would be relevant if RMB were utilized by advanced practice psychiatric nurses in psychotherapy. In keeping with the Grounded Theory tradition of avoiding preconceptions that may interfere with the inductive process of analysis, the integration of this study’s findings with extant theories of interpersonal and intrapersonal processes was suspended until the analysis phase of this study (Glaser & Strauss, 1967).

Theories of CAM Touch Approaches

Intrinsic to theories of touch therapies is the assumption that the mind is not distinct from the physical body, and that in some way, when we touch the body, we are contacting the whole person, including conscious and unconscious aspects of the mind (Marlock & Weiss, 2015). Also, a given touch approach may incorporate multiple theoretical perspectives. The following describes some basic theoretical perspectives of touch approaches.

Energy-based Theories of Touch Approaches.

Energy-based touch interventions which derive largely from Eastern philosophies of medicine view health as a reflection of the wholesome flow of vital energy through the person. Health is believed to be influenced by the balance and flow of energy along meridians, or channels, along which energy moves throughout the body (Lewith, 1985; Teeguarden, 1987).
Blockages and excesses of energy in certain meridians are treated by stimulation at specific points along meridians, such as with acupressure touch or insertion of acupuncture needles.

The flow of energy is assessed through physical examination which includes palpation of pulses located at various areas of the body. Similar to western medicine, these pulses are palpated at the wrists and other key locations, however in traditional Chinese medicine there are multiple pulses assessed at each wrist, including superficial and deep pulses. The quality of the pulses indicates how energy is flowing and whether energy is deficient or excessive in a given area of the energy system of the body. The assessment of energy flow may suggest various disease states (Lewith, 1985). The practitioner determines from the assessment whether the flow is excessive or deficient and whether to stimulate or sedate the energy flow at specific points along meridians; acupuncture often utilizes shallow needle placement (The Academy of Traditional Chinese Medicine, 1975), while acupressure uses manual pressure (Teeguarden, 1987). In traditional Chinese medicine, the mind and body are perceived as integrated, each influencing the other in an inseparable manner (Teeguarden, 1987; Academy of Traditional Chinese Medicine, 1975). Physical organs and emotional and mental states are simultaneously influenced by the flow of energy.

Other energy-based touch approaches with similar theoretical emphasis on energy flow include Jin Shin Jyutsu, Shiatsu, Breema bodywork, Reiki, Therapeutic Touch, and Healing Touch. Some of these approaches use touch contact and some work over the surface of the body to influence energy flow.

Although Rosen Method Bodywork has not been described in the Rosen literature as an energy-based approach, practitioners of Rosen Method may be trained in multiple touch modalities and may have experiences of energy aspects as they work with clients. Rosen Method
Bodywork derives from both a biomechanical and a body-based, psychological theoretical foundation, each of which will be described below.

**Biomechanical and Combined Theories of Touch Approaches.**

A wide variety of touch approaches use a biomechanical theoretical framework or philosophy (Triano, 2012). Swedish massage employs strokes that are directed toward the heart to facilitate circulatory return. Lymphatic massage encourages return of interstitial fluids via the lymph system pathways toward the heart by using strokes along lymphatic pathways (Beck, 1999). Other biomechanical approaches may seek to reduce nerve impingement due to muscle tension and soft-tissue adhesions, improve joint range of motion, or stimulate myofascial trigger points to reduce pain or promote other beneficial physical outcomes (Beck, 1999; Triano, 2012). These biomechanical approaches focus on the body and give little attention to the mind, beyond inducing relaxation or a feeling of well-being (Beck, 1999).

Adjacent to and overlapping with the biomechanical approaches are approaches that take both the body and the mind into account. Many touch approaches, including Rosen Method Bodywork, use a combination of theoretical frameworks, such as combining biomechanical assumptions with spiritual or energy-based assumptions. For example, Trager bodywork uses table work in which the recipient lies on a massage table to receive the touch, and a movement process called mentastics. Both touch and movement elements of Trager bodywork seek to release patterns of limitation in body and mind (Trager International, 2010). Trager bodywork works with the range of movement of the musculoskeletal system, and in this sense, has biomechanical aspects, however the way the practitioner uses touch and movement is guided by an intention to influence mental and neurological patterns of self-experience and movement. The founder, Milton Trager used touch with the intention to contact and influence the conscious and
unconscious mind of the recipient through the freeing of held mental and physical patterns (Juhan, 1993).

Another example of a touch therapy that utilizes more than one philosophical framework is Esalen massage. Esalen massage was developed at the Esalen Institute in California over 50 years ago, and uses long, slow, rhythmic, connecting strokes with the intention of supporting an experience of integration and wholeness of body, mind, and spirit (Esalen, 2015; Findhorn Foundation, 2015). Esalen practitioners, like practitioners of many touch approaches, believe the presence of the practitioner influences the experience of the recipient. Esalen practitioners cultivate a meditative, relaxed and mindful presence while providing touch.

Many touch approaches recognize the integrative nature of the relationship between mind and body. One implication of this relationship is that bodywork can influence the mind. The literature on Rosen Method Bodywork distinguishes RMB from psychotherapy (Rosen and Brenner, 2003), however RMB shares premises with a branch of psychology called body psychology which utilizes the mind-body relationship to facilitate healing, by engaging the body as well as the mind.

**Body Psychology Theory.**

Body Psychology is a branch of psychology that recognizes the relationship between the body and the mind. According to the United States Association of Body Psychotherapy (USABP), body psychology, also known as somatic psychology, is a branch of contemporary psychology. Body psychology is based on the premise that the body and mind are integrated aspects of the person's inseparable wholeness (United States Association of Body Psychotherapy, 2015). Additional premises shared by various body psychotherapy approaches include the following: the body has an innate healing potential; working with the body in the present
moment and in a therapeutic relationship facilitates this healing potential; there is a felt-sense of experience with access to unconscious material; and, memories include bodily experience and are held within the body (USABP, 2015). According to body psychology, psychological tensions have physiological correlates such as muscle tension. Emotions, memories, and responses to life are experienced in the body, and therefore therapeutic interventions are employed to directly engage the body. Touch may be used as part of this engagement.

Examples of body psychology approaches include Bioenergetics, Hakomi, Gestalt, and Somatic Experiencing.

The controversial work of psychoanalyst Wilhelm Reich is often described as an early influence on the development of the field of body psychology (Young, 1997). Reich was a psychoanalyst of the 1900's who was influenced by Freud and Jung and went beyond their philosophies of practice and engaged his patients' bodies directly in his psychotherapy work. He referred to the muscular tensions in his patients as armor representing a physical and unconscious attempt to defend against or resist distress (Corrington, 2003). These patterns of muscular tension are believed to be unconsciously employed to defend against distressing experience. When the armoring tension becomes habitual, it is believed to interfere with receptivity to new experiences (Bond, 1982; Stötter et al, 2013).

The diverse methods and knowledge bases of many body psychology approaches are summarized in a compilation by multiple theorists and practitioners entitled, *The Handbook of Body Psychology* (Marlock, Weiss, Young & Soth, 2015). Content addresses a wide range of topics including the history of body psychology, perspectives on phenomenology, neurobiology, energy approaches, and psychology, somatic related to growth and development, and body psychotherapy in treatment of disorders, including trauma. As Van Der Kolk writes in the *The
Handbook of Body Psychology, there is a growing interest in shifting psychological interventions from intervening with a cognitive approach to intervening with approaches facilitating experiential learning. This shift acknowledges the interference that high emotion brings to reasoning and the gap between knowing and doing. Taking these two realities into account, body psychology seeks to empower the individual to know themselves experientially and thereby become skilled at navigating the stresses of life and integrate experiences of the past, including traumatic ones (Marlock, Weiss, Young & Soth, 2015).

Further developments in body psychology include the increased understanding of trauma and the treatment of trauma. Trauma has been defined as a threatening experience that exceeds the person's ability to achieve a sense of safety and to integrate the experience (Levine, 2010). The unconscious bodily response at the time of the traumatic experience, such as muscle tension, later becomes a habitual, default response (Levine, 2010). The individual lives within a narrowed window of tolerance to stimuli and has fewer possible responses. In a reactive effort to protect themselves, traumatized individuals tend to respond habitually with either hyperarousal (heightened sensation, hypervigilance, intrusive imagery, disorganized processing and emotional reactivity) or with hypoarousal (reduced sensation, numbed emotions, reduced cognitive processing and subdued bodily movement. (Ogden, 2006). Bessel van der Kolk, researcher and clinician in the field of trauma, in a podcast interview about his work, describes the nature of traumatic response as unconscious and bodily. He recommends that his patients receive bodywork because it is important for them to be able to find safety within their own skin (Van Der Kolk, 2014). Therapeutic developments in the field of trauma over recent decades highlight the importance of including the body in psychotherapy (Ogden, Minton, & Pain, 2006; Levine, 2010; Van der Kolk 2014). Complementary mind-body approaches which engage
somatosensory experience and address the relationship between mind and body are viewed as key to effective work with trauma recovery (Cloitre et al., 2012).

Through his clinical experience over decades with trauma treatment, Van der Kolk identifies the bodily experience or felt-sense of safety as an essential experience in the process of recovery from trauma (Van Der Kolk, 2014). It follows that when touch interventions are provided with client consent and in an atmosphere promoting safety, touch may be experienced as comforting and thereby assist in the process of recovery.

The field of body psychology has integrated contributions from Eastern philosophies, dance and movement, Gestalt psychology, existential and humanistic psychologies, art therapy, and neurology (Tickner, n.d.). While the theoretical emphases vary among different approaches within body psychology, each approach engages the relationship between body and mind (USABP, 2015). The theoretical foundation of RMB derives from the European psychoanalytic and body psychology cultures of the early 1900's as well as the physical therapy orientation of its founder, Marion Rosen (Green, 2016; Weaver, 2015).

**Theoretical Foundation of Rosen Method Bodywork.**

Marion Rosen grew up in Germany prior to World War II and was influenced by contemporary psychiatric approaches which recognized the integration of body and mind (Cohen & Pittinger, 1997). As a young woman, she received treatment for asthma from Lucy Heyer. Heyer worked with touch, movement, and breathing processes to help her patients; her patients also received Jungian analysis from her husband (Cohen & Pittinger).

With the rise of Nazism, Marion Rosen fled Europe and eventually arrived in the United States where she pursued physical therapy training at the Mayo Clinic. She uniquely synthesized what she had learned with Heyer with what she had learned through her physical therapy work
(Mayland, 2005). After moving to Berkeley, California in the 1970's, upon request from her clients and their family members who observed benefits of the work, Rosen began to teach her method of working with the mind-body relationship using touch and talk, which became Rosen Method Bodywork. She also developed Rosen Movement, a group format for gently and playfully exploring freedom of movement.

Rosen Method Bodywork employs touch primarily and talk secondarily to access the whole person, including conscious and unconscious mind. Both touch and words are used to guide the recipient's awareness toward the felt-sense of experience in the present moment. The goals of the work include relaxation, awareness, and personal transformation (Mayland, 2005; Rosen & Brenner, 2003; Wooten, 1995). RMB, like other touch therapies, seeks to facilitate freedom from limiting habits of tensions manifested in both the mind and the body.

Theoretical assumptions underlying the touch aspect of RMB focus largely on the respiratory process as influenced by musculature. In a biomechanical sense, RMB works with muscles that restrict the freedom of the natural, spontaneous breath; From the body psychology perspective, Rosen Method works with the habitual, tension patterns, or body armor which restricts the natural breath. According to RMB, muscular holding is viewed as the physical aspect of the person's psychological holding. The neuromuscular patterns associated with respiration are believed to be influenced by mental and emotional experience. For example, when overwhelming experiences occur, the breath is held; when relief is achieved, the breath lets go.

Breathing can be done volitionally, but most occurs without conscious control. Patterns of breathing are largely unconscious, requiring no active volitional control. Breathing patterns involve the interaction of the nervous system and the musculoskeletal system. Spontaneous
changes in breathing patterns have been observed in animals when experiencing stimuli such as anxiety, anticipation, attention, social factors, and defensiveness (Fokkema, 1999). The theoretical perspective underlying RMB is that musculoskeletal patterns involved in breathing are believed to become habitual as a result of the person's life experience. These patterns constitute a default pattern of response. Chronic patterns of muscular holding become limiting when they interfere with free range of motion or with a fresh, present-time response by imposing a preset reaction. The release of chronic holding is believed to provide opportunities for responding to life in new ways. Rosen Method Bodywork seeks to assist the release of mind-body holding by working with muscle tension through touch that encourages awareness and relaxation (Rosen & Brenner, 2003).

In Rosen Method Bodywork sessions, the recipient lies on a massage table to allow tensions to relax. The practitioner uses hands to contact the physical tension and to guide the recipient's awareness to the experience of the mind-body, in the moment (Rosen & Brenner, 2003; Wooten, 1995). The tension in the muscles that lingers, even when reclining and “at rest”, is viewed as unconscious.

Unlike biomechanical approaches which seek to manipulate tissues and release tension through external intervention, Rosen touch uses the integrated mind and body relationship to facilitate awareness of the bodily experiences of tension and relaxation as well as the mental content accompanying these sensations.

The practitioner is trained to continuously attune to the recipient’s experience while staying embodied within him/herself (Green, 2016). The intention of the touch is to reflect to the receiver what is happening in the moment, within the body-mind, bringing the recipient's awareness to the area of the body as well as the mental and emotional experiences that may
accompany the tension there. As habitual muscle holding is contacted, associations, memories, and insights may arise (Green, 2016). The attitude and presence of the practitioner models openness, curiosity and willingness to be with what arises and invites the recipient to be curious and to open to what the body conveys. Marion Rosen found that as her clients became aware of the sensations of tension and of the thoughts and feelings corresponding with the tension, tensions would release. She observed her clients’ discovery, through their bodies, of their potential to relax more deeply, allowing for greater freedom of movement and in engagement with life experiences (Rosen & Brenner, 2003).

A major theoretical concept of RMB is the natural breath as compared with the restricted or regulated breath. Breathing is a function of diaphragm and, when needed, accessory breathing muscles. The activity of the diaphragm is responsive to muscular activity elsewhere in the body as well as emotional and psychological states. From the RMB perspective, the understanding is that in every moment, breathing is influenced by the stream of psychological and physical experiences. For example, the natural breath associated with anticipation might temporarily be more rapid and shallow, and experienced in the chest more than in the belly. Temporary shifts and moment-by-moment variations are natural. However, when tensions of the body-mind become habitual in response to life experiences, changes in breathing patterns become more rigid and locked in. These habitual tension patterns also limit the individual’s awareness of their interoceptive experience by overshadowing the felt-sense of the moment with a veil of tension.

As noted by Green (2016), the relationship between breath and psychological states has long been harnessed by spiritual practices that use the breath to establish specific states of mind. However, RMB seeks the natural, unregulated breath which occurs when one’s immediate experience is transparent. Rosen practitioners guide recipients to allow the breath to breathe
them, supporting the person in stepping out of the way of their true experience and allowing
what is, to be as it is. When the spontaneous acceptance of what is true for the individual is
allowed, a qualitatively unique “breath of confirmation” is observed in which the inflow and
outflow are spontaneous and there is further relaxing. (Green, 2016).

In summary, various CAM touch approaches have different and sometimes overlapping
philosophical foundations. Energy-based approaches use touch to facilitate the flow of energy
through the body, while recognizing the inseparability of mind and body. Biomechanical
approaches vary in the degree to which they emphasize the relationship between the mind and
body; some do not particularly seek to engage the mind while others use touch to the body in
order to access the mind. RMB interacts with the musculoskeletal system through touch and as
such draws upon biomechanical theory; it also uses words to guide and support mind-body
awareness, as in so doing reflects theoretical foundations in the mind-body theory of body
psychology. RMB works with muscles in general, and particularly with the musculature
pertaining to breathing, to release habitual patterns of holding that limit the mind and body,
however RMB also engages the mind in a body-mind awareness process toward the goals of self-
awareness, relaxation, and freedom of responses.

Within the literature on Rosen Method Bodywork, similarities have been drawn between
mindfulness and RMB. Indeed, RMB has been referred to as a mindfulness process (Green,
2016; Kushnir, 2008; Cober, Smart, & Williams, 2014). This study seeks to identify processes
involved in RMB through examination of the accounts of recipients with respect to processes. If
mindfulness is indeed a feature of RMB described by recipients, then it is useful to understand
the meaning of the concept. To understand the body of knowledge that relates to RMB, the
following discussion of mindfulness is provided.
Mindfulness

The concept of mindfulness became popular with the work of Jon Kabat-Zinn who, in the 1980's, successfully integrated meditation and yoga in an outpatient program of stress reduction for people with medical problems for whom medicine had little more to offer (Kabat-Zinn, 1990). He described mindfulness as intentionally paying attention, in the present moment, without judgment. He taught patients how to practice mindfulness using exercises and philosophy derived from meditation and yoga.

Two decades later, an operational definition of mindfulness was proposed by Bishop et al. (2004) in which mindfulness was defined as a process of awareness involving sustained attention, the ability to volitionally switch attention, the inhibition of secondary elaborative processing, and an attitude of curiosity, openness, and acceptance. Mindfulness is described as an unconditional awareness and acceptance of experience, as it is in the moment, without either grasping or resisting the experience (Kabat-Zinn, 1990; Neff, 2003a). Inherent in this definition is the absence of judgment - an openness to and acceptance of the reality of one's immediate experience. With mindfulness, one's suffering is not ignored, nor is it focused upon through rumination. From a mindfulness perspective, the reality of one's humanness and of unpleasant life experiences is accepted without judgment (Neff, 2003a). Acceptance does not imply approval. Mindfulness allows for a necessary acceptance of reality as it is, which allows the individual to free up resources in order to respond most effectively to institute change (Linehan, 2014).

Mindfulness has been described as an essential ingredient for compassion, including self-compassion (Neff & Beretvas, 2012). Mindfulness implies that the individual is aware of his or her own behavior. Rather than a defensive mechanism of denial to avoid facing one's mistakes
or one’s suffering, mindfulness involves an awareness of one's condition with acceptance, in the absence of harsh judgment. The mindfulness aspect of self-compassion contributes to a willingness to acknowledge and change behaviors that do not serve one's well-being (Breines & Chen, 2012).

In recent decades, the concept of mindfulness has become central in several standard psychotherapy approaches, including Dialectical Behavioral therapy, Acceptance and Commitment Therapy, and Mindfulness-Based Cognitive Therapy (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Linehan, 1993; Segal, Williams, & Teasdale, 2013; Siegel, 2010). Interestingly, while mindfulness is viewed as an accepted concept in standard psychological practice, mindfulness meditation is listed as a mind-body CAM practice on the National Institutes of Health website (NCCIH, 2015d), indicating that mindfulness is still in the process of being integrated into standard health care practice.

Mindfulness includes moment-by-moment experiences of the mind and the body (Teasdale et al., 1995). Awareness of the body is central to mindfulness. The body is used as a focal point for awareness training in many mindfulness exercises, including the body scan practice and practices involving mindfulness to breathing (Segal, Williams, & Teasdale, 2013). In addition, several CAM and body psychology approaches have been described as mindfulness interventions, for example, Hakomi bodywork (Kurtz, 1990) and Stötter's mindfulness-based touch intervention (Stötter et al, 2013; USABP, 2013).

Benefits of mindfulness are not simply experiential. Research on mindfulness has demonstrated that mindfulness practice involves neuroplastic changes in brain. Such findings point to possible mechanisms by which mindfulness improves psychological health. The literature on the neuroplasticity of the brain suggests that, through specific activities such as
meditation or yoga, the brain may develop a greater capacity for integration of emotion and other aspects of experience without overload, thus improving coping, resilience and wellbeing (Siegel, 2010), as well as the management of depression (Segal, Williams, & Teasdale, 2013). If RMB promotes mindfulness, it may be a relevant tool in supporting positive mental health outcomes.

**Neuroplastic Changes Associated with Mindfulness.**

Neuroplastic changes in brain structure associated with mindfulness suggest beneficial outcomes from mindfulness practice. In a randomized intervention study, Tang et al. (2006) examined the effects of a short-term meditation training as compared to only relaxation training on 45 healthy undergraduates. Twenty-three subjects in the intervention group underwent a meditation training called Integrative Body-Mind Training involving mindfulness, relaxation with music, and imagery. Twenty-three subjects participated in the relaxation comparison group. Neuroplastic changes in the anterior cingulate cortex were found after a month-long course of 30-minute training sessions done five days a week. Neuroplastic changes suggest that the intervention may improve self-regulation of attention and cravings (Tang et al., 2006).

Neuroplastic changes associated with mindfulness influence improvements in attention, mind-body awareness, emotional balance, and compassion (Holzel, et al., 2011; Lazar et al., 2005). In a correlational study, Lazar et al. (2005) found that 20 regular meditators averaging 40 minutes of meditation per day with a minimum of four hours per week demonstrated greater thickness of specific areas of the cerebral cortex as compared with 15 non-meditating controls with no experience in meditation or yoga. Specific cortical thickening was found in several cortical areas including the right anterior insula, an area associated with somatosensory awareness of the body and visceral sensation. Thickening was also noted in areas involved with visual and auditory sensory awareness. Authors state that increased somatosensory, bodily
awareness is hypothesized to reflect a capacity for processing of interoception (awareness of bodily experiences) and integration of emotional and cognitive experiences - helpful capacities for coping with stress.

Holzel, Lazar, Gard, Schuman-Oliver, & Ott (2011) summarized evidence garnered from studies in recent decades of neuroplastic changes in the brain associated with mindfulness and with psychotherapeutic outcomes. They present a theoretical framework that associates specific areas of the brain with psychological processes involved in mindfulness; they also suggest that benefits of mindfulness are due to a synergistic interaction between these areas. They conclude that improvements in the regulation of both attention and emotion are primarily attributed to changes in the function and structure of the anterior cingulate cortex and contributions from the ventro-medial prefrontal cortex, the hippocampus, and the amygdala. Improved body awareness appears to correspond with activity in the insula and temporo-parietal junction. Combined changes in the medial prefrontal cortex, the posterior cingulate cortex, insula and temporo-parietal junction appear to be associated with changes in self-perception (Holzel et al., 2011).

Mindfulness practice can induce a state of mindfulness, but more enduring change, such as trait mindfulness would presumably be desirable when treating patients for chronic psychological problems. Findings from a prospective, observational study explored changes in trait mindfulness subsequent to a mindfulness intervention. Kiken, Garland, Bluth, Paullson, and Gaylord (2015) studied outcomes of an eight-week program based on Mindfulness-Based Stress Reduction. Community-based adult volunteers (235) participated in the mindfulness program. Fifty-seven percent completed the program and the self-rating data measures. Kiken et al. found a positive correlation between the ratings of increased state mindfulness and the ratings of increased trait mindfulness. They found a negative correlation between the rating of state
mindfulness and self-reports of psychological distress. They observed that while individual rates of change vary, it appears that regular practice of state mindfulness during the mindfulness activity corresponded with increased trait mindfulness. They concluded that trait mindfulness can be developed over time with the regular practice of state mindfulness during a mindfulness activity, such as meditation. These findings suggest that other regular mindfulness practices may be associated with changes in state mindfulness over time, including a mindfulness-based touch intervention.

In a 2014 study of an 8-week Mindfulness-Based Stress Reduction program with 14 psychologically healthy and somewhat stressed subjects between ages 25 and 50, self-ratings of psychological well-being increased significantly following the intervention. MRI scans found increased grey matter in brain stem areas associated with serotonin and norepinephrine for mood and arousal regulation. Authors suggest that these areas correlate with psychological well-being, and that mindfulness-based interventions may change grey matter concentrations in the brain (Singleton, Hölzel, Vangel, Brach, Carmody & Lazar,. 2014).

Findings from research on neuroplastic brain changes associated with mindfulness provide a physiological rationale for the psychological benefits of mindfulness observed in treatment of psychological disorders. A discussion of these benefits is now provided.

**Mindfulness and Psychotherapy.**

Whether integrated into psychotherapy or provided through yoga, walking, or touch interventions, mindfulness practices affect positive outcomes for mental health problems such as depression. Researchers have found that mindfulness training improves outcomes in normal and depressed populations (Geschwind, Peeters, Huibers, van Os & Wichers, 2012; Kenny &
Williams, 2007; Michalak, Ber & Heidenreich, 2012; Piet & Hougaard, 2011; Segal, Williams & Teasdale, 2013; Stötter et al., 2013; Teasdale et al., 2002).

In a systematic review of six randomized controlled trials involving a total of 593 participants, Piet & Hougaard (2011) found that an 8-week program of Mindfulness-Based Cognitive Therapy (MBCT) decreased occurrence of relapse in adults with recurrent major depressive disorder who were currently in remission. Since depression has been observed to become more resistant to treatment with each successive depressive episode (Judd, Paulus & Zeller, 1999; American Psychiatric Association, 2013) identifying an intervention that reduces relapse is important, especially if it is able to reduce relapse for those with multiple previous episodes. When compared with groups receiving treatment as usual or placebo, subjects who received MBCT showed a significant reduction in relapses, particularly those subjects with three or more previous depressive episodes.

Subsequently, Geschwind et al. (2012) studied outcomes of MBCT in a randomized trial of subjects in remission from depression. The stratified, randomization process compared subjects with the one or two versus three or more episodes within both the treatment and the control groups. The treatment group (64) underwent 8-week MBCT program along with their usual treatment. The control group (66) did only their usual treatment. Geschwind et al. (2012) found that adults experiencing mild residual depression following a history of at least one episode of major depressive disorder showed improvement in depressive symptoms with MBCT. Prior to the study, research on MBCT had included subjects with three or more episodes of depression, leaving a question as to the value of MBCT for those with fewer episodes of depression. With their study, Geschwind et al., concluded that MBCT is a useful therapeutic intervention for major depressive disorder regardless the number of previous episodes.
In another study on outcomes of MBCT, Michalak, Burg, & Heidenreich (2012) noted that depressed persons tend to withdraw and shrink from engagement which may be accompanied by physical aspects such as slumped, depressive body posturing, increased tension, and decreased movement. They observed changes in gait patterns among 23 subjects in remission from depression prior to and following the MBCT program and compared their gait patterns to those of 29 subjects who had never been depressed. Following the MBCT program, patterns of speed, limb swaying and vertical positioning of the head all approached those of the never-depressed comparison group. Authors concluded that MBCT outcomes are not simply psychological but involve bodily changes.

In a randomized controlled trial using another mindfulness intervention, Mindfulness-Based Stress Reduction, researchers compared emotional responses of the intervention group as compared with a wait-list group (Farb, Anderson, McKeon, Mayberg, & Segal, 2010). The intervention group comprised 18 out of the 36 self-referred community-based participants. Researchers found that the MBSR-trained group scored lower on depressive symptoms and distress after exposure to a potentially distressing stimulus (a potentially-sad video) than did the control group. In addition to self-rating measures, Farb et al. used functional Magnetic Resonance Imaging (fMRI) to identify activated areas of the brain during and after the sad stimulus. Data from the intervention group indicated activation of the right insula areas and less activation in the Wernecke language center. These researchers postulate that emotional recovery relies more heavily on the sensory integration than on utilization of cognition and language. If this is so, a non-verbal touch intervention designed to promote mindfulness, sensory awareness, and interoception may be useful in training emotional self-regulation; language may not play such a central role.
In a randomized controlled study, Teut et al. (2013) examined the effects of a four-week mindful walking program in 76 community-based, volunteers with self-report of experiences of mild to moderate stress. All subjects were female. At eight and twelve-week time points after the start of the four-week intervention, the intervention group (36 subjects) had significantly reduced stress scores as compared with the control group (38 subjects) which had no interactions with researchers and participated only by returning stress scores via mail at the fourth and twelfth weeks of the study. Teut et al. conclude that while findings do not allow conclusions about which elements of the intervention contributed to reduced distress scores, the mindful walking activity may be a useful method of managing distress for this population.

Using a randomized controlled design involving 28 moderately depressed psychiatric patients with recurring depression (14 subjects in both the intervention and control groups), Stötter et al. (2013) explored outcomes of an intervention the researchers termed “mindfulness-based touch therapy”. The intervention combined Hakomi psychotherapy with gentle massage, and elements of Mindfulness-Based Stress Reduction counseling. Hakomi is a form of body-psychotherapy which uses touch to facilitate mindfulness and the exploration of the unconscious (Kurtz, 1990). The intervention involved 16 one-hour sessions over eight weeks. The control group, unaware of this designation, continued to take prescribed psychotropic medications. Results indicated significant improvement in mood and somatic symptoms as measured by the self-rated Hamilton Depression scale in the intervention group as compared with the control group. Although the sample was small and changes in mindfulness measures were not included, findings suggested that a mindful touch intervention may be a useful psychotherapeutic tool (Stötter et al.).
Mindfulness and Interpersonal Relationship.

Rosen Method Bodywork is an interpersonal activity involving a relationship that forms between the practitioner and the recipient during the session and over the course of a series of sessions. RMB is viewed by practitioners as a mindfulness activity (Kushnir, 2008; Cober, Smart & Williams, 2014). An introduction to the significance of mindfulness to relationship may be important when studying this CAM approach. Studies on compassion illustrate the relationship between mindfulness and compassion and the significance of mindfulness in relationship.

A body of research on the role of compassion, both for self and for others, illuminates the importance of mindfulness in interpersonal relationship. Mindfulness has been identified as a key ingredient in both compassion and self-compassion - two concepts which in turn influence the health of relationship (Neff & Beretvas, 2012). Neff (2003b) defined self-compassion as a concept involving three interdependent elements: self-kindness, common humanity, and mindfulness. Self-kindness is viewed as an inclination toward self-nurturing and self-understanding as opposed to a tendency to be harsh and judgmental. The concept of common humanity entails an understanding that everyone suffers. It promotes a sense of inclusion and connection, particularly important during suffering. The mindfulness aspect of self-compassion contributes to awareness and a willingness to acknowledge and change behaviors that do not serve the well-being of oneself (Breines & Chen, 2012) or that of the relationship (Neff & Beretvas, 2012).

In a randomized controlled trial testing the efficacy of an eight-week Mindful Self-Compassion training program involving weekly two-hour meetings and a half-day silent meditation retreat program, Neff & Germer (2012) found significantly increased self-
compassion, mindfulness, and overall wellbeing among the intervention group (n=27) as compared with the waitlist control group (n=27). In addition, the intervention group reported significant improvements in life satisfaction, as well as reductions in depression, anxiety, avoidance, and the perception of stress. It may be that self-compassion enables more emotional stability because feelings toward self are based on one's essential humanness rather than particular acts, or from perceiving oneself as special, accomplished, or unique (Neff & Costigan, 2014).

Further evidence of the relationship between mindfulness and compassion is observed in a randomized, controlled study of 123 individuals whose depression was successfully managed with medication and who had a history of three or more depressive episodes. Kuyken et al. (2010) found increased measures of empathy and compassion among those who participated in an 8-week MBCT program combined with antidepressant tapering as compared those in the control group (maintained on antidepressant medication).

Theoretically, compassion is a key ingredient to healthy relationships (Fogel, 2009; Kuyken et al., 2010; Siegel, 2012). In an interpersonal interaction such as RMB, compassion is also likely to be important, particularly the compassion of the practitioner for the recipient. In a study on the role of self-compassion in relationship among 104 volunteer community couples, Neff and Beretvas (2012) found a strong correlation between self-compassion and psychological well-being. Self-compassion was associated with fewer negative factors such as anxiety, depression, perfectionism, thought suppression and rumination, while also being associated with positive factors such as happiness, optimism, satisfaction with life, motivation and emotional resilience (Neff & Beretvas). Theoretically, interpersonal capacities gained through mindfulness can help reduce the isolation and withdrawal experienced in depression (Siegel, 2012), perhaps
in part due to enhanced compassion. Neff and Beretvas also found that self-compassion significantly correlated with relationship satisfaction and relationship quality.

Mindfulness appears to be a key ingredient in healthy relationships, both one’s relationship to self as well as one’s relationships with others (Neff & Beretvas, 2012; Siegel, 2010), and can thereby influence psychological health (Neff and Germer, 2012; Siegel, 2010). Mindfulness capacities are believed to be protective of interpersonal relationship in part by reducing distress contagion and decreasing one’s vulnerability to distress associated with relationship conflict (Davis & Hayes, 2011). Mindfulness increases awareness of one’s own emotional experience and facilitates sharing of feelings with others (Fruzzetti, 2006). Mindfulness is important to interpersonal communication and satisfaction in relationship (Davis & Hayes, 2011; Fruzzetti, 2006).

Mindfulness increases intrapersonal and interpersonal capacities for empathy, compassion, and understanding of both self and others (Fruzzetti, 2006; Neff & Beretvas, 2012). The mind has been described in a relational manner as an embodied (i.e. experienced through the body) and relational (i.e., self and environment) process that involves the exchange of information and energy (Siegel, 2010). According to Siegel, relationships are characterized by interpersonal neurobiology which involves processes whereby information, communication, and energy exchange occur between individuals. Such processes would be at play in a touch-facilitated interpersonal intervention such as Rosen Method Bodywork.

Interpersonal processes involve the activity of mirror neurons which allow us to sense another person’s emotion (Bastiaansen, Thioux, & Keysers, 2009) and attune in empathy, compassion, and understanding of another's emotional and body states (Siegel, 2010). In their study of mirror systems within the nervous system, Bastiaansen, Thioux, & Keysers (2009)
explored the neuronal activity in an observer’s brain when witnessing another person. They found that when participants observed another individual having an experience, such as taking an action or receiving a tactile stimulus, the brain of the observer was stimulated, specifically with recruitment of the premotor, parietal and somatosensory regions of the brain. This observation suggest that observers experienced similar sensations as they imaged in those who experienced the actual stimulus. Motor neurons, somatosensory, and affective regions of the brain are involved in shared feeling states, suggesting that processes of experiential mirroring and empathy are not isolated to specific brain regions but rather involve integration of multiple areas (Bastiaansen, Thioux, & Keysers, 2009). Presumably, in a touch-facilitated mindfulness activity such as Rosen Method Bodywork, the mirroring processes are at play between recipient and practitioner. It follows that in mindful bodywork involving interpersonal attention to mood and sensation, both parties might sense each other's affect via the mirror neuron system. This may allow the therapist to sense the affective state of the recipient and may suggest that the recipient's affective state is influenced by the quality of presence and mindfulness of the practitioner.

Theoretically, in an interpersonal activity such as Rosen Method Bodywork, the practitioner's capacity for mindfulness and compassion is important. A study on compassion among meditating psychotherapists suggests the significance of mindfulness practices by psychotherapist in therapeutic relationship with clients. Wang (2007) examined differences between 21 psychotherapists who meditate and 35 psychotherapists who did not meditate. Wang found that among a sample of 56 participants, therapists who practice mindfulness meditations for a minimum of two years self-reported greater attention, awareness, and non-judgment (elements of mindfulness) as well as greater empathy and compassion in their psychotherapy work than did their non-meditating counterparts.
**Challenges to Teaching Mindfulness.**

While research shows that mindfulness skills are associated with psychological well-being and improved recovery from depression, clinical observations of mindfulness training indicate that mindfulness training may be complicated when patients experience abreactions (Germer, Siegel, & Fulton, 2013). For example, when depressed patients are asked to quietly attend to their thoughts and feelings, they may initially be overwhelmed with the depressive content of thoughts and feelings. Some may have difficulty tolerating certain mindfulness exercises, due to physical sensations, depressive or anxious thoughts, or traumatic memories (Germer, Siegel & Fulton, 2013). Patients may become bored, tearful, irritable, or anxious during guided mindfulness exercises where they are asked to attend to their inner processes, sensations, thoughts, and feelings. According to Germer, Siegel & Fulton (2013), disturbing abreactions may be destabilizing and could potentially dissuade patients from learning mindfulness.

Given that some patients have difficulty tolerating mindfulness exercises as taught in standard mindfulness-based psychotherapy, understanding how to tailor psychoeducation to meet the patient’s needs becomes important in working with this population. Psychoeducation methods that teach mindfulness while simultaneously minimizing distress are important to identify as options for individualizing care. A mindfulness training process that employs gentle touch might provide a needed reassurance for individuals as they learn how to attend inwardly without fueling depressive thought patterns.

Research and theoretical literature indicate that there are multiple ways to teach mindfulness, including meditative approaches involving sitting, standing, walking, Tai Chi and yoga (Bishop et al., 2004; Brown, Ryan, & Creswell, 2007; Kabat-Zinn, 2003). Meditative
movement or focusing on external objects (as a point of mindful focus) can be useful ways to support vulnerable individuals in the early stages of mindfulness training (Germer, Siegel, & Fulton, 2005). For people with difficulty tolerating usual mindfulness training, a mindfulness training that employs touch may provide comfort and reassurance that assists such depressed patients. Also, the touch may provide a form of tactile aid to assist the recipient in learning how to switch attention from elaborative distressing thoughts to the here-and-now experiences, such as sensations in the body. Thus, touch might help the recipient access their embodied experience without exacerbating distress, as well as learn how to recognize and gain perspective on depressive thought patterns.

**Touch as a Mindfulness Psychoeducation Intervention.**

As stated above, even when a method of touch is classified as "biomechanical" or "energy-based", it can also integrate additional theoretical perspectives. For example, touch may be used to relax muscles while also encouraging a mindful state of being. In this case, the touch approach becomes a vehicle for the experience of mindfulness. In a manner of speaking, touch may facilitate mindfulness.

Few researchers have studied the intersection of touch, mindfulness, and depression (Stötter et al., 2013). As described above, Stötter et al. examined the effect of a “mindfulness-based touch therapy” as an augmentation of standard mindfulness training in moderately depressed adults. They found significant improvements in depression and suggested that a mindful touch intervention may be a useful psychotherapeutic tool (Stötter et al.).

Stötter et al. (2013) used a model of information processing that may be applied to any touch therapy intervention. Using Ogden’s model of hierarchical sensorimotor processing, they argue that utilizing mindful touch would engage a “bottom-up” pathway for processing of
sensorimotor stimuli (traveling from touch sensation to sensorimotor response to emotional response to cognitive interpretation), and that recipients may do better when a touch approach is combined with the “top-down” education of standard mindfulness training (from cognition to bodily response). They argue that depressed individuals may benefit from engagement of these dual pathways to relearn how to attend in the moment rather than be trapped in negative patterns of thought and emotion (Ogden, Minton, & Pain, 2006; Stötter et al., 2013).

When considering the use of touch, ethical protections of the recipient are important. These protections become more important when the touch intervention engages thoughts and feelings where more vulnerable topics may be raised. An exploration of ethics as it pertains to touch modalities is included to address this important consideration.

**Ethics of Touch in Psychotherapy.**

Standard psychotherapy does not utilize touch. In fact, there has long been a prohibition against psychotherapists touching patients. Consideration of a touch approach to facilitate psychotherapy calls for an examination of the ethical concerns. Body psychotherapists agree that engaging the body in psychotherapy can be helpful (Ogden, Minton, & Pain, 2006; Levine, 2010; Van der Kolk 2014) and that touch can provide both a unique avenue for non-verbal communication, but also a risk of blurring professional boundaries established to protect patients from abuse and practitioners from claims of inappropriate treatment (Schiff et al., 2010; Vickers, 2008; Young, 2007; Zur, 2007). Ogden, Minton, & Pain (2006) describe the traditional stance on touch in psychotherapy, noting that traditional psychotherapy has avoided touch due to concerns about misinterpretation of the meaning or purpose of the touch. In addition, touch might be used to soothe-over and avoid confronting inner material rather than promoting psychological insight. Further, prohibitions around the use of touch have sought to avoid
boundary violations, such as sexual abuse (Ogden, Minton, & Pain, 2006; Salzmann-Erikson & Eriksson, 2005). While these concerns are valid, Ogden et al. endorse thoughtful, purposeful touch in psychotherapy to improve body awareness, to teach how to relate to the body in a positive way, and to help the recipient return to the here-and-now. The use of touch by appropriately-trained practitioners in both touch and psychotherapy interventions can be helpful when practitioners use a sensitive and individualized approach that puts the recipient in control of the contact (Ogden, Minton, & Pain, 2006).

According to the field of somatic psychology and body psychotherapy as represented by the national and international associations, the United States Association for Body-Psychology (USABP) and the European Association for Body Psychology (EABP) respectively, engaging the body in psychotherapy through the non-verbal language of touch can facilitate desired psychological change (EAPB, n.d.; USABP, 2013; Zur, 2007). Mental health patients and their providers value touch when boundaries are clear and ethical guidelines are followed (Gleeson & Higgins; Schiff et al., 2010). Indeed, refraining from touch in some therapeutic circumstances can be considered cold and unethical (Young, 2007; Zur, 2007) and may interfere with potential gains. To address ethical concerns, guidelines have been established for touch in complementary medicine interventions (Schiff et al., 2010) and in body-psychotherapy organizations and training programs (Zur). The Rosen Method Bodywork training process includes education in ethics (Rosen Institute, n.d.). Considering these ethical measures, it appears reasonable for adequately trained professionals to employ touch in psychotherapy when informed consent is obtained.
Rosen Method Bodywork and Mindfulness.

Rosen Method Bodywork is a dyadic intervention involving the practitioner's use of gentle touch and the selective use of words to guide the recipient’s awareness to intrapersonal experiences, i.e., the moment-by-moment experience of the body, thoughts, images, and feelings. The practitioner provides Rosen Method Bodywork while the recipient reclines on a massage table. A **listening** touch is used to help the receiver become more aware of his or her embodied experiences (Fogel, 2009). On a physical level, the gentle, attentive touch is believed to increase parasympathetic activity and muscle relaxation, which in turn allow increased range of motion and potential for freedom of movement (Fogel, 2009). Rosen Method Bodywork is described as a **listening** touch which enhances awareness of body sensations, emotions, and thoughts, in a context of non-judgment and gentle curiosity (Fogel, 2009) and thereby promotes relaxation. This description echoes the intent of mindfulness practices. Indeed, according to Rosen & Brenner (2003) a Rosen session is “like a meditation” (Rosen & Brenner, 2003, p. 21).

The purpose of Rosen Method Bodywork is to enhance awareness and relaxation. As the title of their book suggests, it is a way of “accessing the unconscious through touch” (Rosen & Brenner, 2003). Awareness is increased when the non-intrusive, listening touch helps recipients become more aware of felt experiences. Unlike the mind, that may seek to contrive ways to think about feelings, the body is where feelings are experienced, and it is the body that informs about feelings. The gentle touch can bypass the intellectualization of the mind and help bring awareness to muscle tension that is considered an expression of the holding back of feelings or experiences.

According to the Rosen Method Bodywork theoretical framework, patterns or habits of muscle tension develop over time. Some tension patterns began early in life before we have the
resources to cope with our circumstances and to integrate our experiences (Rosen & Brenner, 2003). Through the bodywork, recipients find the capacity to accept experiences. With this acceptance, physical and psychological defenses are released. In these moments, the muscles become receptive and soften. Relaxation of the body-mind, including the diaphragm, is accompanied by a profound easing of the natural breath, allowing it to move freely. Such experiences of letting go, teach the body, and the witnessing mind that observes this experience, that such ease is possible. Through this process a fundamentally different way of being in life becomes possible (Rosen & Brenner).

The literature on Rosen Method Bodywork suggests parallels between mindfulness meditation and experiences of Rosen Method Bodywork (Kushnir, 2008). Kushnir describes how Rosen Method Bodywork and mindfulness meditation have a direct relationship in their shared attention to awareness of the moment-by-moment experience in the body. They also share a non-judgmental and compassionate receptivity to what arises in experience. Both encourage non-identification (an ability to step back and witness one’s experience rather than being identified or attached to it) (Kushnir, 2008). Rosen touch can improve capacities for interoception and mindfulness to inner thoughts, emotions, and body sensations (Fogel, 2009; Kushnir, 2008). These descriptions of RMB resemble descriptions of mindfulness elsewhere in the literature (Brown, Ryan, & Creswell, 2007; Kabat-Zinn, 2003), as discussed above. Therefore, it is reasonable that Rosen Method might be considered a mindful intervention, that is, a method of touch that facilitates mindfulness.

In summary, mindfulness is an important element in modern psychotherapy. It is observed to have behavioral, psychological, social and neurological influences. Mindfulness can be taught in multiple ways. Touch appears to be a mode through which mindfulness can be
taught. Touch may offer a unique method of mindfulness training for people who have difficulty responding to other mindfulness exercises. RMB appears to be a form of mindful touch – a mindful intervention that facilitates self-awareness relevant to psychotherapy.

**Attachment Theory**

Rosen Method Bodywork involves the interaction between the practitioner and the recipient. A discussion of attachment theory and related concepts puts the RMB process in a wider context. Attachment theory has been contributed to by multiple theorists and researchers since the term was coined by Bowlby in the 1960’s. The theory states that the development of a sense of self, the patterns of interpersonal connection, and an individual’s ability to regulate experience within his/her window of tolerance, are influenced by early interpersonal experiences with primary caretakers. Early attachment experiences influence subsequent attachments.

In the process of growth and development, infants are understood to experience no separation of self and other. In optimal conditions, within several months, as the child explores and discovers the coming and going of people and things (such as in playing peek-a-boo), they begin to differentiate and to develop a sense of themselves as separate from others. In optimal conditions after about 2 years, a sense of relating develops that includes both one’s separateness and one’s relatedness. (Bowlby, 1973; Prochaska & Norcross, 2007). Secure attachment allows a child who becomes distressed while exploring the world to return to the protective comfort of the parent; once security is re-established, the child is again motivated to explore the world on its own (Nichols, 2006). The good-enough care giver attunes to the child, sensing mood through the child’s affect, body language, tone of voice, and behaviors. The care giver offers, on the one hand, reassurance to contain excessive emotional arousal, and on the other hand, provides
stimulation of engagement. With this resource, the child learns to maintain arousal and eventually to regulate arousal within the window of tolerance (Siegel, 2010).

Attachment is influenced by the unique nervous system and temperament of the individual as well as by experiences with the care giver (Siegel, 2010). Secure attachment can be impeded with caregiving that is abusive, neglectful, inconsistent or otherwise experienced as unsafe. Insecure attachment can present different ways, including insecure-avoidant, insecure-ambivalent, and disorganized disoriented attachment. (Ogden, 2006). Body-oriented psychology approaches to treatment may include assisting the client in tracking moment-by-moment bodily sensations, encouraging feeling and describing sensations and emotions, tolerating arousal, and offsetting numbed hypoarousal thus expanding the window of tolerance, and gradually increasing tolerance for positive experiences and emotions (Ogden, 2006). Body-oriented therapists keep in mind that a client’s attachment and defensive patterns will emerge at any time, manifest in the relaxing or tensing of the body, respectively. Tracking these shifts and staying in attuned engagement without invading or abandoning are important ingredients to maintaining therapeutic alliance and working with these patterns (Ogden, 2006).

Therapeutic alliance is an important predictor of therapeutic outcomes in psychotherapy. In a meta-analysis of 24 studies on attachment and therapeutic alliance in individual adult outpatient psychotherapy, the Bernecker, Ley & Ellison (2014) found that self-reports of attachment style were related to self-reports of therapeutic alliance. Avoidant and anxious attachment styles were related to weaker therapeutic alliance, while the secure attachment style was related to stronger therapeutic alliance.

According to attachment theory, attachment styles develop in early life based on interactions with care givers and these early relationships establish templates for subsequent
attachment patterns, however, attachment styles may change as life experiences in subsequent
relationships provide corrective experiences (Siegel, 2012). A systematic review of studies of
attachment in psychotherapy explored changes in attachment during psychotherapy. The authors
found that of the 15 studies meeting criteria, data suggested that attachment templates may be
amenable to change through the psychotherapeutic relationship. (Taylor, P., Rietzschelb, J.,

**Research on Touch Approaches as Interventions for Depression**

Researchers studying the effects of touch interventions, such as Therapeutic Touch,
massage, Reiki, and Healing Touch, have found improvements in depressive symptoms among a
wide spectrum of non-psychiatric populations including people with cancer and chronic pain,
and the elderly (Fulcher, Badger, Gunter, Marrs, & Reese, 2008; Jackson et al., 2008; Richeson,
Spross, Lutz, & Peng, 2010; Smith, Arnstein, Rosa, & Wells-Federman, 2002; Weze, Leathard,
Grange, Tiplady, & Stevens, 2006). In a pilot study comparing the effect of cognitive behavior
therapy (CBT) with relaxation versus CBT with Therapeutic Touch within a chronic pain
population, all 12 subjects received CBT and relaxation training, while the intervention group (7)
received an additional three sessions of Therapeutic Touch (Smith, Arnstein, Rosa, and Wells-
Federman, 2002). The researchers found decreased pain, reduced perceived distress, and less
attrition in the treatment group compared to the comparison group.

A review of the evidence on treatments for depressive symptoms among oncology
patients indicated the need to assess and diagnose depression in this population and examined the
benefits of including CAM approaches (Fulcher, Badger, Gunter, Marrs, & Reese, 2008).
Various approaches to treating depressive symptoms in these populations include a range of
pharmacological and therapeutic interventions, including CAM interventions of hypnotherapy,
relaxation, massage and herbs (St. John's Wort). Cassileth and Vickers (2007) found that for the 1,290 Memorial Sloan-Kettering Cancer Center patients receiving massage inpatient (approximately 30 minutes) and out-patient (approximately 60 minutes), all patients reported post-massage improvements as compared with pre-massage measures of several physical and psychological symptoms; self-reports indicated a 48.9% reduction in depression and 59.9% reduction in anxiety within the 48 hours following massage (Cassileth & Vickers, 2007).

A study of a gentle, non-manipulative touch with 147 participants who self-identified as having psychological distress or a mental health diagnosis found improvements in overall psychological well-being. (Weze, Leathard, Grange, Tiplady, and Stevens, 2006). Over a six-week period, Weze et al. tested an intervention involving four, 1-hour sessions of a "gentle" touch intervention in which the practitioner applied gentle, firm contact around the body to support physical and psychological self-healing. Pre-and post-intervention measures included a subjective questionnaire about physical and psychological self-ratings of distress and a validated tool measuring quality of life (EuroQoL scale). Authors reported a significant decline in stress, anxiety and depression and an increase in function in daily living, particularly among participants who had claimed severe symptoms as compared to those with moderate symptoms. The authors concluded that the touch intervention may be useful in a variety of circumstances, such as the interval between initiation of antidepressants and their therapeutic activity or for people at risk for psychotropic side effects (Weze, Leathard, Grange, Tiplady, and Stevens, 2006).

A review of 12 studies on various therapeutic touch interventions (massage, Reiki, healing touch) for oncology patients found that pain, anxiety and depression were often reduced (Jackson et al., 2008). Richeson, Spross, Lutz, & Peng (2010) conducted a pilot study on the
intervention of Reiki among 20 community dwelling elderly (12 in treatment group and 8 in wait-list comparison group) and found that measures of depression were significantly reduced following Reiki session, although the authors acknowledged that causal inferences were not possible due to other possible variables.

Touch may help reduce depression among persons diagnosed with depression. Van Aken and Taylor (2010) combined grounded theory and case study to explore the accounts of 15 depressed individuals receiving Healing Touch. A core problem of “disconnection” was identified through interviews and was found to be improved by the Healing Touch experiences. Participants described moving from disconnection with self, others, and the world to reconnecting and emerging out of depression with the intervention (Van Aken & Taylor, 2010).

A qualitative study explored experiences of seven psychiatric out-patients with previous hospitalization for psychosis with respect to touch in their lives (Salzmann-Erikson & Eriksson, 2005). The participants reported a sense of loneliness and tendency to isolate and withdraw from engagement with life due to their symptoms (Salzmann-Erikson & Eriksson, 2005). Participants reported a negative response to touch that was unwanted or perceived as disrespectful, however they also described a need for touch and how touch helped them feel a sense of connectedness, belonging and acknowledgement. The touch they described ranged from hugs from health care providers to caresses from friends, family or intimate partners. These findings suggest that on an interpersonal level, intentional caring touch can reduce feelings of loneliness and isolation and engender a sense of connection (Salzmann-Erikson & Eriksson, 2005).

While outcomes of depression are not always overtly evident, touch interventions may result in benefits that theoretically may reduce depression. Collinge, Wentworth, & Sabo (2005) pilot studied the effect of regular psychotherapy augmented with touch therapy. Their sample
included 25 adult participants from an outpatient community health setting, all of whom had histories of trauma and 10 of whom had histories of sexual abuse. Participant diagnoses included post-traumatic stress disorder (PTSD), major depression disorder, anxiety disorder, and/or dual diagnosis. In addition to usual therapy, participants received an average of five touch therapy sessions of either massage, Reiki, Healing Touch or acupuncture, depending upon clinical judgment, availability of practitioners, and recipient preference. Participants responded to a Likert-rating scale indicating how helpful they found the intervention and to an open question regarding their observations. The quantitative data showed a significant correlation between the number of sessions received and the perceived helpfulness of the intervention; a mean rating of helpfulness of 8.6 was observed within a range of 2-10. In response to the open question, Collinge, Wentworth, & Sabo found that for some participants benefits included significant improvement in interpersonal self-confidence and in relationships. The authors conclude that touch interventions may provide a unique way of engaging the whole person in processes of change that improve self-confidence and interpersonal interactions, and reduce depression (Collinge, Wentworth, & Sabo, 2005).

Some researchers of massage studies have identified positive outcomes with respect to depression, but findings have been conflicting. Moyer’s meta-analysis of massage outcomes found multi-session massage outcomes comparable to multi-session psychotherapy outcomes for reducing depression (Moyer, Rounds & Hannum, 2004). Barcelona, Harville, Savage, & Giarrantano (2016) found massage to be protective against depression for pregnant women. On the other hand, in a systematic review of the effects of Swedish massage on depression, Coelho, Boddy, & Ernst (2008) found insufficient evidence to demonstrate effectiveness, although the authors acknowledged that massage is not harmful. One factor that may account for such
conflicting findings may be differences in the kinds of massage provided in different studies suggesting that the specific method of touch may make a difference in the outcomes. For example, purely Swedish massage with its biomechanical focus may not have the same effect on mood as an Esalen massage which focuses on relaxation and integration.

Precautions in the use of touch would be important for depressed individuals who also experience psychosis. In a qualitative study of mental health nurses’ views about touch, Gleeson & Higgins (2009) found that nurses were particularly sensitive about the use of touch with patients experiencing psychosis, due to altered perception and risks that recipients may misinterpret touch. In these cases, they would minimize touch. In contrast, in a qualitative study involving interviews of four adults with a history of psychosis, Salzmann-Erikson and Eriksson (2005) found positive responses to touch when it is perceived as gentle and caring. Participants reported that caring, gentle touch provided comfort, support, and relaxation. Further, they reported experiencing encouragement, connection, and acknowledgment of their humanness when touched (Salzmann-Erikson and Eriksson, 2005). As noted above, this suggests that how touch is provided and the intention behind touch may be significant variables to be studied in the future.

Another important point in the evaluation of studies on touch interventions is the number of sessions that subjects receive. Moyer and colleagues (2004) observed greater changes in depression and anxiety after multiple massage sessions than changes following a single session, and they proposed that massage therapy, like psychotherapy, involves various factors that contribute to change over time (Moyer, Rounds & Hannum, 2004). Among these are interpersonal factors that occur between the practitioner and receiver of the intervention. In addition, Moyer (2004) suggests that greater benefits may be derived from touch interventions
after the recipient has “learned how to receive” the touch therapy (Moyer, 2004). Learning how to receive touch therapy involves both interpersonal processes (between the practitioner and the recipient, such as teaching and learning), as well as intrapersonal processes (within the learner). It would seem natural that familiarity with the practitioner would also help reduce anxiety, deepen relaxation and facilitate the process. Understanding more about these two types of processes may contribute to understanding the potential role of a touch therapy, such as Rosen Method Bodywork, in mindfulness training.

**Vocabulary: Some Terms Used in Body-Based Therapies**

A few terms from the fields of interpersonal neurobiology and body-based interventions, (body-psychology, bodywork, and trauma recovery) are helpful to review as they describe phenomena pertinent to this study. *Interoception* has been called a “sixth sense” because it describes the sense the internal bodily processes and states, as they arise within of the body (Porges, 2011). It is a felt sense of being, different from the thinking about the body or the self (Fogel, 2009). This sixth sense includes sensory activity from muscle and bones as well as visceral sensations and the flow of information from sensors in organs to the brain (Siegel, 2012). Interoception contributes to how we discern emotional experiences within the body (Siegel, 2012). According the Porges, accurate interoception is essential for physical, psychological, and interpersonal function (Porges, 2011). Porges observes that science and language have focused considerable attention on the other five senses while developing little understanding and language for the internal sensations in the body. The tendency to favor giving attention the other five senses promotes an outwardly focused orientation and a lack of awareness about the inner bodily sensations, including the felt-sensations of “feelings” or emotions.
Attunement is a way of communicating in which the physical and emotional state of one person is attended to and perceived by another person. This ability to sense the affective and bodily state of another person is achieved in part by mirror neuron networks (described above) (Siegel, 2012).

Coherence is an acronym derived from evidence that links the following terms: “connection, openness, harmony engagement, receptivity, emergence (things arising in new and spontaneous ways), noesis (a sense of nonconceptual knowing), compassion, and empathy.” (Siegel, 2012, A1-16). Coherence can occur within the individual in relation to one’s own experience, and it can occur within an individual as they perceive another.

Resonance occurs between individuals when at least one individual attunes to another with coherence and allows his/her internal experience to mirror that of the other person, feeling the experience within (Siegel, 2010). For example, in RMB, the practitioner is aware of his/her own experience while also resonating with the recipient’s experience, thereby feeling with the recipient and supporting the recipient’s deepening interoception (Fogel, 2009).

The “window of tolerance” is the “span of arousal” in which an individual can remain able to cope and adapt harmoniously; beyond the frame of this window, the individual does not function optimally (Siegel, 2012, 33-1). This window or scope of awareness is framed by two extremes: experiences of hypoarousal, non-awareness, numbing or tuning out, at one end, and hyperarousal and overwhelm at the other. For a given individual, the window of tolerance narrows and widens, depending upon situations. Taxing stimuli (whether external or internal, conscious or unconscious) tend to narrow the window (Siegel, 2012), unless the individual receives support that helps them contain the experience (Ogden, 2006). The window of tolerance
increases when the individual has the resources to readily process and integrate the stimuli (Siegel, 2012).

Bottom-up and top-down processing in the nervous system refer to the directions in which information is conveyed. Bottom-up processing conveys sensory information from lower anatomical regions to the higher regions in the brain. Conversely, top-down signals go from higher regions in the brain to lower areas (Siegel, 2012). Top-down processing is mediated by the cortex. Top-down processing makes it possible to regulate emotions, to be mindful about one’s experience, and to make meaning of one’s experience (Ogden, 2006). It makes it possible to attach new meaning to incoming sensory experience. The two processes interact. If bottom-up signals are intense, such as when sensory input triggers flashbacks of abuse with resultant activation of a stress response, the bottom-up processing can then become so intense as to override cognitive regulation and the individual becomes overwhelmed and unable to regulate their experience (Ogden, 2006).

**Research on Rosen Method Bodywork**

In the past decade, a handful of seminal studies on Rosen Method Bodywork have been published. Prior to these, in 2008, Holt-Lunstad, Birmingham, and Light studied physiologic changes in married individuals with a touch intervention derived from RMB. They studied differences between the intervention group (34 married couples) which was taught to use a touch intervention derived from RMB (for a half an hour three times per week for four weeks) as compared to the control group who received no training and was only asked to keep track of their mood and physical affection. Researchers measured physiological parameters associated with stress pre-and post-intervention, including blood pressure, salivary cortisol, alpha amylase. Salivary oxytocin measures were also taken during the first and last weeks of the intervention.
Compared with the control group, the intervention group had reduced alpha amylase and the blood pressures of husbands in the intervention group were lower than those of the control group. No effect was observed for cortisol or oxytocin.

In a 2009 descriptive study, Hoffren-Larsson, Gustafsson, & Falkenberg employed qualitative and quantitative methods to explore reasons for seeking treatment and perceived benefits of Rosen Method Bodywork treatment among 53 community-based recipients. The survey was constructed from two previously-validated questionnaires and included fixed-response questions as well as open questions. Some participants had more than one reason for seeking treatment. Twenty-eight participants reported physical reasons for seeking treatment including seeking relief from muscular tension (10), physical pain (10), or for coping with physical disease (8). Psychological reasons for seeking RMB included relief of stress or burnout (19) and psychological well-being (20). Eight participants reported seeking RMB relief from experiences of anxiety, depression and suicidal thoughts. Participants reported perceived benefits of physical and psychological improvement, enhanced body-mind connection, a sense of personal support, and support during personal life changes (Hoffren-Larsson, Gustafsson, & Falkenberg, 2009). Participants reported decreased anxiety (4), depression (10), and decreased suicidal thoughts (3). Almost all participants reported greater positive feelings such as happiness and well-being. Seventeen participants reported reduced physical pain; other physical benefits included less muscle tension (35), greater ease of breathing (8), improved intestinal function (3), and greater energy (4). Improved mind-body awareness was reported by 26 participants. Twenty-four participants identified a benefit of feeling supported in their personal growth. Eighteen participants reported that through receiving RMB they had become more aware of their needs and changes they needed to make in their lives to meet their needs. Five of the
participants reported receiving no benefit. The researchers acknowledged that self-selection of
the participants contributed to selection bias and that the study underrepresented experiences of
dissatisfied clients. The researchers found that participants who received multiple sessions
tended to identify greater physical and psychological benefits. The processes by which these
benefits arise have not yet been examined.

A quantitative study with a qualitative component examined the effects of Rosen Method
Bodywork on day-to-day fluctuations in physical and emotional experiences of five individuals
with chronic low back pain over a five-month period of weekly bodywork sessions (Fogel,
2013). Pre-and post-questionnaires and individual interviews were utilized. Measures included
the Margolis pain rating method, a 0-100 fatigue self-rating scale, the Profile of Mood States
(POMS), and the Pearlin and Schooler Mastery Scale. The findings suggested that the processes
involved in RMB may not be linear. While all participants reported a decrease in their most
extreme pain over time, and all participants also reported less disability, greater satisfaction at
work and reduced fatigue, symptom reduction was not a linear process but was subject to
multiple fluctuations within a period of overall improvement (Fogel, 2013). Fogel examined two
concepts related to depression (mood states and sense of mastery), each of which improved
overall in most participants. Some participants volunteered that they learned how to attend to
their bodily sensations (Fogel, 2013), suggesting a progressive improvement in a fundamental
ingredient of mindfulness, body awareness (Segal, Williams & Teasdale, 2013).

Hoffren-Larsson, Löwstedt, Mattiasson, & Falenberg (2013) conducted an exploratory,
qualitative study of 11 RMB recipients to identify whether caring was perceived as an important
aspect of the interpersonal relationship of RMB. Seven female and four male recipients of RMB
were interviewed. Recipients ranged from satisfied to dissatisfied with their RMB experience.
One initially-dissatisfied participant had discontinued and restarted RMB with another practitioner and thereafter found the work beneficial. Another discontinued treatment entirely. The number of session received ranged from two to 50 with a mean of 15 sessions. In interviews with participants, researchers found that these recipients recognized caring as an important component of the therapeutic relationship. The qualitative data was analyzed using content analysis. When recipients perceived caring from their practitioner, they were better able to trust and process emotional experiences or traumatic memories, as these arose. When recipients did not feel cared for, they ended treatment with the practitioner. Findings of this study point to the significance of relationship and to the possibility that the therapeutic relationship changes over time in the process of RMB. Understanding the development of the caring relationship and the RMB processes would help illuminate how this CAM approach might be useful in mental health treatment.

A qualitative study (Bernard, 2014) explored RMB among individuals with a history of trauma. Interviews of eight RMB recipients with a history of trauma and a focus group of four practitioners were conducted to explore how RMB influenced interoception, facilitated healing from trauma, and the role of the client-practitioner relationship in RMB. The study found that recipients’ interoception improved and they could better sense their internal and emotional experiences. In addition, participants reported relief of various trauma-related complaints. Further, the relationship with the practitioner was central and was characterized by qualities including presence, listening, resonance, authenticity, trust, and a willingness to hold the space for the participants’ experience.
Summary of Literature Review

Many touch interventions involve the assumption that touch is not limited to the physical experience but rather is believed to engage the whole person, mind and body. Some methods of touch, such as RMB, may be draw upon biomechanics while their intent and theoretical framework extends beyond the physical. Touch approaches often seek to engage more than the physical body, alone.

There is a body of research pointing to the value of touch therapies, including RMB, for mood. Some touch therapies have been described as facilitating awareness and mindfulness. Similarities have been drawn between RMB and mindfulness. Mindfulness is a central concept in contemporary psychotherapy and training in mindfulness is a goal of these psychotherapies. Given the significance of mindfulness to mental health as well as the different learning preferences, capabilities, and tolerances of individuals, research on a touch intervention that may support mindfulness may be useful for mental health care providers.

While a branch of psychotherapy called body-psychotherapy works directly with the body, touch interventions are still largely under-utilized in standard psychiatric practice (Young, 2007; Zur, 2007). Ethical concerns about touch in psychotherapy stem from valid issues for which ethical standards of professional practice are essential. Ethical concerns are addressed in touch therapy training programs such as RMB, and ethical standards for certification have been adopted by various schools of touch therapy. Attachment theory can shed light on dynamics in dyadic activities such as psychotherapy or bodywork, as can terms that describe the felt-sense of experience, such as interoception.

Researchers have begun to study Rosen Method Bodywork. To date, the interpersonal and intrapersonal processes involved in RMB have not been extensively researched.
Researching these processes will inform future studies of Rosen Method Bodywork and may suggest to mental health providers, including advanced practice psychiatric mental health nurses, how Rosen Method Bodywork may be integrated into mindfulness training and mental health care. Ultimately, exploring the role of touch interventions through research will build a base of evidence regarding the utilization of touch in psychotherapy. A grounded theory approach was selected for this study to identify the processes involved in RMB, occurring over time, as perceived by recipients.

This Study

The purpose of this research study was to explore the processes of Rosen Method Bodywork in order to develop a theoretical framework of what occurs in RMB. Data was gathered from the perspectives of adults who have had direct experience receiving RMB over multiple sessions. These participants provided rich and detailed accounts of their experiences with RMB, over time. Recipients of RMB experience themselves during the sessions, as well as their interactions with the practitioner. Their first-hand accounts will illuminate what occurs for them during RMB sessions, both within themselves and between themselves and the practitioner. Their accounts will help clarify benefits they observe and suggest directions in which this complementary approach may be utilized. This study explored the changes participants observed from receiving multiple sessions of RMB. This study addressed the following research questions:

1. What interpersonal (between the recipient and the practitioner) processes occur with RMB as perceived by recipients of RMB?
2. What intrapersonal processes occur within recipients during sessions, between sessions, and across multiple sessions?
A goal of this study was to advance the understanding of the processes involved in Rosen Method Bodywork in order to develop a theoretical framework of how this CAM intervention influences recipients. This framework suggests that RMB practitioners and mental health providers, such as mental health nurses, may utilize RMB therapeutically to address physical and psychological pain, depression, anxiety, and trauma recovery. In addition, it suggests how RMB may be employed for stress reduction and in support general wellbeing, all of which fall within the scope of practice for various mental health providers, including advanced practice psychiatric mental health nurses. The findings are useful within the field of mental health nursing, particularly advanced practice psychiatric mental health nursing which addresses each of these treatment areas. Findings from this study may elucidate the benefits of RMB that are relevant to physical and/or mental health. Such information is important for future intervention studies and for advanced practice nurses who may include RMB treatment in their practice.
Chapter 3: Methods

Rationale for Grounded Theory Approach

The purpose of this study was to increase understanding of the processes involved in Rosen Method Bodywork from the perspective of recipients. The qualitative method of grounded theory was used to develop a model reflecting these processes. A grounded theory approach was selected for this study to gain a broad understanding of the processes involved in Rosen Method Bodywork from the expert perspective of those who have received it. Inductive inquiry poses general questions and minimizes assumptions in order to learn directly from the recipients and the data they produce (Charmaz, 2014; Schreiber & Stern, 2001). In grounded theory methodology, general problems are initially known, but specific problems emerge from the data (as does the theory), in a post hoc fashion rather than a priori. While the researcher may have a general comprehension of a subject, s/he cannot know in advance what will be found in a detailed inquiry (Charmaz, 2014, Morse & Field, 1995). From the data (participant interview transcripts), this study used inductive logic to build a theory about the processes involved in RMB, including what happens within recipients and in their interactions with their RMB practitioner. Analysis of the data includes examination of experiences of beneficial outcomes which in turn suggest directions for future outcome studies on RMB and its potential as a therapeutic intervention and in nursing intervention.

Theoretical Framework

Grounded theory methodology was selected for this study. Corbin and Strauss (2008) describe the epistemology of grounded theory as stemming from Pragmatism (Dewey, 1910; Mead, 1934) and Symbolic Interactionism, a term coined by Blumer (1969) as he built on Mead’s work. Pragmatism views “truth” as that knowledge which is available at this moment in
time and from this perspective. Truth remains open to future changes. Pragmatism views knowledge not as finite, but as ever-developing, with knowledge and action informing each other. At the root of Mead’s philosophy of pragmatism is the belief that knowledge is developed through action, not through ideas or talking. Reflective thinking informs action which in turn informs reflective thinking, such as thinking about the consequences of one’s action (Corbin & Strauss, 2008). Blumer’s Symbolic Interactionism (1969) emphasizes the symbolic nature, for example, through language and images, of human conceptualization of experience and meaning. Humans express their experience of truth through words and symbols; words and symbols are the product of expressive action. Human interactions are dependent upon the symbolic interpretations that people make about each other’s actions and the meanings they ascribe to these actions.

Three premises of Symbolic Interactionism include: 1) our behaviors reflect the meaning we make of things, 2) we derive meaning from social interactions, and 3) an interpretive process that occurs during communication gives rise to the meaning we attribute to our experiences (Blumer, 1969). Symbolic interactionism describes how people interpret each other’s behaviors and how our interpretations create the meaning people make of their experiences (Corbin & Strauss, 2008). Blumer observed that people dialogue with each other and also within themselves in order to make sense of things and to determine what actions to take. In addition to interpersonal processes of interpretation, people also reflect inwardly, interpreting behavior, and make meaning of them (Blumer, 1969).

In addition to considering symbolic interactionism as a philosophical foundation for grounded theory methodology, symbolic interactionism may also be applied to the Rosen Method Bodywork processes themselves. For example, recipients’ experiences during sessions
are intrapersonal (as described above). While witnessing oneself, recipients make meaning of observations and respond in physical ways, e.g., consciously or unconsciously tensing the body, or in verbal ways, e.g., sharing some aspect of the inner experience with the practitioner. Similarly, the philosophical framework of Rosen Method Bodywork views the presence of muscular tension as meaningful. Absence of tension in the resting body is rarely the case, because the body carries unconscious tension accumulated through life experiences as a protective mechanism (Rosen & Brenner, 2003). In Rosen Method bodywork, the practitioner senses residual, unconscious tension through touch and observation. When the body “at rest” is observed to have perceivable tension, practitioners assume that there is some meaning to that tension (Rosen & Brenner, 2003). The practitioner does not presume to know the meaning but supports the recipient’s process of discovery about what is there, in the holding. The recipient’s awareness is gently directed to this holding, through the practitioner’s touch and words. From the perspective of symbolic interactionism, the tension of the body is a kind of “doing” or action that derives from some meaning that the recipient is making of his or her life experience. The philosophical framework of symbolic interactionism is useful in understanding the grounded theory process of inquiry used in this study, and it may also shed light on the processes at play in the bodywork itself.

This study utilized grounded theory methods to construct a theoretical framework to describe actions, interactions, and processes occurring over time during Rosen Method Bodywork (McCaslin & Scott, 2003), as reported by recipients. Grounded theory is selected for its capacity to build substantive knowledge about how changes occur during processes, contexts and conditions contributing to those changes, interactions occurring, and consequences following (Corbin & Strauss, 2008). The grounded theory method constructs theory based on a foundation
of data which are purposefully and systematically collected from expert informers (those with experience in the phenomenon under study) to derive a theory. In this study, grounded theory methods will illuminate processes occurring in sessions, including both the interpersonal processes between practitioners and recipients, e.g., recipients’ accounts of presence, caring, and rapport, and recipients’ intrapersonal processes, e.g., descriptions of awareness of bodily sensations, thoughts, states of mind, images, memories, associations, and emotions. A grounded theory approach is suited to identifying these processes through its analysis of the data which provides the foundation for theory construction through constant comparison, coding and categorizing, and identifying theoretical propositions that emerge (Charmaz, 2006).

**Sample**

Grounded theory employs three kinds of sampling during different stages of the study: convenience, purposive, and theoretical sampling (Bryant & Corbin, 2007). The convenience sample is composed of the initial willing participants and provides the researcher with an opportunity to gain an overview of the phenomenon (Morse, & Field, 1995). Purposive sampling then allows for greater exploration of the variation of participant experiences. Theoretical sampling is implemented specifically to fill gaps in the emerging theory.

Initially, a convenience sample was composed of recipients who contacted the researcher and expressed interest in the study. When it was observed that several potential participants were referred by the same practitioner, purposive sampling was implemented by both limiting the number of participants from a single practitioner and by reaching out multiple times to practitioners across the country to recruit participants from a diverse regions and practitioners.

Between the months of June 2016 and May 2017, the researcher was given contact information by 21 practitioners for 35 individuals, 20 of whom participated in the study to
completion. Twelve practitioners referred the 20 participants; four of these participants were referred by one practitioner, at which point researchers capped the number of participants from a given practitioner in the interest of maximizing a broad sample. Eleven potential participants either did not respond when contacted or did not participate after receiving the consent form for review. 24 individuals returned signed consent forms; four of these did not continue for reasons of: scheduling difficulties (2), technological difficulties (1), and a change of mind (1). Beyond the 35 individuals originally contacted, two potential participants were not contacted because there were too many participants referred from their practitioner, and two were not contacted because their contact information arrived too near the end of data collection.

Most participants had received regular sessions from one RMB practitioner. Two had received regular sessions from two practitioners at different periods of time. Frequency of sessions varied from weekly to every few months, with most receiving sessions every one to four weeks. At the time of interviews, one participant had not had a session in approximately 10 years; prior to that, the individual had experienced multiple sessions. Data from participants who have not had sessions in several years is valuable because what they experienced was important enough for them to report about and they speak to the impact of RMB on their lives, despite the time that has elapsed.

Participants lived in the following regions of the USA at the time of interview: Western (13), Southern (3); Midwest (2), Northeast (2). Greater detail is not included in order to protect anonymity of participants, as some states have few RMB practitioners and identification of participants might be possible.

Recipients of RMB have unique knowledge about their personal experience receiving sessions and individuals who have received multiple sessions of RMB are considered
knowledgeable experts that can contribute valuable accounts (Morse & Field, 1995). Data collection and analysis demonstrated a variety of experiences related to the research question.

**Inclusion and exclusion criteria.**

According to grounded theory methodology, initially a convenience sample was selected from adults who had experience receiving Rosen Method bodywork. The inclusion criteria for recipients in this study were: adult (18 years or older), recipients of RMB with a minimum of five RMB sessions who had not attended RMB trainings (other than an introductory weekend workshop), and who had sufficient English to articulate the complexity of their experiences and to read, understand, and sign consents in English. Recipients who had participated in RMB trainings (other than an introductory weekend) were not included in the study, as they may bring preconceptions about the work which come from the theoretical understanding conveyed in the RMB training. Children were excluded because most recipients of RMB are adults. Additionally, the research questions could be addressed without involving younger individuals of a more vulnerable age.

The five-session minimum criterion was selected for the current study. Inclusion of recipients with experience of multiple RMB sessions is important because it may be that multiple bodywork sessions are needed to learn how to receive a touch intervention (Moyer, 2004). The Hoffren-Larsson, Gustafsson, & Falkenberg (2009) study included participants who had received a range of RMB sessions, from 1-140 with a mean of 29. Several studies on touch intervention involved eight sessions (Richeson, Spross, Lutz, & Peng, 2010; Stötter et al., 2013) and mindfulness-based interventions often utilize eight sessions of the intervention (Segal, Williams, & Teasdale, 2013). While eight sessions appear to be common in these quantitative studies to determine outcomes, for this qualitative study, five sessions were estimated to provide sufficient
experience for participants to provide perspectives about changes they observe over time. While there may be recipients who have had a single pivotal RMB session and may have valuable accounts of their experiences, data about a single session does not fulfill one of the study goals which is to understand the processes of change over time. A minimum criterion of five sessions ensured that data captured change over time.

The decision to include recipients who have had several RMB sessions derives in part from Peplau's theory of interpersonal relations. According to Peplau (1991), when recipients have repeated contact with the same practitioner, the therapeutic, interdependent relationship can develop and proceed from the initial interpersonal processes of orientation and identification to the phase of exploitation in which much of the intrapersonal processes may become more evident to the recipient. In early stages of the interpersonal relationship, the recipient is busy relating to the practitioner and to the newness of the experience of the work. In the exploitation phase, the recipient has settled into some familiarity with the practitioner and the unique method of interaction and is better able to attend to their personal and interpersonal experiences. (O’Toole & Welt, 1989).

The number of sessions that participants had experienced ranged from five to over 240. Three had seven or fewer sessions; the remaining participants had 20 or more sessions. Seven had 50 or more sessions. All had at least five sessions with the same practitioner. Two had sessions from more than one practitioner (one had worked with two practitioners and another with three). Some people received RMB on a weekly or monthly basis. Some received RMB in episodes, such as several sessions with a break of several months or years before resuming.

Recipients with past but not recent experience with RMB were intentionally included (one participant fit this qualification). Recipients with sessions in the past who had strong
recollections of what occurred for them and an interest in conveying their accounts of RMB in the study were included. The goal was to capture the participants’ experiences over time; the study was not looking for objective findings that could be subject to errors of recall. Two participants had remote experiences (greater than five years) of RMB. One participant had a single session of RMB and did not resume for several years at which time the participant worked with two other practitioners (sequentially) for multiple sessions. Another continued to have sessions with interns.

**Sample size.**

The goal of grounded theory is to develop a theoretical framework that is inductively derived from the data. Toward this end, the data must be rich in detail and provide examples to generate categories during analysis that begin to illuminate the processes involved in the phenomenon of interest. Data must also encompass the breadth of diverse experiences of the phenomenon. For this reason, the quality of the data rather than the specific number of participants determines sufficiency of the data. The data and its theoretical sufficiency determine the adequacy of the sample (Charmaz, 2006; Morse & Field, 1995).

In grounded theory, sample size is initially estimated (Morse, 1994). An estimate of 30 participants has been proposed for grounded theory studies (Morse, 1994). The actual number of interviews depends upon the quality of the data which is in turn dependent upon the selection of participants who can articulate the richness of their accounts, the effectiveness of the interview questions, and the saturation of the data (Charmaz, 2006; Morse & Field, 1995). When interview questions are effective, fewer interviews may be needed to gain saturation (Bryant & Charmaz, 2007).
According to grounded theory practices, after initial coding and analysis have begun to identify patterns and constant comparison analysis begins to reveal a theoretical level of abstraction, theoretical sampling is employed to further elucidate specific aspects of the emerging theory until a substantive theoretical framework is obtained (Bryant & Charmaz, 2007; Morse & Field, 1995; Morse et al, 2009). Theoretical sampling involves drawing upon new participants or returning to previous ones to fill in gaps. The process of theoretical sampling occurs concurrent with data collection and analysis. These concurrent components of the study mutually drive each other in an interdependent fashion until a substantive theory develops (Charmaz, 2006). Adequately saturated data provides the substance from which useful theory is drawn (Charmaz, 2006).

For this study, the initial estimate for the sample size was 30 interviewees, based upon Morse's recommendation (Morse, 1994). After the initial convenience sampling, purposive sampling was employed to broaden variations in the data by limiting participants from one practitioner to four and by reaching out multiple times to practitioners in less populated areas. In an ongoing manner, the team considered sampling methods to include more negative cases and to broaden the sample. During theoretical analysis, redundancy in the data was observed at the 12th interview at which time the data pointed to an emerging theory. Saturation was suspected at the 16th interview at which time four additional interviews were conducted to confirm saturation. The data obtained in the study appeared to adequately describe the emerging theory; for this reason, additional theoretical sampling was not conducted.

The sample’s ethnicity was two of Asian or Asia-American descent and 18 Caucasians. Three had some college or AA degree, seven had Bachelor’s degrees; 10 had a Master’s degrees or PhD. Seven were male and 13 were female. Their ages ranged from 35 to 70 years.
Setting

In grounded theory methodology, the setting is selected based on its ability to provide a dense possibility for obtaining the desired sample (Morse & Field, 1995). The population under study is individuals who have experience receiving RMB. According to the Rosen Method Professional Association (n.d.), within the United States the densest populations of RMB practitioners, and therefore recipients, are in eastern and western states. Initially, both in-person and online interviewing options were considered; however, the face-to-face, in-person option for interviews was discarded due to travel logistics (the researcher lived distant from states with multiple practitioners) and because this would result in certain geographic areas being more represented than others. To draw a sample from a broader, geographically diverse population, internet-facilitated, face-to-face interviews were conducted using Skype or Face Time.

Research suggests that the use of an online medium can be an effective means of performing interviews (Walker, 2013). In addition, an ethical benefit of online interviews is that participants who have mobility or transportation issues, or participants from distant geographic areas, are able to participate (Walker, 2013); this improves the data by broadening the sample. Participants were invited to choose convenient times and locations for their online interviews. The use of online interviewing precluded participation by those who were unwilling or unable to use that technology. Use of online interviewing allowed participants in remote locations of the United States to be included in the study; this both enhanced ethical fairness and contributed to the quality of the data by increasing the diversity of the sample (Charmaz, 2006). Given that the interviews were done remotely, online audio-visual interviewing greatly facilitated interpersonal communication because in addition to the audio connection, as possible through a phone call, the video dimension allowed for seeing gestures, changes in facial tone, expression, and coloring,
and helped in appreciation of pauses. For example, when a pause occurred, both parties could see each other and sense each other’s contemplation. Only the audio portion of interviews was recorded.

**Recruitment**

This study received approval by the Kent State University Institutional Review Board (Appendix A). Recruitment began June 2016 and continued into May 2017. The first consent form was received July 18th, 2016. The last interview was conducted on April 7th, 2017. Recruitment procedures are diagrammed in Appendix B. A convenience sample of RMB recipients was identified initially through email to RMB practitioners throughout the United States. Practitioners were contacted through a practitioner yahoo group and through the Rosen Institute member directory. Access to Rosen Method Bodywork practitioners' email addresses was possible given the researcher’s membership in the Rosen Institute and a yahoo.com group that links practitioners. Practitioners were informed of the purpose of the study and encouraged to inform their past and current RMB recipients about the study. It was anticipated that practitioners would have an interest in supporting a study about RMB and would be motivated to invite recipients to participate. Practitioners were provided basic information to convey to their recipients about the nature of the study and how to contact the principle investigator directly. (See Appendix for Email to Practitioners Introducing Them to the Study (C), Script for Practitioners Assisting in Recruitment (D), Recruitment Flyer (E), and Script for First Contact with Potential Participant (F). Prospective participants contacted the principle investigator by email or telephone, or the researcher contacted them via the information provided by their practitioners.
Once contacted, the consent form was emailed (Appendix F). An initial phone call was arranged during which the study was described, the informed consent form was discussed, the demographic form was started (Appendix G), questions were answered, and a date for the interview was set, contingent on receipt of the signed consent. The researcher introduced herself to establish connection and rapport by verbally informing them that she was a RMB practitioner so had some understanding of the experience but was interested in hearing participants’ experiences so as to add this knowledge to the literature. In addition, that their sharing was graciously received as a gift that would help the understanding of what RMB is, how it works, and how it may be useful. Once the participant gave informed consent, the demographic form was completed. Participants signed and either scanned or took a photo of their consent forms and emailed them back. One participant opted to mail theirs.

In grounded theory, identification of variations in categories derived from the data is important to the quality of the findings. By including a variety of cases, variations in categories can be identified so that the evolving theory encompasses the range of experiences of the phenomenon and can show the complexity of the phenomenon. (Charmaz, 2006). One way to accomplish this is to include participants from multiple practitioners, including those in different geographic regions. It is appropriate that 10 of the participants were in California, as that area has many practitioners. Interviewing participants from the West provided an opportunity for maximal intensity of exposure to the phenomenon of study (Morse & Field, 1995).

**Data Collection**

Data was gathered through individual online interviews lasting approximately one hour. Participants were provided with instruction via phone or email regarding the procedure prior to online interviews. All interviews were digitally audio-recorded and transcribed verbatim.
Digital recordings were employed without connection to the internet for additional protection of confidentiality. During online interviews, the interviewer wore a microphone, and a microphone was placed by the computer speaker to record the participant's responses. Recordings allowed the researcher to more accurately gather participants' responses, thereby keeping true to the participants' descriptions of their experiences. The principle investigator performed all aspects of data gathering. Data was backed up immediately after collection and securely stored in two separate, password-protected locations to maintain confidentiality and to protect the data. An identification code number was used for each participant and identifiers were stored separately from participant interview data. Emails or otherwise written responses to interview questions from recipients were included as data. All data was de-identified and coded according to participant number. Interviews were transcribed verbatim by the interviewer and once transcripts were printed, they were listened to again while checking the transcripts for accuracy and making corrections. Interview audio-recordings and transcripts were uploaded on a secure Kent State University course website for the research team to review.

According to grounded theory methods, an interview guide provides a useful tool to map out open interview questions for sensitive inquiry (Charmaz, 2006). The questions in the interview guide were developed with attention to establishment of researcher-participant rapport and to answer the research questions (Appendix I). As recommended by methodology, the interview questions were modified during the interview process (Charmaz, 2006). For example, a question was added to gather information about previous life experiences that participants viewed as relevant to their being receptive to RMB.

At all phases of the study, attention was given to managing researcher preconceptions. The interviewer reflectively sought to identify assumptions she may have brought to the
interview process. The research team provided critical input to identify potential areas where preconceptions may have influenced the interview questions. The researcher conferred with the research team about the content of questions in the interview guide to ensure that precautions are taken not to guide the participants responses based upon such assumptions. For example, although experiences of mindfulness may have been possible, participants were not overtly asked about a mindfulness. The data collection procedure was field tested by a mock interview performed by the principle investigator with an early consultant to the study, RMB practitioner, Gail Bourque, Psy.D.

According to (Guillemin & Heggen, 2009) rapport between researcher and participants is prerequisite for participants to begin to share sensitive information. Sensitive information enriches the quality of the data. At the same time, when rapport is established and sensitive information is shared, the participant becomes more vulnerable (Guillemin & Heggen). For this reason, throughout this study, attention was given to demonstrating respect and appreciation for participants' contributions and empowering them with choices such as whether or how long they participate or opting out of certain questions (Graor & Knapik, 2013). The researcher engaged in sensitive inquiry, mindful to the emotional responses of participants. Additional ethical considerations are discussed later in this chapter.

During interviews the interviewer focused on attuning to the participant and employed gentle probes to invite comfort, facilitate communication, encourage detailed descriptions, and to support development of rapport between the researcher and the participant. Participants were thanked for their valuable contribution of their time and attention. They were encouraged to listen to their experience and to respect their feelings, such as not wishing to respond to a question or wanting to speak about something not asked. Attention was given to communicating
with non-judgmental statements and the interviewer focused on keeping an open mind to unexpected information. Interview questions began with open, grand tour questions inviting the participant to share without imposing a focused objective. Open-ended questions were followed by semi-structured questions to focus more deeply on aspects of the participants’ experiences. The interview guide was revised based upon responses.

Focused questions sprang from the interview itself (Charmaz, 2014). In grounded theory, data collection and analysis cyclically inform each other. As the analysis progressed, interview questions delved into participant experiences based upon categories that were identified in the data analysis (Schreiber & Stern, 2001).

The audit trail was composed of data from memos, demographic forms, transcripts and debriefing notes following interviews, team meeting notes; interview maps, files of quotes on categories, and a diagram of the developing model of RMB processes (Charmaz, 2006; Morse & Field, 1995). The three initial team meetings were recorded as part of the audit trail; notes from these were added to the memo. The memos recorded the data collection process, including decisions points and the rationale for decisions, problems that arose, and the context in which each item of the data was collected (Morse & Field, 1995). Memo-writing provided a link between the data and the emerging theory. All writings were kept as part of the audit trail, to track decisions about sampling, coding categorizations, and the emergence of the theory, and were used to write up the study (Charmaz, 2006).

Data were stored under password protection. Transcription of audio files was accomplished by the interviewer using a dictation program (Dragon Naturally). The researcher read aloud (dictated) directly from the audio-recorded interview as it was played back through head phones. Participant interviews were dictated and transcribed verbatim. Vocalizations were
left in the transcript but were omitted from the write-up purposes so as not to interfere with the clarity of the meaning. For example, frequent use of “like” or “you know” were omitted. Identifying information such as names of participants, practitioners, or locations were deleted from the transcripts to protect confidentiality.

Data Analysis

In grounded theory methodology, data collection and analysis are interwoven in a concurrent, continuous, and iterative process. Data was evaluated for how it revealed the range of perspectives and how it illuminated underlying process, views, differing opinions, and actions (Charmaz, 2014). Data analysis focused on processes and theory development. Analysis moved through stages of comprehending, synthesizing, theorizing, and recontextualizing (Morse & Field, 1995). Comprehension began with cross-checking transcriptions for accuracy and with initial line-by-line coding using gerunds to indicate processes. Gerunds kept codes close to the data (Charmaz, 2006) and indicated processes which could then be further analyzed through comparison with other data. Word-by-word and incident-by-incident coding were included. Codes represented concrete and abstract, i.e., metaphorical, meanings in the data about participants’ beliefs, actions, assumptions, and experiences (Charmaz, 2006) during the Rosen bodywork process. Cross-comparisons of coded data from the team aided in cross-checking and verifying initial categories and in identification of recurring themes, patterns, and processes. The process of categorical analysis grouped the identified codes and led the analysis to a more abstract level (Munhall, 2012). Data analysis included descriptive statistics regarding the participants' demographics, such as the number of sessions received over time. (Appendix I). During coding, the team discussed similarities and differences in analysis of the initial codes and categories. After coding to categories, a single document was made for each category,
containing all the examples from that category from each participant. This file was used to further analyze the category and to identify exemplars.

Looking at many cases is a way of identifying variations in categories (Charmaz, 2014) so that the evolving theory encompasses the breadth of possible data. Ultimately, the goal was to encompass the complexity of the phenomenon within a concise theory. The grounded theory researcher seeks to develop theoretical sensitivity in order to construct an optimal and representative theory that accurately encompasses the experiences of the participants. Theoretical sensitivity (Charmaz, 2006) is gained by prolonged engagement which allowed for study of the phenomenon from multiple perspectives. Engagement with the data was prolonged by conducting several interviews after data saturation was suspected and by performing a minimum of three reviews of the each of the audio-taped interviews and transcripts. The exploration continued through making comparisons, following leads, and remaining curious and open to the unforeseen (Charmaz, 2006).

In the ethical interest of participants and the scientific interest of adequately and accurately representing their experiences, the analysis was performed on an individual and team basis. The team was composed of two faculty and one graduate student who conducted the study. Initially the interviewer transcribed the interviews; the transcripts were then cross-checked for accuracy and to remove any identifying information. Printed transcripts were then independently coded by each of three researchers using line-by-line coding. The researchers meet at two-week intervals to review the coding and make decisions about categories emerging. Multiple perspectives helped to confirm categories being identified. The researchers worked to see possibilities and to ask reflexive questions, in an effort to avoid automatic impressions based on bias (Charmaz, 2014). Team input and individual reflexive questioning was critical to reduce
inadvertent imposition of ideas onto the data. Adequate time was allowed for data analysis to avoid premature conclusions.

In grounded theory, the researchers’ examination of personal biases and assumptions is necessary to stay open to the data and to constructing a theory that is rooted in the data (Charmaz, 2006). One researcher had assumptions based on RMB experience as both a practitioner and a recipient, as well as from her mindfulness and psychotherapy background. She acknowledged an assumption that RMB is a mindfulness intervention and held this aside in order to make room for the expressed experiences of participants. To this end, the word “mindfulness” or suggestions of it were not introduced by the interviewer so as not to lead the responses of participants.

The data was continually evaluated for the range of perspectives, opinions, and actions that it demonstrated and for how it revealed processes (Charmaz, 2014) within Rosen Method bodywork. Charmaz maintains that the team analysis guards against premature conclusions regarding saturation. Team members observed when redundancy began to be evident in the data around the 12th interview. Researchers stayed open to the data and avoided assumptions as redundancy presented. They discussed and ultimately decided when the iterative analysis revealed saturation and no further changes to understanding were observed. Three interviews were conducted after saturation was suspected in order to verify this observation and to complete interviews that were previously arranged.

The interviewer was aware of being present to and attuning to participants through interviews. Prior to interviews, the interviewer took several minutes before initiating the call for centering and to contemplate being receptive to the participant’s person and perspective. These practices helped the interviewer settle into the moment and prepare to receive the other person’s
experience. The interviewer also listened reflexivity to her own feelings and bodily sensations in response to participants’ sharing. For example, noting shifts in sensations when the emotional tone of the participant changed, or they appeared to become more vulnerable. This reflexivity supported reflecting back the importance of what was being shared.

After interviews, the interviewer paused to reflect on the experience, noting any challenges that presented themselves, such as technical difficulties or interruptions. Reflexivity was expressed in the debriefing notes and in subsequent memo writing as the interviewer analyzed the data and noted impressions. Interviews ran for approximately one hour. The time of natural completion of these interviews varied and was determined by the participants, as the interviewer followed the lead of the participant in where they wanted to go with their sharing and when they seemed finished with the interview. Either the participant-initiated closure or the interviewer came to the last open question and the participant had no further responses to share. One interview was abruptly interrupted by an apparent break in the internet signal; this occurred late in the interview when it had seemed that the interview might be nearing completion. Both parties attempted to access each other and ultimately contact was reestablished for closure.

Participants were thanked for their contributions. Their experiences were validated by receptive listening to their accounts and conveying interest in their thoughts and feelings. When a participant appeared moved or became tearful, space was allowed for these experiences and the interviewer listened with sensitivity for possible meta-messages, at times gently checking these out with the participant. Participants were invited to check in about their comfort in sharing and reminded of their option to continue.

In addition to asking about challenges or difficulties that arose in RMB sessions (part of the initial interview guide) the interviewer asked about what positive experiences the participant
had with RMB. The interviewer asked about the felt-sense of the positive outcomes they
described. At the end of interviews, participants were asked about how the overall process of the
interview and how they felt and how they might care for themselves after the interview. If they
had conveyed some distress during the interview, they were asked whom they might talk to or
how they might like to care for themselves after making this effort and contribution.

Through the interviews and analysis, theoretical analysis continued, first with reviewing
of the data, when initial codes and categories begin to be constructed (Schreiber & Stern, 2001),
and then with further abstraction as certain categories seemed to subsume others (Charmaz
2006). Explorative propositions were written to link initial categories and reviewed with the
team. Those categories that rose in abstraction from the rest became concepts. Concepts were
further linked by possible propositions, beginning to give shape to the theory (Charmaz 2006).
Constant comparison of all levels of analysis (raw data, codes, categories, concepts and
propositions) ensured that the emerging theory was grounded the in the data (Charmaz, 2006).
Theoretical analysis continued throughout the study (Schreiber & Stern, 2001). The data was
reviewed multiple times during the data analysis. This exposure to the data over time, improved
the theoretical sensitivity of analysis, in which there was a growing ability to comprehend the
meaning within the data (Schreiber & Stern, 2001).

The research team gave vigilant care to avoiding preconceptions including cross-
checking whether and where the concepts and categories sprang directly from the data.
Identification of specific examples (exemplars) from the data helped assure that more abstract
levels of analysis are clearly grounded in the data. Use of dense description, the imagery of the
emerging model, and substantive quotes helped to explicate theoretical conclusions (Charmaz
Team reflection about proposition statements drawn from the data helped to avoid inferring beyond the explicit evidence.

Patterns emerged from the data and began to shape the theory. Memos recorded various explanations for the data and were explored and compared to identify a parsimonious explanation that fit all the data, including variations (Corbin and Strauss, 1990). Clustering of data in a graphic form (the model) aided exploration of possible relationships between categories or concepts.

A further step in identifying the emerging model was taken to cross-check how the emerging model represented each individual participant’s account; subsequently, the researcher named this method “interview mapping”. The interview mapping procedure began with a blank template of the proposed model. The researcher then listened to each interview while reviewing its transcript and plugging into the template the quotes or line numbers from the transcript. Appendix K is the blank template of the model and Appendix L is a sample. Each participant’s completed model comprised the raw data for a case study of that participant’s experience. This allowed the researcher to see where the data fit within the model and whether any data did not fit or suggested a change to the model. This process assured that the model both fit and encompassed the data. It also helped to refine the titles of the categories and subcategories. This method also allowed the researcher to view the process, for that given participant. This wholistic perspective yielded greater satisfaction and understanding of the relationships between the concepts that made up the processes within RMB for that individual.

Gerunds were used in coding and in memos to help maintain the researcher's perspective on identifying processes. Use of gerunds supports perceiving sequences and connections in a way that static description of themes does not. (Charmaz, 2006). Using gerunds also continually
directed the researcher to examination of the process rather than the individual participant to identify fundamental phases in the process of RMB and to develop an explanatory theory (Charmaz, 2006). Once the model was made explicit, the model was examined for how it fit with existing literature and how it might be applied (Morse & Field, 1995).

**Human Subjects Considerations**

Inherent to the qualitative research process is the dynamic relationship between researcher and participant. This relationship is often more direct and involved than in quantitative studies. As in any relationship, the dynamics of power influence interactions. Ethical challenges in qualitative research include the power differential between the participant and the researcher in which the participant initially has less power and is therefore at risk of harm (Graor & Knapik, 2013, Guillemin and Gillam, 2008). To address this potential risk of harm, the researcher attentively observed opportunities to shift the power differential in favor of the participant. This effort served both the wellbeing of the participant and of the study which depended upon data from willing participants who felt safe and comfortable enough share from the depths of their experience (Graor & Knapik, 2013, Guillemin and Gillam, 2008). To protect participants and build effective research relationships, the researcher attended to those moments in which choices and power could be offered the participant (Graor & Knapik, 2013). Such moments were sought early in the researcher-participant relationship, such as during the process of establishing informed consent (Graor & Knapik, 2013) and continued throughout the research process. Power shifts were initiated at the onset of contact through acknowledgment of potential participants’ interest in contributing, to identifying an interview time that would work for them, to options for Skype or FaceTime per their preference, as well as throughout each contact. Following the interviews, a Thank You note and compensation check for $35 were sent to
participants (except for those who stated that they wanted to donate the compensation back into the study), indicating respect for their preferences.

To convey respect for the participants’ time, participants were compensated for individual interviews through payment of $35 which was mailed after the interview. This action also promoted a shift in power from investigator to participant by materially acknowledging their contribution (Graor & Knapik, 2013). Two participants declined compensation saying that they wanted to contribute to the study; after the first of these, the researcher conferred with the research team and it was agreed that participants be allowed to donate their compensation back to the study and that doing so was respectful of their wishes.

Reflexivity informed ethical decisions. For example, one participant told a poignant, metaphorical story about a non-RMB experience that metaphorically captured the experience of being seen with kindness by another person. In spite of its poetic and moving nature for the research team, it was not included in the write up as it might easily have been recognized and have identified the participant. Similarly, practitioner names were omitted and sometimes gender was omitted to minimize participant or practitioner recognition. Memo writing and recording of process notes regarding researcher-participant interactions provided reflective activities and helped to illuminate possibilities for shifting power to participants by allowing the principle investigator to study the dynamics during interviews and other moments of contact with participants. The timing of interviews was arranged to be manageable for both the participant and the researcher so that burdens by time will not interfere with the interview process, either pressuring or foreshortening participant responses. Silence was accommodated in interviews to give participants and the interviewer time to reflect. During interviews, the focus was on exploring the participant's definitions and reality (Charmaz, 2014). Development of rapport and
expressions of appreciation for participant contributions helped to facilitate participant empowerment.

In qualitative research, describing experiences can be beneficial for participants by providing a neutral environment in which to review and share experiences (Munhall, 2012). That said, the interview process may also raise feelings or concerns that trouble participants after the interview is over, even if distress is not evident during the interview (Schreiber and Stern, 2001). Participants were protected during interviews by monitoring them for distress and by ensuring that they understood that they may stop the interview at any time. Resources for distressed participants were discussed in advance by conferring with participants about what specific resources might be helpful to them, if needed. Emergency contacts were included in the demographic form. While several participants dismissed or minimized the need for this, they conveyed that they understood the rationale and agreed. As described above, confidentiality was protected by de-identifying interview data and by secure storage of identification information separately from identifiers.

Justice and fairness were upheld by inclusion of participants who met criteria, could meet online and were available within the time frame of the study. Participants were informed that the study results would be available to them upon completion. Time was allowed between initial discussion of participation and interviews for them to decide whether to participate to avoid coercion. In addition, information about who participated in the study was confidential. For example, when a practitioner informed a client of the study, the practitioner was not informed about whether their client participated in the study. One practitioner was contacted due to confusion about contacting a referred, potential participant; the practitioner was not informed by the researcher as to whether the individual ultimately participated in an interview. This
confidentiality helped avoid the effect of social desirability on participants, which may have otherwise led them to participate out of a sense of obligation to their Rosen Method practitioner.

Participant autonomy was protected, and coercion was avoided by discussion of the potential risks and benefits of participation during the recruitment process, and by the use of a written informed consent as well as reminders about continuing freedom to participate or to opt out, at any time. Obtaining the initial consent to participate online reduced the possibility of coercion, as participants had time and distance to make their decision and were not obligated to decide in the presence of the researcher (Walker, 2013).

Participants had the option to stop the recording when telling about a particularly sensitive experience. None requested this. Participants were informed about the securing of data to protect their privacy. Participants were informed that only the audio part of the interview was recorded. To protect participant confidentiality, audio-recorded interviews were saved under password and downloaded for secure storage as soon as feasible after the interview.

There are differing opinions among qualitative researchers regarding the merit of using software as a tool during analysis. Concerns include that researchers may rely excessively on software and limit the extent of direct interaction with the data, and therefore insights might be missed to the detriment of analysis (Charmaz, 2006). On the other hand, in the hands of a diligent researcher, the tool of software is also argued to be useful for managing the volume of data and in assisting the analysis such as constant comparison in which the researcher switches back and forth between different parts of the data (Schreiber & Stern, 2001). The decision as to whether to use a software program for this study was deferred until analysis began at which point the research team decided not to use software.
**Limitations Related to Methodology**

The principle investigator for this study was also a RMB practitioner with relationships in the Rosen community of practitioners as well as a personal set of assumptions and beliefs about the work. The researcher was also an advanced practice mental health nurse. Each of these attributes had implications for the study (Graor & Knapik, 2013; Lykkeslet & Gjengedal, 2007). As a Rosen Method Bodywork practitioner, the researcher had insight into the bodywork and could identify important areas of inquiry about which to interview study participants. On the other hand, as a practitioner, the researcher had been trained in the theoretical aspects of RMB and carried assumptions about these into the research process. In addition, a knowledge base about mindfulness from psychiatric nursing practice and personal practice was part of the researcher’s background.

While the above considerations hold true, there is also dialectical merit in having a first-hand understanding of a phenomenon being researched. In his discussion of a model for meditation research, Walsh (1982) expressed concern that researchers with insufficient familiarity with the phenomenon of study (in this case, meditation) can misinterpret or miss important findings from the data. Walsh encouraged researchers to read the ancient meditation texts to learn from the wealth of understanding about meditation in the eastern literature, and to practice meditation themselves, rather than embark on research without first-hand experience. Based on his observations in the field, a lack of first-hand understanding of meditation leads to misconceptions and misinterpretations of data from studies on meditation. Walsh's argument supports the value of being both a researcher, RMB practitioner, and advanced practice nurse in this study.
As a psychiatric mental health nurse, the principle investigator was familiar with the therapeutic role, and while this familiarity may have increased sensitivity to participants' feelings and needs, it could have been easy to unwittingly slip into the role of the therapist when participants share sensitive content in interviews. To maintain clarity of roles, the researcher practiced centering prior to contact with participants and self-reflection throughout the entire research process to maintain clarity of role. This reflexivity helped in establishing and maintaining ethical boundaries and beneficence toward participants. The allotment of self-reflective time, memo writing, and debriefing with the research team also provided opportunities for reflexivity.

**Evaluation of Rigor and Trustworthiness**

The methodology used in this study was conducted with rigor to meet criteria for establishing trustworthiness so that confidence could be placed in the findings as identified for this sample and within this population (Denzin & Lincoln, 2011).

The reflexive process of critical self-examination by the researcher ran throughout the study. Debriefing notes (field notes) about the interview experiences, ongoing memos containing musings and hunches, and which tracked decisions and strategies, together comprised the audit trail. Debriefing discussions among the research team served to minimize assumptions and maintain openness to what the data conveyed.

Credibility was established with a team examination and analysis of the data as well as prolonged exposure through repeated reviews of the audio and written transcripts. In addition, the process of “interview mapping” served to systematically test the applicability of the emerging model for fit with the data from each individual participant. Transferability of the findings is facilitated by demographic data about the participants. Dependability was reflected in
the systematic procedures of inquiry described in ongoing memos regarding the strategies during the study. Memos included reflexive writing. Confirmability was enhanced by documentation demonstrating where the data supported the findings. This documentation was provided in the citations of transcripts for exemplars in the write up and in the tables of snippets indicating where the data for categories can be found.

Resonance is demonstrated by how the categories and model reflect the wholeness of the processes in RMB. The “interview mapping” step in the analysis helped to illustrate the resonance of findings with the phenomenon of interest.

The usefulness of the study is reflected in the implications listed in the write up and in how the study sets the stage for further research. Implications are listed for both mental health providers (including advanced practice psychiatric mental health nurses) as well as RMB practitioners. Usefulness is also demonstrated in the examples of how RMB may be useful in psychotherapy, mindfulness training, and trauma recovery.

**Summary of Methods**

This systematic, grounded theory study explored the processes involved in Rosen Method Bodywork over time, from the perspective of the recipients. Traditional grounded theory coding and analysis methods were utilized, as was a systematic method of cross-checking the model for fit with each participant’s account, which the researchers call “interview mapping”. Interviews of participants provided data for identifying the processes within RMB and the progression of change. Ethical considerations guided this study in planning and implementation. The trustworthiness of the findings was supported by the rigorous implementation of the study.
**Findings: The Model**

A model of the RMB process became apparent through data analysis (Appendix K). This model consists of five integrative phases, beginning with a reason for entering the process (disconnection). The RMB process includes five integrative phases represented by the major categories: Feeling Stuck and Disconnected, Being Open and Trusting, Exploring, Learning, and Transforming, and Feeling Connected.

To set the model in context, this chapter begins with a description of the priming experiences that participants believed may have influenced their receptivity to RMB. In addition, a brief description of the flow of a RMB session as described by the participants is provided. The bulk of the chapter is a description of the model, outlined in order of the flow through the RMB process (Appendix J).

**Priming Experiences**

These participants experienced RMB within the context of their lives. Participants were asked about what life experiences might have contributed to their interest in or receptivity to RMB. On the whole, the participants were familiar with receiving touch. Sixteen out of 20 participants had previous experiences with other various types of bodywork and mind-body approaches, including: massage, chiropractic, Rolfing, yoga, energy work, reflexology, acupressure, yoga. One of the participants was a bodyworker (using other approaches than RMB) while another had no prior bodywork experiences. Most had experiences with hands-on modalities, such as massage, for many years.

Many were familiar with exploring and sharing personal thoughts and feelings from previous experiences such as 12-step (Alanon), personal growth programs (ie, Landmark, spiritual retreats, support groups, sensory-awareness training or personal growth workshops.
One cited acting training as helpful background for accessing inner experiences. Many participants had some experience with meditation training and practice. Multiple participants had extensive experience receiving psychotherapy individual, family, or group therapy, and two participants had training in psychotherapy. Several participants did psychotherapy concurrent with RMB, and two were referred to RMB by a therapist. Several participants had extensive backgrounds or formal training in spiritual disciplines or religion including Shamanism, Zen Buddhism, Hinduism, Christianity. Most had experience with meditation.

One participant described first going to RMB for physical benefits and believing that he should be passive, and that the practitioner would “do the repair work… They fix you up”. Only later, when he understood that RMB invited of his engagement and participation, did he notice psychological benefits as well as physical ones. He saw his role in the process as significant: “The therapist is there to assist 20, maybe 25%; 70% is up to me … It is me. It is my life”.

Particular beliefs or world views seem to facilitate receptivity of these participants to Rosen Method bodywork. Participants believed that emotions and psychological tensions are carried in the body and that one needs to face the discomfort of these tensions to release them. They believed that “the body doesn’t lie” and they trusted “the language of the body”. Some said they philosophically accepted discomfort as a part of life. Some said they valued open-mindedness, critical thinking, and evidence. One commented that she experienced tremors of her body during a RMB, and:

“[Although] it didn’t make sense, I couldn’t deny what my body experienced…It was separated from cognition, but I was all right with it …[it was] physical evidence of having big releases of emotion and big releases of tension”.
Participants heard about RMB in various ways including by word of mouth from a trusted person such as friend, spouse, acquaintance, or colleague who was getting RMB, or by seeing positive changes in a friend or partner who received RMB. Some were referred by their Alanon sponsor, psychologist or psychiatrist, bodyworker, Rosen Movement instructor, or from reading about RMB. A few heard about it as one of various healing modalities offered through a cancer treatment program. Participants found their RMB practitioners from word of mouth or the internet.

Participants’ Described the Overall Experience of RMB Sessions

A description of a RMB session is described above (in Chapter 1, Background and Significance). Here, a description is provided from the participant’s perspective, to set the stage for the description of the model identified in this study. Participants were asked to describe the basic process of getting a RMB session. For some, the session began when they entered the room with the practitioner and sat together for a few minutes to talk about what is going on with them. Other participants described simply coming into the room, staying in clothes or disrobing partially, and getting on the Rosen table for the hands-on part of the session. As one participant said, arriving on the table was a transitional time:

“When I first arrive, there will be that initial… arriving… making contact with the table, feeling myself on the table, starting to breathe. Allowing that sort of craziness of the mind, the drive over there, whatever it is. So, there’s always that sort of initial happening right at the start...And then as soon as [the practitioner] puts hands on my body, then there’s that connection made and it’s easier for me to come into my body”. [When asked] something like, “What’s happening now?”, then maybe I would start to say, ‘Oh there’s tightness in my back’. So, it normally starts with the body sensations and then
from that a lot of memories might surface just out of the blue, like things that were not necessarily in the forefront of my mind, but I’ll suddenly start having an image or recollection of something which then connects to emotion, and normally we would explore that.”

Generally, part-way through the session, the recipient will turn over from their belly to their back, although at least one participant stays on the back the whole time to avoid neck discomfort. At the end of the session time, practitioners often say, “I’m going to finish in a little while”, allowing time for the recipient to prepare to be done.

At the end, [the practitioner will] leave the room, and I normally take five minutes just to lie there. I might still be crying. I might feel peaceful. But I normally lay there in the quiet and breathe and take time to really ground myself because you can feel quite different by the end of the session especially if you’ve experienced a lot of emotions, and so then I’ll normally get up slowly, get dressed, probably have a drink of water and just really ground myself”.

Participants described taking time to linger on the table after the session ended or taking time later to rest.

**Feeling Stuck and Disconnected**

The entry point in this model of the RMB process is when something motivated these participants to come for the work. Nine of the 20 participants used the word “stuck” when describing symptoms that led them to seek RMB. Examples of feeling disconnected included: the “barrier” of physical tension; disconnection from the body and emotions; disconnection from a sense of confidence, integration or wholeness; disconnection from life and from nature; disconnection from others; disconnection from a sense of purpose, and from a sense of peace,
ease, and well-being. Other approaches to address stuckness, such as psychotherapy or personal growth approaches, had not worked to the desired degree. Participants’ perceptions of their stuckness evolved over time as they became more aware through RMB.

One participant pursued RMB for relief of symptoms that she did not believe standard treatment would understand or know how to treat. She reflected on her decision not to seek standard treatment when stressed and experiencing anxiety:

“I realized this was a problem. I had to deal with this. And I imagined myself going to a typical family physician and saying, ‘I kinda get headaches, my eyesight gets kinda goofy sometimes, I’m having trouble breathing, I’m holding my breath, I’m kind of stressed, I don’t poop all the way’, and trying to describe that and thinking, ‘What kind of treatment do I think that they would come up with?’ And I’m like, ‘They’ll probably give me an antidepressant and I’m not interested in taking an antidepressant. I don’t think that they would have a good diagnosis for my symptoms aside from panic attack or something like that… Well, if I can’t breathe and my body is shutting down and I have aches and pains all over, maybe I should just get a massage. Maybe I can at least do that.’ And by looking up massage in the area, I came across Rosen.”

**Holding Tension.**

Participants described feeling physical tensions associated with chronic pain, life stressors, or psychological issues. “Locked down” feelings and muscle spasms, as well as emotional symptoms, compelled them to seek help. One participant had chronic, intermittently disabling pain for 40 years prior to RBM sessions. Another described their tension as “things get stopped up.” One participant started RMB for psychological reasons and discovered that she’d been unaware of her physical tensions; the practitioner “will feel my neck tensing, and I can’t
even tell”. Participants associated their physical tensions with their psychological experience. As described by one:

“I didn’t think this [panic attacks] would ever happen to me. I’m pretty good at stuffing the trauma and the feelings down, but I finally got to the point where I was kind of having panic attacks. Not big full-blown dramatic panic attacks or anything like that, but just you know sitting at my computer working and feeling everything tightening up or having a little episode of angina. Not being able to breathe. Finding myself holding my breath. And I felt like my body was starting to shut down. That my body was just this thing that kept my brain alive. And also, with these shutdown symptoms, my body wasn’t working very well.”

While physical tensions brought some of these participants to RMB, they recognized that physical tensions were associated with psychological tensions such as interpersonal problems and daily stress or a life-long “gripping” that interfered with their “vitality”.

**Feeling Disconnected from Emotions.**

Participants recognized feeling emotionally and psychologically stuck. They had previously learned to tune out their emotions, and therefore had difficulty identifying and allowing them. Reasons that participants gave for being disconnected from emotions included learning to avoid feelings in their family of origin or other social contexts and becoming stuck in emotions for which they had no words. Some participants disconnected from their emotions due to the pain of relationship stress, grief, or loss. Participants were baffled and intrigued by their emotional responses in RMB, such as unexplained tears during sessions. Sessions may bring one in touch with “a sadness in me”. Explaining this disconnect, one participant said:
“We shut down a lot of these things because we have experiences where we feel things and we receive a certain reaction or we just kinda learn in whatever ways from our caretakers, from interactions in our lives, that it’s just not safe to feel certain things.”

Another disconnection participants described was the challenge of accessing and integrating emotional discomfort rooted in preverbal experiences: “So much of what I went through was before I really had words”. Others described disconnection from their emotions as a barrier to being in touch with themselves and moving forward in life:

“For me it’s more about releasing stuck emotions that are in my body and can’t really be accessed through regular therapy …. “people don’t like to feel emotions. People like to check out and not go to emotions, so it is not the easiest therapy to go through” … “Like, no one wants to feel their emotions. But I feel it’s the whole point. To not feel your emotions is to not be in touch with yourself and then not be able to know what to do.”

One participant reflected that her practitioner was often more in touch with her feelings than she:

“I feel that it is a lack not to be in touch with my feelings, not to know how to deal with my feelings at all … feelings being a large part of our lives … Why does another person have to tell me what I am feeling? Well, that’s where I am right now. I have to have another person tell me how I am feeling.”

Some participants observed that their emotions were often reactive. After experiencing losses from an auto accident, one participant described his anger and “hypervigilance” about driving.” For a while, he allowed himself to “let the anger fly in the privacy of his car. “I needed to do that for a long time because I had suppressed all those feelings for so long”, but after a while the anger was building on itself:
“[It] was getting me into the psychological mood which was almost jacking up the fear. I was so ready to grapple with people… to the point of me wanting to fight.”

He observed that he felt emotionally reactive even situations were safe: “The hypervigilance was not leaving room for much else.”

**Feeling Disconnected from Self and Wholeness.**

Participants described feeling disconnected from themselves and “incomplete”. “Before, I always just had the sense that something was missing, … there was something wrong with me”. One participant had been through invasive medical treatment and found aspects of encounters with the medical world dehumanizing. So, having a Rosen practitioner confirm her humanity was a vital reminder. Many participants shared that they judged and related to themselves harshly. For them, disconnection from self-compassion was a motivator for receiving RMB work.

Participants described a disconnect between their body and mind; they described feeling cut off from the experience of their bodies. They described feelings like being stuck in their head, being “a brain on a stick”, or that “my body was just this thing that kept my brain alive”. They sensed something “chewing” at them about this disconnection. Participants appreciated accessing their embodied experience: “For someone like me who is a talking head, Rosen work brought me back into my body in a way that I wasn’t aware that I wasn’t there.”

One participant described how she could think about her emotions, but had difficulty feeling them, and that this had made her work in previous psychotherapy difficult when:

“[The psychotherapist was] trying to get me to feel that emotion, [but] it wouldn’t shift in the body. An intellectual recognition of an emotion did not shift it. It was only when …
[the RMB practitioner] would touch me to feel that feeling, in a gentle way [that I could begin to] be able to feel that emotion.”

Another participant commented on what she views as the strength of RMB: “to address body-oriented, psychotherapy, emotional stuff, knowing that my body and my psyche are related. That my mind and my body are two different things and they can talk to each other. I mean, it’s one of the great things about Rosen.”

One participant reflected that in addition to harsh treatment as a child, he had also been “neglected”. He “felt like needing or desiring things was something that didn’t serve me and was not my job. My job was to be inconsequential and not to need anything and to acquiesce whenever possible, or to simply disappear”. He learned to tune out his desires.

**Feeling Disconnected Interpersonally.**

One participant observed her feelings of distrust and disconnection from the world, which increased during her adulthood:

“I think when I was younger I was much more open and less guarded. I was much more trusting, and gradually over the years with different things that have happened I realize I’ve become less and less trusting and more and more guarded and more trying to protect myself, and what it does is make you close in on yourself and then you’re shutting the rest of the world out and it feeds into depression and anxiety. Focusing on yourself in that way is not good at all, and I know it but when I’m doing it, it is very difficult for me to stop and unhook from that, and that’s what I’m trying to learn how to do [in RMB].”

Participants usually came to the work for other reasons, but discovered interpersonal challenges such as difficulty trusting, managing emotions or communicating needs. They observed that their compassion for both self and others improved with sessions, indicating an
initial disconnection from feelings of kindness and compassion. Speaking globally, one participant said of the RMB client-practitioner relationship:

“I consider it [touch] to be a fundamental need for most human beings who don’t get proper TLC in any other way. Because most of us have disjointed relationships. Many of us missed the opportunity to have simple loving touch …People need this kind of relationship because we are in a broken world, and we don’t even know it… When you scratch the surface, we are all wanting. We are all in disrepair”.

Participants reported having difficulty with interpersonal connections as adults stemming from childhood experiences, such as “I was not allowed to have my own boundaries, so I struggle as an adult”. They recalled not receiving “simple loving touch” in childhood or “modeling from parents to learn how to love themselves…and feel complete and whole”. They contrasted the practitioner’s gentle, attentive touch with what they missed in their upbringing. Some specifically referred to what they missed from their mothers. The gentle treatment in sessions highlighted for them what they had lacked.

For one participant, the experience of interpersonal disconnection was sometimes experienced on a physical level as being “brittle”. Participants noted that as adults they “don’t get a lot of touch” in daily life. Some had or were experiencing relationship breakups and did not want to repeat unconscious, interpersonal patterns in future relationships.

Another area of disconnection was reported by participants who were disappointed by what they experienced with a RMB practitioner. These accounts are discussed further in the Being Open and Trusting description, below.
**Being Stuck in Trauma.**

Thirteen out of 20 participants introduced the word “trauma” into the interviews. Still others said RMB was helpful for them, given “abuse” or “neglect” in their past. Two participants said they believed RMB would be helpful to people with trauma history but did not identify themselves as such. Many of these participants sought RMB as part of recovery from what they called traumatic experiences. Several participants related their physical and psychological tensions to histories of “trauma” or “abuse” from which they sought healing. Sometimes they had tried multiple approaches over many years. Some began RMB with the intention to heal these wounds while others did not anticipate this direction when they began RMB.

Participants described effects of their abuse, including withdrawal and habits of holding the body rigidly, “holding my breath” and “the tightness in my chest”. Several connected their past abuse with their physical pain as an adult. One participant described having been abused as a child by her parent. She had responded by curling herself up physically to withdraw. She reflected that this life-long, “crunched up” habit was connected to her physical pain of fibromyalgia.

Many participants connected critical messages from childhood with difficulty being kind to themselves as adults. As described in the following discussion, many participants saw RMB as an important ingredient in their recovery from trauma. One participant had read a book about trauma by van der Kolk:

“There was something in [the book] that said if the body doesn’t release… the body will hold on to that trauma because it gets frozen there. … I couldn’t understand why my mind would loop in an anxious cycle. I’m a professional. I do a lot of things. Why do I
have this irrational side? So, it wasn’t until reading that book that I understood that you actually get frozen when you experience trauma. If you can’t run or you can’t flee, you freeze. … My body trauma got frozen.”

In summary, the participants said that they pursued RMB due to feeling disconnected in various ways. They sought the relief from disconnection on several levels: physical, emotional, in terms of embodiment, and in their relationship to themselves and to others. They sought RMB for self-discovery, spiritual development, understanding and freedom from barriers that kept them stuck; they wanted to heal relational wounds. Their engagement in the RMB was characterized by an attitude of openness and by the development of trust – trust in the practitioner, in the process, and in themselves.

**Being Open and Trusting**

The category of Being Open and Trusting is influenced by subcategories of sensing the practitioner, being listened to, feeling comforted and accepted, being open to uncertainty, and being ready. Losing trust is also addressed within this category to describe negative cases.

Participants were open when they chose to first try RMB. It was easier for them to trust the process of RMB and the practitioner when they knew someone who had benefited from sessions or they received a recommendation from someone they trusted. Being open was viewed as an important aspect of receiving RMB and getting benefit. It is important “to trust the practitioner and feel safe [because it is] hard to tell a stranger your issues and your problems”. Being open and trusting are interrelated: some trust is needed to feel open, and openness is needed for trust. One participant described the relationship between trust and being open:

“I looked for [my practitioner] to be the guide to know what to do and where to go. I did trust her. … sometimes I would point something out that I felt I wanted to work on. For
the most part, I trusted her. I knew what her intentions were. Her intentions were to help me heal and I felt very safe with her. I was completely open.”

Participants described factors that helped them feel open. These included their initial impressions of the practitioner, the “serene and peaceful” physical environment of sessions, their perceptions of the practitioner in sessions, and the words and touch of the practitioner. Several participants referred to the consistent, familiar routine and sequence to the sessions, over time, which helped them feel at ease.

While trust and openness were often quick to be established, they were not automatic; they were cultivated. For some, talking before the session helped build trust and openness. Practitioners varied in their styles of practice. Some began sessions sitting with the participant and listening to what was happening in the recipient’s life before they started the table work. Of those participants whose practitioners talked with them, all appreciated checking in this way before getting on the table. It helped “to work up to where I can really open up”. Of those who did not speak before sessions, none mentioned that they would prefer to speak before sessions.

Not only did participants credit openness to gaining benefit from RMB, they also reported that RMB increased their openness.

“I am a happier person. … I’ve been able to do a lot of grieving through my Rosen practice which has opened me up more, like lightened my load, allowed my heart to be more open. I mean, it’s really, really changed things… I actually feel quite emotional talking about it.”

Sensing the Practitioner.

While the focus of RMB is on the recipient, the recipient of RMB also senses the practitioner. Feeling safe with the practitioner is “critical I if I’m going to expose that kind of
vulnerability”, and “You have to have that ‘know, like, and trust’ factor” to build a relationship over time.

Participants perceived their practitioner as strong, gentle, and non-judgmental. The practitioner listened and did not impose an agenda. Participants valued feeling that there was time for their experience; they did not feel rushed. Practitioners were perceived as attentive, professional, and loving. The practitioner conveyed “simplicity and courteousness in both touch and demeanor”.

“I did not have to armor myself…. I felt that I did not need to brace myself which is the feeling I have had when other people have had their hands on me and I have gone, ‘Maybe, maybe not... I’m not entirely sure. I’m holding my breath a little bit’… [Instead, in RMB I say], ‘Oh I don’t need to brace myself internally.’”.

Trusting the practitioner depends upon the recipient’s perception that the practitioner is attentive, sensitive, and beneficent, as sensed through words, voice tone, touch, and body language. Touch can feel like being held in a “safe harbor” where contact is “noninvasive” and “kind”. Participants saw their practitioners as “genuine”, “humble”, “unassuming… not a formidable, authoritative…[there was] no power battle”. They perceived RMB as “simple” and “authentic” work. “There were no bells and whistles. I really trusted that too”.

Several participants assumed that their practitioner had been through their own personal growth and understood how difficult the process could be. A few participants said that they felt kinship with the practitioner and appreciated the practitioner’s openness. Having a feeling shared humanity with the practitioner led to reduced feelings of being alone with struggles and to greater trust in the practitioner. Words from the practitioner such as, “We are all in the same boat…we are all struggling” encouraged them to be open.
Trust and openness was built when practitioners were honest with recipients. One participant described how a handful of times over the course of many years of weekly sessions working with his practitioner, he’d perceived her as “off balance” during a session. When he checked this out with her, the practitioner validated his perception. He came away with a greater sense of trust in the relationship and in his perceptions.

**Being Listened to.**

Participants experienced being listened to by the practitioner. This helped them feel open and trusting. They appreciated the “patient-driven” experience of “letting me do the talking or letting me lead the sessions”, or feeling “no pressure” about scheduling future appointments. “It was up to me to decide”.

Participants appreciated their practitioner’s attentiveness to them. One said, “She was hearing me… she was there for me”. One participant described the significance and rarity of this kind of presence:

“It doesn’t really happen very much when someone is so present with you 100% that there isn’t anything else that they are thinking about a worrying about or wondering what they’re going to say. That’s almost nonexistence. Even in talk therapy. It’s like you’re being supported totally through whatever you are experiencing. That’s the really important part of it. There must be some connection with her being so present with me and my feelings, and me being able to also be present with my own feelings.”

Participants appreciated the closeness they felt with their practitioners; they found the work “intimate”. They also valued the practitioner’s sensitivity to interpersonal boundaries. Boundaries were conveyed when unique positioning needs were respected and when preferences regarding touch were observed. One participant recounted, “If I said, ‘No, I don’t want to be
touched there’, he wouldn’t touch there. It’s really that simple”. They felt listened to and respected when the practitioner sought feedback about touch sensitive areas, such as the chest, or when the practitioner informed them of the approaching end of the session. Participants appreciated being listened to rather than being controlled or manipulated.

“So, the hands are not being put anywhere that that I don’t want them to be put. They’re not necessarily putting pressure or moving in any way that doesn’t feel like that’s what my body wants or where my body wants to go. It’s just more of a quality of presence and witnessing, I would say, rather than doing and manipulating.”

Participants noticed when the practitioner listened to their bodies and sensed when the recipient did not want to explore an area. This occurred for one participant when she had a flashback of abuse and had to stop the session. Another participant recalled one or two times when she “could feel some resistance come up … There were times when I wanted to continue holding on to whatever it was. And I felt like she could tell when that was happening.”

Another participant stopped coming to sessions due to feeling directed rather than listened to by the practitioner who wanted “to bring in other pieces besides this piece [the RMB] … and I was resistant to that.” Outside reading and other changes were recommended and, “I didn’t want to go there”.

**Feeling Comforted and Accepted.**

Participants spoke about how feeling comforted and accepted by their practitioners contributed to being open and trusting. They sensed the practitioner’s presence and caring through touch. “Touch helps me feel her attention…her touch helps me feel tended… attended to… tenderness.” During sessions, recipients often had their eyes closed, so “the hands gave me
that sense of touch, gave me that feeling that she’s there, she’s listening. She’s comforting.”

Touch provided a sense of security and reassurance.

“I felt like I was in my mother’s arms. So, at one point in the first session, she had crossed her hands in some way over my chest but in a way that was not threatening at all, but in a way that was so comforting and calming. It was almost like swaddling a baby … I felt like I almost went back to the womb and was being rocked in there”.

Participants contrasted the RMB touch with their parental upbringing and described how RMB met a previously unmet need. Several referred to the “maternal” or grandmotherly quality of their female practitioners. Whether the practitioner was male or female, participants experienced their touch as nurturing, loving, beneficent, soft, and gentle. The practitioner’s touch feels like a “security blanket” and “I feel cradled. It opens up something in me.” Several participants said that they had a sense of “coming home.”

Participants sensed that the practitioner’s “intentions were to help me heal.” They felt that they personally mattered to the practitioner: “I wasn’t just a body to her.” Participants felt strongly about the power of the practitioner’s kindness and comforting presence. When describing their practitioners’ compassionate presence, several participants were moved to grateful tears.

“The relationship with the practitioner is huge. I love what I feel for her” (tears)… I am so grateful to [her] for caring about me so much (tears). She means so much to me. The love what I feel from her and experience because of her is really awesome. So, at the end I feel like I can’t stop crying because I’m so grateful, so it’s not negative crying. It’s ‘thank you’ for being there for me because I don’t get that. I mean where do you find that?”
Some participants also described experiencing times over the course of receiving RMB when they felt emotionally dependent upon the relationship with their practitioner. One participant described having had a history of depression and the importance of her practitioner to her:

“I don’t want to go there [into depression] again… So it’s been really important for me to stay connected to [my practitioner] … my lifeline, my grasp at reality and safety. No matter what else goes on in my life, I know [my practitioner] will be there. And that is huge.”

Participants described the importance of feeling accepted by their practitioners. They valued the practitioner’s presence and the absence of goal-directed effort:

It’s not about getting to a place. That’s not good for me. That feels really confining and like I am doing something wrong if I don’t get to the goal and I failed. It’s a process. It’s not right or wrong. It’s just whatever comes up which is to me way more supportive.”

Participants experienced the practitioner as non-judgmental. They noted that “Rosen lets people be people.” It allows “me to express what I am feeling without a feeling of judgment or a feeling of being a specimen being studied.” They felt the practitioner’s presence with “no strings attached.” One participant noted that in early sessions, “I did not share anything.” Even so, he noted that, “She did not lose hope. Still she didn’t refuse to see me. Still she didn’t reject me.” The practitioner’s non-judgment also helped these participants be less judgmental toward themselves.

**Being Open to Uncertainty.**

How participants responded to uncertainty is discussed here in relationship to being open and trusting. Participants described ways that they experienced uncertainty. They often came to
RMB without knowing much about it. Explanations of the work were limited. Even during these interviews, multiple participants with years of RMB experience said that it was hard to describe. Their openness to RMB included an acceptance that not all experiences can be captured in words: “You have to be open to not being able to explain it … and just be with what happens.”

“It’s very hard to put a lot of these things into words because they are energetic experiences. Almost energetic exchanges really … “It’s hard to talk about spiritual experiences in words, because they are much bigger than the words that we have.”

Not only was the RMB experience hard to describe, but these participants expressed appreciation for the nonverbal aspect of the RMB experience that helped them access parts of themselves different from psychotherapy. One participant specifically described not wanting to engage at a cognitive level.

“[The practitioner] and I are constantly talking, but the real thing that occurs for me is a kind of surprise and discovery. Usually when I am speaking, I know where I’m headed. I don’t know that on the table. I used to out-smart all my counselors. I would out-talk most of them. And I would realize that I’d walk out [of the session] being charming and entertaining and not having done a damn thing for myself. I’m not necessarily looking for catharsis. I’m looking for a sort of gentle unfolding, and that is occurring in surprising ways, and disconcerting ways, and uncomfortable ways, on the table.”

For these participants, being surprised or meeting the unexpected or unknown in RMB seems to have raised their curiosity and compelled them to continue receiving sessions. In addition, their curiosity helped them cope with uncertainty. They encountered unexpected experiences from within themselves such as surprising emotions, sensations, and memories.
Being open included a willingness to accept or manage the uncertainty of not knowing what is happening in a session or why an emotion arose when touched in a particular place or how the bodywork works.

Experiences in RMB can be unusual, intriguing, and sometimes disconcerting. Feeling extremely tired after a session perplexed one participant who was reassured by the practitioner’s suggestion that she needed rest; she reflected that indeed she had been overworking and not sleeping well. One participant had started RMB to reduce physical tensions related to stressful work. In those early sessions:

“My body released huge amounts of tension. I found myself … not having seizures, but shaking and trembling, crying, things that I never thought that I would do… And [my practitioner] didn’t warn me about them, either. She didn’t say, this could happen. It just happened. So, on the one hand you know, I found myself having experiences that didn’t necessarily make sense to me but were happening for real. I could not deny” … [I chose to have] “three, maybe four years of experiences with Rosen before I ever read anything about it. As I mentioned I’m kind of an analytical person, and I really wanted to experience this directly and firsthand without having a lot of cognitive understanding of what was going on.”

Participants observed how emotions sometimes arose when certain areas were touched, and they wondered, “Why am I finding myself in tears here? I don’t understand this. It seemed to come out of nowhere.” They sometimes observed memories emerging; sometimes these were unexpectedly painful. Despite these experiences, they felt trusting and curious enough to continue the sessions. Especially in early sessions, they might not understand what was happening but reassured themselves that they eventually would.
Most participants used the word “surprise” in relation to their sessions. One recalled, “I wasn’t prepared in advance.” Several remembered being surprised at the intensity of emotional experiences that arose during sessions. They were surprised by how consistently emotions were evoked with simple touch to certain areas. As one explained, “things unfold” in sessions, and “We don’t go in a linear way.” As another said,

“My first reaction was, ‘That’s all there is to it?’ Just touching my shoulder or putting your hand on my abdomen and holding it there. I thought, ‘How does this do anything?’ So, at first it wasn’t so much that I was skeptical, but I was intrigued.”

According to participant accounts, the practitioner’s gentle guidance was an essential ingredient helping them tolerate unexplained sensations and emotions without the anchor of cognitive understanding. Practitioners guided them to go inside the body instead of thinking, attending to being in the body rather than searching for answers. As one individual described, it can be tempting to pursue thoughts and explanations.

“It’s a process, … It is not easy, especially when you’re trying to find an answer. Your head gets in the way too quickly. But once you can take that out of it … that can only happen with the gentleness ... I think you’ve got to feel that touch. That connect… even that energy…. It is a feeling of knowing that, ‘It’s okay’. And, “Do look inside. Look deeper.”

This individual came to recognize the process of being guided by the practitioner to attend to the moment-by-moment body experiences with gentle, open attention and without the strain of having to figure things out. She described becoming familiar over time with this process of shifting attention from seeking explanations to listening to the body, as prompted by the practitioner.
RMB is subtle. Initially several participants were unable to tell if anything was happening or changing through the bodywork. Sometimes benefits were not immediately evident. For some, the degree of uncertainty they felt made it more difficult to trust the process. They would have liked the practitioner to have given more input about what to expect to reduce this uncertainty. A barrier to trusting and being open emerged for some when they experienced insufficient explanation and context for their experience from the practitioner. They waited out the uncertainty. As one said, I wasn’t used to questioning so I didn’t ask, ‘What we are doing [in Rosen Method]’.” Others asked, but answers did not always satisfy. Some struggled emotionally, as discussed more fully in Exploring Tension under Dealing with Discomfort.

**Being Ready.**

Being ready to participate involves being open to the RMB process, the practitioner, and to oneself. One participant announced in her first session, “I am here to grow”, giving the practitioner “permission to work with me as a whole person… I opened as much as I could and let her help me; that was my purpose.” They go into sessions with the intention to discover and be changed. One participant reflected on maturity as a factor in readiness:

“Like if I were to think about when I was 25, I’d be, ‘Man! I’m not gonna do that!’… It just is a process of self-healing and you gotta want to do it. A lot of people don’t want to do it. It’s too hard. And they don’t want to feel the pain from their childhood. They are content in their unhappiness, and they are in that pattern of addiction or negativity. ... I just think you have to be open and ready. Or not ready; I guess you could be not ready and go in, and decide you are ready. But I think it’s harder to get the people in there that like the patterns of being negative or like the patterns of what their life is. They don’t want anything better. Change is so hard for people.”
Being ready was challenging for these participants when certain feelings arose. For example, not wanting to cry “in front of someone else”. Participants encouraged themselves to bring up a difficult topic or to feel in spite of fear by reassuring themselves that, “It’s okay because [my practitioner] has my best intentions”, adding “Where else to cry if not there?”, or “It would be a struggle to hold something back.”

As the relationship with the practitioner deepened, participants settled in. There was “real comfort that she knows my story of what I am working on.” The experience of a safe, familiar, and caring relationship helped participants feel ready to explore themselves further in the RMB process.

**Not being open or trusting.**

Timing of sessions was sometimes a factor making it difficult to be open to the RMB process. Three participants recollected a time when they were not receptive in a session due to lack of time. They felt rushed and wanted to get it over with because they “didn’t have a clear place for myself that day.” They may have come from a stressful work day or through a busy commute and found it difficult to be open to the session. They “didn’t get that much out” of those sessions.

At times, participants felt hesitant to trust or trust was lost. One participant recognized that, “It is kind of funny because sometimes I am hesitant” when starting a session, despite many years of receiving sessions. Others noted that they might hesitate to bring up a topic or to explore an area of their body.

Although most participants described the development of their trust, trust could also be lost. One participant who was in therapy and grieving the death of a loved one remembered her first session with a RMB practitioner to whom she never returned.
“I just think that when people are in new grief, they are doing all they can to stay together and get through the day…and go home and cry and do what they need to. [In that first RMB session] …something about what it evoked, it was like a volcano erupted. I was already grieving … It wasn’t like I was stuffing my grief. So, I don’t know if I can articulate what got dismantled. I spoke to someone who does bodywork, and she said people who are grieving are just trying to hold it together. I think regular massage can be dismantling when you are that raw.”

She felt overwhelmed and had suicidal thoughts after the session. She met resistance and lack of understanding when she cancelled future appointments with the then-new practitioner, and trust in that relationship was lost.

Another participant described being surprised and losing trust when the practitioner seemed uncomfortable with the sexual themes that arose for the client. The practitioner did not overtly say, “‘I can’t talk about that’, [but] I could perceive the discomfort …through tone of voice.” The practitioner seemed uncomfortable with the sexual topic and so the recipient stopped exploring.

Trust builds over time, and it can erode. One participant described, “I was starting to cry …It was near the end of the session and she kind of had to, ‘Well, we’ve got to end this right now, but maybe we can pick this up again.’… I don’t remember another weepy time, with her.”

Participants recognized that Rosen Method bodywork training does not have the same training as psychotherapy; however, the two participants with psychotherapy training wished that the RMB had more training in transference and countertransference in order to respond when those issues come up in session.
In summary, being open allowed participants to develop trust; this in turn helped them continue to be open to exploring, learning, and connecting. The experience of a safe, familiar, and, caring relationship set the stage for the rest of the process. Participants came to RMB willing to explore themselves, even when they encountered the discomfort of their stuckness and disconnection. They valued the presence, attention, and non-judgment of their practitioners which they sensed through the practitioner’s touch, words, and demeanor. The practitioner’s attentive presence helped set the stage for them to explore themselves. On the whole, these participants trusted their practitioners: as one said, “I trust [my practitioner] with my life.” Even so, there were notable exceptions. Being open and trusting are prerequisites for exploring oneself. Participants described how their experience of the practitioner supported them in being open to exploring themselves.

Exploring

Being open and trusting in RMB set the stage for participants to explore themselves. Exploration then leads to learning, transformation, and connection. Participants indicated that prior to starting RMB they believed there was a connection between the mind and the body. Mind in this case includes psychological processes of thought, emotion, memory, images and includes states of mind. Participants came to RMB knowing on some level that there was a way that their psychological processes and life experiences were reflected in their bodies.

Exploring is a process of becoming aware. Participants described the practitioner’s use of touch and selected words as they began to explore themselves. As one participant stated, the touch and talk together created a verbal and tactile “dialogue back and forth” (10, 100+114) that facilitated exploring through the body.
Becoming Aware.

Becoming aware is facilitated by both the practitioner’s touch and by talk. Not all practitioners began sessions immediately with touch. Exploring may begin with some talk before the recipient lies down on the table for the hands-on part of the session. One participant described having “a little time to check in verbally before the hands-on part of the session. “She needs to know where I am and what I am struggling with”. The need for talking varies among individuals and within an individual over time. One participant described how her need for talking prior to getting on the table has changed.

“More recently now, there’s less need to talk before session. What I’m trying to do is make that distinction before I get in there with her, so I don’t get started just rattling on and she has to get me to slow down and get me on the table. So, I can identify whether there’s really something I need to ask her about or bounce off her, or whether I can just get on that table and make the most use of that time because … I feel like I’ve shortchanged myself because we didn’t have very much time left with the table work.”

After talking, the participant would lie down, first prone, then supine. The practitioner sensitively listened to them which encouraged them to listen inwardly, too. The practitioner provided touch that was “holding”, “supporting and exploring”, “gentle” and sometimes “insistent” as it guides attention to the body. The touch “brings awareness” and “wakes you up” to experiences outside everyday awareness.

Although RMB touch brings awareness, participants were not always aware of the touch itself, aside from one participant who was a bodyworker and likened it to the touch of Orthobionomy bodywork. Most participants were not aware of the touch beyond its gentleness because their attention was riveted to what arose within them in response to the touch – to their
embodied experience of sensations, emotions, images and inner stories. They were aware of being touched but engrossed in the inner experience rather than the touch itself. They said, ‘the touch is extremely gentle; often I don’t give it any thought’ or “I was feeling how it felt emotionally the way she touched me.”

“I was really starting to realize …I was feeling that nurturing. At first, I wasn’t feeling what was happening in my body so much. I was feeling how it felt emotionally the way she touched me. And that was …I’ve never gone to a practitioner who did something like that… So simple and yet so profound.”

In the process of exploring tensions, the practitioner is not leading, but is rather following the recipient closely. As one participant described it, the interaction is like a “dance” – the practitioner is not directing. In more intense experiences, it can feel as though the practitioner is “grabbing on to” the experience and “following me down the rabbit hole.” Participants described how the practitioner followed them closely, sensed what is going on in the body, asked questions, coached them to listen inwardly.

Several mentioned becoming more aware of their breathing through RMB. They realized that they had habits of holding their breath or “I can’t take a deep breath when I’m walking or to speak of when I’m swimming. [The practitioner is] always happy when I take a deep involuntary breath.”

**Listening to the Body.**

Participants described being coached by the practitioner’s words and touch to shift attention from thoughts about their experience to the felt-sense, moment-by-moment experience in the body. The practitioner gave “feedback about both what she senses in my body and what she might hear [from me] about what’s going on. That does connect me to paying attention to my
body.” This kind of listening was different for these participants. “I’d never felt that before… You can’t do this just with talk. You need touch…I have to be directed, steered back” [to the body].” This coaching helped them explore thoughts and feelings held in the tension.

“It’s not psychology but it’s really allowing for self-realization and exploration of one’s own delusions, one’s own emotional attachments, and to be able to actually shift and let go of the grief and to come to terms with betrayal, and it’s all held in our bodies”.

Participants observed how their attentive practitioners helped them listen to themselves. One participant said that the practitioner sensed shifts her body associated with changes in her thoughts, even when she had not spoken them.

“She knows almost instantly when my mind shifted. … She’ll catch me when my mind actually moves into little cubbyholes. I find that fascinating. And just when I have had an opening, she will be able to sense it somewhere in my body because that might be the only time that she’ll say something. Is, “So, where are you now?” And it will make me see that I had just had a revelatory thought that came spontaneously, and she caught it in body, almost in the same moment that I am registering it in my mind.”

For participants who described themselves as highly verbal and less connected to their bodies, the work helped them become more aware of their bodily experiences. The work helps participants in “noticing now when I’m not embodied, which is still a lot.” The practitioner’s touch and words keep “reeling me back in, to where now, after so many years, I reel myself back in.”

Feeling, Thinking and Embodying.

As one participant put it, there is a “cultural idea that it’s possible to be a talking head... That it is a possible reality, whereas that is actually never the reality. It’s always connected to
some body.” Participants described how RMB helped them find this connection between head and body through exploring in sessions; it was sometimes difficult to make these connections. For them, touch provides a more direct access to the felt experience than do words.

“I am very cerebral, so I think a lot a lot. So, that makes it difficult for me to be in my body. During a session sometimes, I’ll just go off somewhere in my head and she will say, ‘What just happened?’ She can sense it. …I would just like to know when I am having those thoughts …to feel in connection more.”

Another participant appreciated accessing the meaning of tensions stored in his body.

“A lot of what I am working through in the Rosen was preverbal, so it is difficult for me to put words on it. But it is also the most effective therapy… therapeutic process that I have ever experienced because it doesn’t rely on words … [Having grown up in a chaotic and painful household] “I’ve internalized a lot of stuff … You can ask me to describe it and I can put words on it, but I am really, I am painting a picture of the thing that we could actually just touch … I might not know why I’m carrying tension in a certain part of my body. Were I to search [for an answer], on some level I feel as though I would be interpreting. That echo is more present in the body, and the release and even the touching of it is an awakening that occurs … a re-acquaintance that occurs which is beyond language. I mean language is also part of the process… but the real thing that occurs for me is a kind of surprise and discovery. … I trust the language of the body more than I do words.”

One participant stated that the purpose of RMB is to “…find out why you are tight. What stories you have held in there [the body].” That said, exploration is experiential rather than analytical. Participants described how the simple and descriptive talk in RMB helped them
move away from analyzing and into experiencing, in the moment. Without excessive talk, they felt the “present experience” and appreciated not having to explain their memories in what would have been “tedious detail” for them. Their practitioners helped them feel emotion rather than think about emotion, because an “intellectual recognition of an emotion did not shift it.” One participant observed that the practitioner encouraged her to feel by simply reflecting her words:

“[She] would touch me to feel that feeling, in a gentle way, … repeating what I said.

“Oh, you are feeling alone. You are feeling hurt.” It was like, “Yes, you’re right. I am feeling that”. So that encouraged me to be able to feel that emotion.”

The practitioner’s few words deepened participants’ experiences of themselves and encouraged embodied experience. One participant described an embodying experience. At one point in a session the practitioner offered a few, reflective words; they had great impact in his body and elicited an image and sensation that resonated within him:

“It felt like an ink drop on blotter paper. It just dispersed everywhere and made sense … and it was two or three words, but it jelled my awareness… it was a drop that was absorbed.”

Another participant reflected on the value of focusing on the embodied experience, and not the words.

“The things that I’m curious about for me are largely nonverbal and preverbal… Feelings that I don’t have a way of addressing with language and with ideas.” There was a lot that … I had to do to survive [as a child], and I had to shut down and put away or not have … Language won’t get me to those places or unlock those worlds… It just doesn’t know how.”

As participants explored themselves in session, they were surprised at
“...how the memories are locked in the body. I knew it intellectually, but to see part of it for myself was really amazing - and healing. It also gave me some more compassion for who I am and the choices I’ve made over the years.”

**Exploring the Unexpected.**

Exploring in RMB may include encountering unexpected experiences. One participant described how each session is unique:

“I never know what’s going to come up ever, even though I think, ‘Oh, it’s definitely going to be about this.’ Or, ‘This has been on my mind.’ It’s never that, because for me it’s always, “What’s in my body. What’s my body showing?” Not, “What’s my mind doing?”

Participants were sometimes surprised by strong sensory experiences either during or after sessions. Sensations sometimes evoked visual images as well as being felt in the body. Memories might arise and be accompanied by vivid visual or auditory components. Sometimes during a calm session, visual images might be like a light show. After one session, a participant described seeing colors vividly when walking outdoors; she attributed this to what had occurred in the session.

Self-exploration on the Rosen table sometimes involved encountering unexpected sensations and emotions. One participant described significant “body shaking, like leaping off the table” in early sessions; she attributed this to releasing a lot of tension. She was surprised by this response, and believed it was better not to know in advance that this might happen because she might have inhibited the movement. She admitted it was” maybe a little bit scary, but real”.

For another, when surprising sensations of “trembling” arose in a session, he viewed these physical responses as an indication of unresolved issues. Another described experiencing
chronic sensations of trembling in daily life that are not particularly apparent to others; The “tremor” ceases during sessions suggesting to him that deep relaxation is happening. In contrast, sometimes unexpected emotional releases are “breaking into sobs”. How these participants related to unexpected experiences that were distressing is described next.

**Dealing with Discomfort or Distress.**

The sample for this study was selected both by practitioner referral and by self-selection. By selection alone, this sample is assumed to have leaned toward those with positive experiences of RMB. An interview question about negative experiences with RMB was included in hopes of countering this limitation of selection and to encourage participants to mention challenges, discomforts, difficulties and criticisms.

Participants were asked about experiences they might have found difficult, uncomfortable, or distressing in RMB. They were asked if there were any negative experiences that they recalled or something they wished might have been different. Several participants seemed perplexed by the question. One said, “I never had a bad session”. She recalled leaving one session thinking, “This was like a $500 appointment.” Some responded by recalling difficult emotional experiences and how the touch of the practitioner conveyed, “I’m here; you are not alone.” Others talked about the difficulty of having powerful experiences in sessions and not knowing whether these were “normal” or how long they would last. One expressed regret that the practitioner did not relate to transference and countertransference issues. She acknowledged that the RMB training is different from psychotherapy and added that she would prefer to receive RMB from someone also trained in psychotherapy. Dealing with discomfort included tolerating physical discomfort when the touch contacted sore muscles or when emotions that arose were painful, such as sadness, fear, and feelings of inadequacy or confusion.
Several participants said that good sessions were often painful. A difficult session might access tears and tender feelings yet be helpful.

“Wonderful sessions are always painful (laughs with tears) … psychologically. Those are the hard ones. Is it wonderful? Not really, but I released it…. It allows me to continue on in a way that isn’t perhaps too debilitating… either mentally, physically, or emotionally. I mean, somehow I can continue on.”

Some participants were uncomfortable with not understanding the process of RMB, particularly since they were experiencing emotional distress and painful memories in session. When encountering difficult emotions or content during a session, several participants described having moments of reluctance to explore something and then talking themselves into exploring something difficult. One remembered thinking in a session, “You don’t want to say that.” He weighed not sharing this experience and thought to himself:

“I don’t want to go there. Well, you already know what’s on this side.” He reasoned with himself that, “It’s a choice to be open or to hold on longer. Having the practitioner there means it’s safe. Let’s go!”

One participant described how it is worth it to go through the discomfort. “It’s a little uncomfortable talking about problems, but it’s also a release of trapped emotions in the body.” Another participant also described feeling reluctant to share what she was thinking and talking herself into sharing it:

“Whereas when you’re going through the day, it’s like that’s the thing that’s like making your mind feel cluttered and not able to think, and then you don’t even want to bring it up when that’s just when you should bring it up. So maybe it gives me the opportunity or
the freedom to feel that. So, if you want to bring that up, you can. So, maybe I am doing that more often, knowing that it usually works out very well.”

Examples of distress ranged from mild, such as confusion, to strong, such as panic. Participants reported frustration with themselves and their perceived barriers, frustration with not understanding their responses the RMB, confusion about the RMB experience itself, and thinking, “I don’t know if I’m doing it right” as a client. They wondered if the practitioner was put off by their distress. Sometimes, sessions are too intense. One participant had to stop a session when memories of abuse became too strong and distressing. One participant was confused by emotions linked to the tension and pain in a specific area of his body and he was frustrated with not understanding the connection between the emotions and tension:

“I had an experience recently where [a muscle] was just absolutely tight. ... And I thought, ‘I have to have done something to this. This just doesn’t make sense’. But, there is an emotional component to this. And [the practitioner] says, “Well, let me just put my hands on it”. And it all of a sudden it generates all sorts of emotion for me, and I was just like, “It happened again!” I was so quick to imagine that [it was] a mechanical thing when it turned out to have a pretty strong emotional connection. … one of the things that’s been a source of frustration for me is I can’t explain why. I want to know why. I want to know why [that area hurts] … I want to know why there’s anger down there. I don’t get it. And I’m often not able to answer the question. But, it is what it is. I don’t fight it anymore, even though I don’t understand it.”

Several participants complained that they had felt confused about RMB and that they were given insufficient explanation about the RMB process. One said that the practitioner provided reassurance which was “important because there were times I thought this was almost
intolerable... it feels like a kind of suffering I’ve never experienced before, and I don’t understand it.” The practitioner’s reassurances to “hang in there” helped this participant tolerate the experience when he wanted to “get up and run”. Even so, he wished for something more the practitioner could say to give him “a roadmap” of what he would experience next.

Two participants voiced a desire to know more about other people’s experiences of RMB with an interest in putting their experiences in context. They were frustrated that they did not adequately understand their own experiences and explanations provided by the practitioner or their reading about RMB did not address their need.

“My impression of Rosen practitioners and the kind of practice it is, is that it is very cloaked. Cloaked in describing what is being done, in not a very straightforward way…. It just seems shrouded in some secrecy, and I don’t understand why … When I looked at some of the articles [on RMB], I didn’t find them very accessible. I think I was really searching for an answer about what is going on when a practitioner touches my skin or my body. Why am I reacting like this? What is the cycle? And I didn’t find anything that was written that really spoke to that. … I don’t know if practitioners are told, ‘Don’t disclose. … Don’t tell them what’s going to happen. That’s going to influence their experience.’ I don’t know what practitioners are told, but, … I didn’t feel very supported in my journey from that level of the intellectual understanding.”

This participant “wasn’t prepared that it was gonna bring up so much trauma”. She noted that, “Coming to either of the practitioners that I went to, there was never any kind of talking. It’s just, ‘Okay. Lay down on the table.’” For her, even though her personal experience was that RMB was beneficial, it was also “very traumatic every time I went”. For this participant, having
“context would’ve been very helpful for me to know what was going to be brought up”; for her, this included having a discussion of how many sessions she might need.

One participant described another form of discomfort: concern that the practitioner might have difficulty tolerating the participant’s “dumping” their problems in session and wondering how the practitioner tolerates it when the person on the table is “wriggling around” in pain and “reliving scary moments.” When asked, the practitioner said that “the goal is to get you in touch with your loving self beneath the pain.” This notion helped the participant tolerate the experience.

Being deeply present to emotions may not always be productive. At such times, sessions may not be helpful. One participant described a time of grief when she needed to not feel emotions and to instead “hold myself together.” This participant took a break from RMB and returned some years later.

What arose for another participant in the first RMB sessions was both surprising and terrifying for her. She had trauma history and knew little about RMB in advance. In her first session, she suddenly heard the voice of her abuser and remembered a terrifying moment. Although she had read about trauma recovery, “I was surprised I was holding all that.” In spite of this painful experience, she felt less pain after the sessions and returned for more RMB. In subsequent sessions she sometimes felt confused and disoriented. “I felt supported by the practitioner, that was a safe space, even though at times when she touched me, it was so painful, it was almost as if she was hurting me.” It was helpful when the practitioner “would encourage me to feel the emotion with that, whatever that emotion was, and then I could actually feel it going out, moving out of my body.”
Some participants had previous experiences with meditation, psychotherapy, or personal growth approaches in which they had encountered distress. These experiences helped them be prepared to cope with difficult experiences that arose in sessions. As one participant put it: “my background in [meditation] training [gives me a] deep trust that no matter how horrible what I’m feeling is, that I am okay…even like the most extreme feelings of terror or rage …. I have that level of trust in myself that I don’t know that everyone would necessarily have.”

Participants reassured themselves when experiencing discomfort. One participant described the “impulse to be rough on myself” when encountering distressing experiences on the RMB table. As modeled by the practitioner, he practiced “being kind” instead, and breathing through emotional discomfort in a session. Experiencing benefit from RMB sessions over time helped these participants deal with discomfort in difficult sessions.

Two participants managed their experiences by negotiating with their practitioners about sometimes calling or emailing them after a session. “I send her a one-way email about what’s come up after the session, after it’s percolated. This helps me say something that I can’t say in person. I want her to just hold the experience.” Another called the practitioner (who had some psychological training) on the phone when having difficult emotions related to their work in sessions.

**Being Present.**

Becoming aware included awareness of the present. Participants valued how RMB helped them be more present. “It’s really easy to get caught up in whatever fears you might have, you know, if you’re just ruminating on something endlessly. So, to just feel what’s actually happening in the present” was helpful. Participants noted that being present helped them be
aware of many aspects of themselves: physical sensations including habitual muscle tension and habits of holding the breath or breathing shallow as well as thoughts and emotional responses.

Practitioners played an important role in helping participants stay present when exploring difficult experiences. Participants said that the practitioner’s touch and words provided important reassurance. The practitioner’s presence helped them stay present with their experiences: “her being present allowed me to experience it more fully.” One participant described the safety provided by the presence of the practitioner that enabled her to explore a difficult area of herself. The touch felt safe and “I’m not alone… I have choice [to explore the challenging thing or not] … I know it’s better to get it out… it’s in the past, it’s not real.” Being present included noticing emotions:

“The sore part isn’t always just physical, there is an emotional complement, and Rosen allows people to be present. Rosen encourages being present during that emotional connection. It doesn’t just brush it off. It doesn’t move on.”

One participant described how the practitioner helped him return to the here-and-now when he dissociated. The practitioner “will notice that and bring me back and help to ground me here in the present [sometimes by] asking me to open my eyes.”. Another participant said that the practitioner “knows I’m distressed when I shut down and am quiet.” Several participants said that the practitioner’s touch reminds them that “I’m not alone”, creating feelings of safety in the present.

Participants also used internal strategies to stay present in sessions. One acknowledged that sessions may involve the disconcerting feeling of “having feathers ruffled.” He manages to stay present during such experiences by:
“Simple breathing, and attentiveness and attention. I have a tendency to want to be really brutal with myself. Like, slam the door closed, lock it up! Or tear it open. What I am gathering through the process, just the gentle touch, is that it doesn’t have to be that way. And I’ll walk away feeling untethered, unmoored from my old identity, and it is disconcerting. And I suddenly feel like I am at sea. And the only way to get through it is to simply live in it. And breathe. It’s not like I want to make feelings go away or suppress them. I just need to get to know them and see what comes up.”

Having choice helped participants stay present during difficult moments in a session. “You don’t ever have to talk about anything or feel anything…You have choice.” Also, having had previous experiences such as psychotherapy was helpful to these participants when experiencing difficult emotions.

“Yes, it’s probably going to feel uncomfortable or it’s going to be painful to relive something, but I will feel better in the long run. It’s like a knowing that I am either going to hold it in my body forever, or I’m going to release it, and also just knowing that as much as I might relive something in a session, it is in the past; it is not real. My body is having all these reactions, but it is not happening now. It’s really not. It’s like, I’m safe in this room on this table with this person next to me and that I’m going to be okay. So, I think it’s a combination of things that sort of allow for me to really revisit painful memories or painful feelings, trauma, that kind of thing.”

The practitioner’s presence supported, coached, and cued participants, helping them be present to their experiences even when they had the urge to avoid the experiences. “I feel like having her be with me, really present with me, helps a lot to be able to connect with it whatever
it is. I usually come out of there crying.” One participant recognized how, “When I talk too much, that generally is a barrier to me feeling things.” Talking distances him from his present, felt experience. In his family of origin, people avoided emotions; they “waited for [emotions] to go away.” In sessions, he observed urges to run away which reminded him of his childhood feelings. In sessions, “[the practitioner] clearly had touched on something that was painful that I was not ready to deal with, and so I took off verbally.” He recalled that the practitioner would encourage him back to the present by asking, “Do you still feel my hands.”

The importance of being present was not limited to difficult experiences. Participants also noted that staying present was not always easy for them when positive feelings arose. Again, their practitioners played an important role in helping them stay present with positive feelings such as safety, confidence, and peace, rather than speeding by these experiences.

**Exploring After and Between Sessions.**

Participants described ways that exploring continued after sessions and between sessions. Participants described taking time after sessions for reflection, rest, and to integrate what is learned in a session with daily life. Some wrote notes or journaled: “I would sit my car and write it, so I wouldn’t forget.” They might take time for quiet, napping, talking about the session with a spouse, or simply having “time to be.” Several participants described being very tired or hungry after the sessions, particularly in the early years of getting the work. One described occasionally having more energy after a session.

Taking time after sessions was helpful for integration of the experience. As one participant mused, ideally “having an hour before to be calm and having an hour afterwards to digest it is really optimal, and we don’t always have that luxury of three hours to devote to our
body and psyche.” That said, one participant described reinforcing his calming RMB experience by extending the calm once he was back at home.

“I would lie down for half an hour or an hour. And indeed, in early times, maybe even go to bed and go to sleep, … this was a period of re-inhabiting, in my own space, the comfort that I was feeling with [my practitioner].”

Participants described feeling vulnerable after sessions. One participant frequently felt nauseous after sessions: “Your body is still healing and dealing with what you talked about.” For one, the drive home after a session allowed “alone time or re-gathering time, so… If it was a big teary session… I would have that time in the car to recover and then get back in and go on with life.” While working on past trauma issues in sessions, one participant described scheduling nothing after sessions:

“I would feel, not fully regressed but just younger and more vulnerable, and so need to kind of take care of myself around that. ... I don’t know how anyone goes off to work after bodywork…To allow myself to integrate it or just be alone with myself or take a walk. And I am clean and sober, so it wasn’t like I could go home and numb myself from what came up in the session. I was just aware of… how intense it could be sometimes. Yes, so sometimes I would just go home and curl up like a little ball.”

The integration of sessions was not an intellectual process; it was a time to incorporate the experience into body, psyche and spirit: “I would reflect - not so much intellectually with words but I just sort of savored the feeling afterwards.” Some talked about their session with a trusted person. Generally, they would “See what’s there, keep exploring”, and something in the session might be processed further during the week. One participant chose to space appointments so as not to be overwhelmed with juggling family and work responsibilities while
allowing time to process what comes up in a session. This individual stated that “if I go once a month, I’m excited to go, I’m ready to go and do the work and feel the changes or deal with it ever comes up without it being overwhelming to me.”

In summary, for these participants, exploring through RMB involved becoming aware of themselves in a way that they were not in daily life. They learned to listen to their bodies and to their embodied experiences. They were sometimes surprised as they explored themselves, and they sometimes experienced difficult thoughts, emotions or physical sensations which they tolerated in part due to the reassurances of the practitioner’s presence, felt in part through the touch. They practiced being present to their experiences, and their awareness of themselves continued after and between sessions.

**Learning and Transforming**

Participants described how their openness and trust helped them explore through RMB. They described learning to relax and let go physically and psychologically. They explored themselves. They observed feeling and thinking differently. Some accessed their emotions in a new way and found compassion for themselves. They described changes in relationships. They described how these changes became integrated and transformed them. Many spoke of their recovery from traumatic experiences through their RMB. Participants described RMB as an experience of learning, changing and transformation.

“One thing that Rosen does or helps me realize is how to feel good. So, if the defaults are anxiety or fear or a sense of insecurity, then it’s not so much that you have to get rid of those feelings, it’s just you have to, for me at least, I had to learn to feel everything else to kind of balance those things out. Like, what it actually feels like to feel secure. If you don’t know what that feeling feels like, then you’re just insecure or you just feel nothing,
but to actually have the felt-sense as the new feeling of what it actually feels like to feel secure, that can be completely life-changing…a revelation … none of it is a mental exercise of how to relate to the world. It’s like, this is what it means to feel secure and happy and once you know that, you can just be that. So, that completely changes the way that you can relate to yourself, to your life, to others. You know, contentment or joy or trust or love and just like all the different flavors of all these different emotions…there is really no greater gift you can give someone - that’s what everyone’s looking for.”

Relaxing, Releasing and Letting Go Letting Go.

Participants described the process of letting go on multiple levels. Over the course of receiving RMB sessions, they learned “how I tighten when I don’t have to”, and they noticed changes in their chronic tension.

One participant learned through RMB to release muscles and “it has eradicated my low back pain.” Another found “peaceful spots” in her body where she’d previously only been aware of pain. Another described exploring an old physical injury that had an “emotional component”. She observed a change in her emotional response to the old injury.

What the Rosen did was it helped me to, … it went towards the injury … went towards that, towards the fulcrum of the contraction … things unfolded there, and I realized that there was an emotional component. And I teared up a little bit and we just sat with it, and then when the response finished, we moved away from it…the next session we went towards it. I wasn’t triggered at all. So, emotionally, that’s a good thing.”

Several participants described how they have been able to relax more quickly and deeply in sessions. As one participant put it:
“on the table no matter what’s been going on, how anxious I’ve been feeling, how upset I am about something, I can just kind of let go within… As soon as I lie down on the table I can feel myself starting to relax and let go, and I just feel so supported and so safe. It’s hard to even describe adequately… I find myself wanting to just stay like that like forever. (Laughs) …in that place where I don’t have to do anything else. Just relax and just breathe. And feel…”

Participants described how sensations of physical relaxation are accompanied by psychological ease, comfort, and safety which contributed to their opening up more. One participant described the experience of body-mind letting go when the practitioner touches his back:

“It helps me like a pain reliever or something. So, then the stories come … My body calms down. So, there is a trust. There is a relaxation. There is a peace. There is a tendency to open up.”

Participants talked about wanting to learn to access their “mind-body memory of being calm” outside of sessions and “to develop the kind of memory recall for how to come back to this calm place, even though I have been really knocked off my game.” One participant said, “It’s very difficult for me to stay in that place [of relaxation]. …I can hold onto that for a while, but as soon as I get in the car and start driving … I feel it just vanish. It’s very frustrating because I want to be able to keep that feeling …. But we’ve been talking about stopping when I’m feeling really stressed and trying to take some time by myself to focus. Actually, the other day I even did it …And it did help, but I have a difficult time just staying in that zone.”
Feeling Different in Body and Mind.

Feeling different is part of the experience of RMB. “You feel physically and emotionally different after every session, not familiar.” As another stated, “We live with so much stress, it feels odd to come off the table calm.” They described feeling different, unfamiliar, and “altered”, as though “on a cellular level…some kind of reconfiguration is going on.” This altered state sometimes included vivid, visual experiences in which colors appeared brighter. One participant was intrigued by:

“After having a session… it was like everything was in Technicolor... And I remember coming home from the session, and everything seemed brighter. All the colors were… I never had quite an experience like that [and] I don’t quite remember it happening again like that at all. But I felt like it was directly connected to what it just happened [in session].”

Sometimes, participants described knowing that something was different, but not being able to put it into words. One participant felt an emotional and physical “shift” continuing after a session. Reflecting on an unresolved childhood memory, he noted that afterward “that whole thing just got completed for me, you know, just working with her - with the practitioner - and exploring it…It was a release of tension where the muscles relaxed. Breathing was easier.”

Feeling different can feel strange. Staying with the bodily experience was not always easy, such as when the body responds in unexpected ways during a session. For one participant, this involves spasms and shaking. “It was a little scary… I didn’t really have any control over. It was separated from cognition …. And I was okay with that. I was all right. A little strange, but it didn’t keep me from coming back.”

One participant described integrating feeling different into his life.
“As far as acutely noticing things that are feeling different, that might last for like a couple of weeks to months, but it’s not like those feelings then just go away. It’s like those feelings are available and become part of the new normal, you could say. And then you reach a certain point of stability with wherever you are at and you go on with your life, but you don’t just snap back to where you were. Things kind of … disintegrate and reorganize or then you reach a certain sense of stability again that is more open than you were before … It’s like going in a new direction and new ways of being.”

Multiple participants described how their thinking processes were different as they let go of fixed emotional states, cognitive perspectives, and attitudes. They sometimes experienced shifts in perspective emerging from within. Other times, they were aware that the practitioner’s “wisdom” would come with a “totally different viewpoint” that their shifted perspective. One said that with sessions, ruminative thinking “tends to just not have that grip on you”:

“You are able to let it go … It evaporates a little bit more…is not as heavy… You have different perspectives and can choose to look at it differently or not … it’s not revolving in your head anymore. It may come up every 2000 thoughts instead every thought.”

Changes in perspective can develop over the course of sessions. One participant experienced this in his body. Over time, his responses became “less brittle and more fluid”; he described feeling more “robust” and resilient.

Feeling different is transformational. As one participant said, “I feel like… the person that went in the door and had the session felt different than who I was when I walked out. I would just feel more alive. I felt often, not just relieved of a burden, but just more in my body and aware of the surroundings and of everything.” Another described how important a direct
bodily experience is to her, as compared with a cognitive understanding. Through her RMB sessions:

“Rosen has helped me really feel things viscerally and integrate things so they’re not just like this concept like, “Oh, of course, I know that”. No. To actually feel, to experience it in my body. Then, the whole world is different. … And it doesn’t ever go back. You’re changed forever!”

Participants described becoming aware of their bodies in new ways. One participant with chronic pain said that sessions have helped her to “feel more than my pain … [We] find the tiniest spot with no pain … I never did that.” Outside of sessions, she is aware of moving more and being less “rigid”. Several participants said they wanted to learn how to relax more in daily life. Between sessions, they remembered their practitioner’s calm.

Feeling different included observing changes in awareness of areas of chronic tension. One participant described exploring the chronic muscle tension in her rib cage, even outside of sessions.

“She [the practitioner] knows that that is my area…we don’t go to that area every time…for a while we didn’t do any of that area, and then all of a sudden she went back to it, and I went, “Oh my gosh. That’s still there?” Almost like… I never felt it that way until she moved my body … almost in a back and forth, side to side motion, and I had never felt that concrete brick in me. And so again, I lost that feeling until she brought it back… [now] I bring myself back to it, whether I’m at home with it or I am in a session. It’s in me.”

Several participants described how sessions help them listen to their emotions and trust themselves more. One participant described her learning process.
“I want to be more in touch with my body and my emotions and trust myself more. So, in that sense, it’s a long process. … A lot of times, I don’t listen to my feelings and I don’t give myself permission. [My practitioner] gives me permission to have a fit or not do something. I’m not able to do that for myself, so to have someone else help me with that is good. It’s just trying to learn from that. Trusting myself.”

Emotional Learning.

Participants described how the practitioner coached them to notice physical sensations and changes in tension associated with emotions, helping them distinguish between talking from cognitive ideas versus talking from direct experience in the moment in the body: “She can tell me when it’s the mind or the emotions speaking.”

Participants described learning to feel feelings. Several learned that it is “safe to feel” and to name their experiences and emotions. One participant learned that there is a “strong emotional connection” in his body, and that “in different places of my body I carry different kinds of emotional content.”

Participants described learning that it is safe to feel and how to recognize when they are having feelings. One participant reflected that previously she had learned not to feel or express feelings; she commented that this way of responding “may have been helpful before, but not now”. She valued emotional learning because “feelings are a large part of our lives.” Emotional learning happened when participants were guided by the practitioner to experience things about themselves they might normally miss or avoid, such as getting in touch with feelings that they would otherwise rush past. RMB sessions would “amplify” feelings. Learning how to pause and feel emotions, including positive feelings, was profound. As one participant described:
“He [the practitioner] makes me stay there for a bit. It’s almost like I don’t want to stay there, like, “Oh yeah” (with a dismissive tone). But it’s like [the practitioner guides me by saying], ‘No. Okay. Feel that. Feel that. Where is that? How is your breath? Do you notice what you are doing?’ And it’s like, it’s a teaching. It’s not like, “I’m going to do this thing to you and then I’m sending you out in the world”. No, it’s me. I do this. I’m getting to learn how I do this.”

Another participant described his emotional learning. He said he is feeling “less threatened” and is learning to respond differently when his fear or anger are triggered; he is shedding the impulse to be harsh and is accessing a felt-sense of being kinder.

**Feeling Kindness and Compassion.**

Among the positive emotive experiences participants accessed were kindness and compassion. Most participants spoke of a shift in their capacity to be compassionate and kind to themselves. For example, they might feel “way more gentle with myself” than before Rosen. One participant who reported having experienced significant trauma in the past, said she had gotten in touch with a gentler part of herself:

“So, the Rosen method helps you get into contact with trauma that’s been stored in body, but then also get in contact with that inner child or that softer, loving side of yourself. For me, it’s a nice journey to know that you’re going to get to that point.”

Participants attributed their emotional learning in part to the kindness modeled by the practitioner. One participant said his practitioner models being present and kind to him. He noticed that he is “more fluent in the language of kindness towards myself. I didn’t have that before.” He continued:
“I can say that I am more awake and sensitive and less threatened in the world, as a result of the work… it is something that [my practitioner] models by being there and responding that way, and that I began to associate as cogent and applicable.”

Another noted that the seeds of self-acceptance are planted because her practitioner models being aware without judgment - a positive presence without self-criticism. She is learning how to access this on her own. Another participant is “learning to be gentle” because she felt the “compassion of touch” from her practitioner. Another describes having “poor self-esteem” and being overly “apologetic”; her practitioner says, “you are being too hard on yourself…she gets me in touch with good parts of myself”.

Several participants said that they were more understanding and compassionate toward themselves and their stuck places. For example, when encountering ways that they had tightened to defend themselves, they told themselves what they had heard from their practitioners: “Whatever this body has done… in the past was what it needed to do in order to get through that time as best it could.” Another said that she had learned to appreciate how her memories were stored in her body, and this perspective gave her “more compassion for who I am and the choices I’ve made over the years.”

Emotional transformation happened in relationship with the practitioner as these participants explored the emotional experiences that arose in RMB. One participant said Rosen Method bodywork is “cleansing; it’s an “emotional hygiene that allows for a transformation through that connection.”

**Interpersonal learning.**

Participants were open to exploring themselves in RMB and were changed in the process. They described learning about themselves in relationship with their practitioners. They were
transformed by the experiences they had on the table and observed changes in their lives and relationships, such as learning that “it’s safe to feel things in relationship to others.”

Several participants described how their Rosen Method bodywork influenced their thoughts and feelings with respect to their family of origin experiences. Several participants described, “I’m experiencing the compassion I did not get growing up.” They described now having more compassion for parents who were unable to provide the emotional validation and nurturance they would have liked to have had. One participant described healing of past interpersonal wounds; she said that sessions guided her “through the pain, betrayal, isolation, and to recognize that I can heal and receive love and be loving.” She added, "I can love and be loved …That’s where Rosen has been extremely helpful.”

One participant described initially feeling quite dependent on the practitioner. Over time, he came to internalize what he was getting in sessions and became more emotionally resilient.

“I could feel myself on the table, …[thinking] something like, … ‘Don’t leave me. I feel held, feel supported… feel the nurturing connection that you are enlivening and re-awakening in me, and if you were to take that away I would be lost. I would feel hurt. I would be very unhappy.’ …[Eventually] our time together had worn through the brittleness … to a point where… I was far more robust and … not this complete dependency … It was not the sense of need and, ‘I don’t know how to do this myself’….A keyword for me is robust.”

One participant observed that she had become kinder toward others as a result of doing RMB. She was a “nicer person, much more compassionate and empathetic.”

“I mean I could really feel change in myself. Once I had been released from that kind of cocoon or mask of pain, I was able to experience the people in my life
differently in a much more softer and much more gentle way. I was able to … see how my perspective of people and life had been so very deeply influenced by early experiences, and that I was still seeing other people in my life through that lens. Through that lens of childhood experiences. And with Rosen, being able to open up on a very deep level, I was able to get past that somehow. I was able to see what I was doing, through my body. You know, this was not a whole lot of psychological stuff. I just felt better. And I was able to treat people in my life better and really see them for who they were. So, I felt like it worked because it worked on me in such a way that it improved my relationships with other people in my life.”

Participants described improvements in their relationships with others including seeing others more for who they are, feeling less threatened in general, less prone to anger, and being more in the present. They said that people in their lives notice changes. Two participants said they hoped that through their work in RMB, they will be better able to navigate future, close relationships.

**Learning how to receive RMB.**

Participants described a process of learning to receive RMB. One participant started out in his first series of sessions with RMB thinking it was something like massage. He did not “connect the dots” between the touch and the “stories trying to come out” of him. Sometime later, he read that Rosen included some talking about the thoughts and emotions that arise in session. He then returned to Rosen and he related to sessions in an entirely new way. As he described his early experience:
“[In early sessions] I was lying down like in massage therapy. But this is a whole different world. I didn’t know that I have to engage with the practitioner… There were stories trying to come out, but I did not connect the dots. And I was also kind of inhibited from two reasons: why I could not take her as a therapist in that posture or in that position [on the RMB table], or as a woman, or I don’t know what was blocking me at the time. So, I told myself, whatever emotions that come up, I will take it out in privacy. I will process that alone … so, I could not be transparent with [her] at that time.”

Another participant believed it can take “at least” three sessions for a person to learn how to receive RMB:

“The first time, ‘Well, what was that?’ The second time, ‘So, I’m familiar with this.’

The third time, ‘Well, I think I could get some benefit from this’. So. at least three [sessions] to orient people to… to understand.”

This participant added that RMB sessions involve a certain commitment on the part of the recipient, “because … you can get yourself into some pretty deep sessions with this work. You are saying ‘yes’ to something really big.”

Participants described the significance of learning how to receive touch when their background involved negative experiences with touch such as the absence of touch (neglect) or hurtful touch. One participant said, he had a “general distrust of other people with regard to touch” since childhood. With RMB, at first the touch was “very unfamiliar”:

“I didn’t grow up with a family of folks who were good touchers. The touching was negative and violent…. So, it was a really unfamiliar experience which pulled up a lot of feeling related to longing which I was not aware that I was holding on to…. It’s almost like I’m in the process of rewiring my brain around the way that touch works” … [and]
this kind of touch has been very different because I haven’t been able to get up and run. I’ve had to sort of sit with it and try to feel it and not judge it and take it at face value.”

**Transforming Between Sessions.**

Part of learning about how to receive RMB seems to include finding ways to integrate the experiences in session with one’s life. Several participants described allowing themselves time to reflect after a session without demands to jump into tasks or interactions with others: “For the first couple of years, I really enjoyed the fact that I had an hour-long drive on the way home just to begin to pull myself together little bit. Yeah, it was pretty intense stuff.”

Most participants reported they were tired after sessions, and they often took time to rest, reflect, and integrate new sensations, and insights. They let things “percolate.” The very first time I think I slept for two hours afterwards. I mean there was no option of functioning. It was like I had to go to sleep. So, I feel like [RMB] heals. You are continuing even after the session. Your body is still healing and dealing with, you know, maybe what you talked about and releasing of the stories.”

They described letting the experience settle into themselves; they did this “not so much intellectually with words but just sort of savored the feeling.” This process appears to be an essential ingredient in the learning and transforming that occurs, not just on a cognitive level, but also on an emotional and physical level in which the recipient becomes acquainted with the new experience in the body and its connection to thoughts, feelings, and images.

Most participants described remembering the practitioner’s words or presence when engaged in their day-to-day lives, thereby remembering the felt-sense of relaxation. One remembered the practitioner’s touch on her ankles, helping her access a feeling of being
grounded. She recalled this embodied experience outside of sessions when feeling stressed, finding it “calming and supportive.”

Although some participants described feeling “contained” or “sewn up” by the practitioner at the end of the session, experiences begun in RMB often continued to unfold. The post-session experience can involve continuing shifts or learnings over the next days or weeks. One participant described not being especially impacted by some sessions but going home and finding that “something begins to emerge.” Another said,

“I’ll have a session and over the process of maybe a week, things kind of continue to unfold … it’s almost like breaking down a dam or un-sticking something. So, there’s whatever was immediately not available to be felt, and then there’s a kind of relaxation into those feelings that are newly available, and then more feelings emerge underneath …. It keeps working. After the immediacy of the session, there is more that unfolds.”

**Transforming Trauma.**

The interview guide for this study contained no questions about abuse or trauma. Participants spontaneously raised the topics of abuse and trauma during their interviews. They perceived RMB as important in their healing and recovery. Several participants referred to their understanding of trauma as stored in the body and believing that trauma-triggered experiences will continue until the trauma gets released. Some came to RMB specifically to address and resolve these issues, while others discovered later that RMB helped with their healing. One said she was “blown away” to realize how much she was holding in her body.

Several participants reported having injurious childhood experiences. One had been bullied for being different; another had grown up in a culture where trauma and beatings of children were “normal.” Several referenced years of physical, sexual, emotional, mental, or
verbal abuse or neglect in their family of origin. Others referenced childhood invalidation that they did not call abuse but which they found hurtful.

Participants volunteered descriptions of how RMB helped them. As described earlier, the RMB practitioner provided non-judgmental, listening presence, encouragement, caring, and coaching through touch and talk. The practitioner gave feedback about what he or she sensed in the body. As one participant put it, the practitioner would “repeat what I said back to me” which was helpful because she could feel it in her body whereas “an intellectual recognition of emotions did not shift it.” She described the work as:

“It’s so deceptively simple. I was clear that, okay, someone is touching me where they sense tension, and then they are repeating whatever I am saying which encourages me to feel it, and then that simple process of reliving those moments completely defuses that trauma and that tension, and that is long-lasting”.

As described in the Exploring section above, participants acknowledged that old memories and painful emotions can be “terrifying”, but the presence and coaching of the practitioner comforted them and helped them tolerate their pain as they explored.

One participant said that through her readings on trauma, she understood her pain intellectually, but this intellectual understanding did not change her symptoms; working with the body helped her. She recounted revisiting a traumatic memory during a session:

“I went back to a point where I thought it was going to get killed. I was being beaten up and it took me right back to that point. So, I just somehow knew I needed to go back there because I had also read a whole book about trauma, and I realized there was something about having to release that and experience it. So, I did have that knowledge. But I never experienced it. Rosen took me back there in a trusted way that, ‘Okay, it
hurts like hell and it’s really uncomfortable, but there is a way out. There is a reason for the pain.”

Feeling sensations of peace was healing for these participants. The practitioner’s touch and words reassured them that they were safe, in the present, and that what happened in the past was not happening now. They were also reassured by the feelings of calm and peace they experienced. Being able to access experiences of calm or release, even if transient, mattered to these participants. They described having been “starved” for kind touch. One participant described a family of origin in which “I had extensive abuse, physical abuse. I mean, beating and shaming.” He experienced a chronic internal tremoring in his body which he related to past traumatic experiences; it signified to him “how much I am traumatized. How much my nervous system is on alert, even when there is no threat.” When touched in RMB sessions, he felt his body calm down. “When I calm down, it is almost like I am in a different dimension, you know? I make it a point to feel that.” For him, the pleasure of touch was an integral part of his healing from trauma.

Participants described being coached in RMB to gently approach their trauma-related experiences. Their tensions were met with the practitioner’s gentle, listening touch. One participant described transformation of her attitude in working with her trauma in RMB. With the practitioner’s listening touch, she realized that despite urgently wanting to be rid of the trauma, that “you can’t tear the trauma out of my back, only dissolve it. Only love dissolves it. Loving compassion, not ripping it out.”

Another participant described being coached by the practitioner to cope with disturbing images that arose in sessions by dismissing them:
“At first, I was angry when she suggested I dismiss the images. I thought she was saying they were not important. But she said, ‘No, that’s not what I mean… don’t let it settle in or set into your heart’.”

This participant said that it helped her learn to manage the images; “it’s a learning process.”

After dealing with painful issues in a RMB session, one participant described how the practitioner helped her contain her emotional experiences at the end of a session:

“However emotional a session has might be, because I normally do experience quite a lot of emotional release, there has probably been one session where I have not cried. Normally, there will be tears that come out at some point, but by the end, however hard it might have been or however traumatic the memories may have been, [the practitioner] has a way of almost, I don’t know what the word, it’s like he sews you up. It’s like having surgery and then you kind of get sewn up at the end, but not in a way that sort of shuts it down. Just contains, so you’re able to step out and walk back out into the world without being a complete mess.”

While many found RMB helpful to their healing, their work was difficult and sometimes overwhelming. As one participant put it, “I had one session where I just had to stop the session, I didn’t want to do anymore… there was a flashback of my abuse… Yes, so sometimes I would just go home and curl up like a little ball”. One participant who had experienced significant distress during early sessions found that she relaxed deeply after sessions. The sessions themselves were very difficult, but the after effect was decreased anxiety and “such a peacefulness in my body afterwards.” This peacefulness encouraged her to return for additional sessions, despite anticipation of discomfort:
“I always felt so much better after those sessions. I felt in my body a deep sense of peace… It’s not like I really dreaded going back, …but when I would drive over there to the session, I was like, ‘Oh God, here comes reliving all those horrible things again. … How much do I have to release? How long is that going to take because, this is not fun.’ … But I felt like I was willing to go there. No matter what it made me feel, I have the courage and believe that going into that would release it. Because I could actually feel my body… I have a tense neck, so when we worked a lot on my neck and it’s like, ‘Wow, I actually have a lot more freedom of movement in my neck’. So, I could immediately feel afterwards the somatic benefits as well as emotional benefits.”

A concern voiced by two participants was whether the practitioner might have difficulty tolerating their discomfort. They wondered if it was difficult to listen to, or how the practitioner tolerated it when the person on the table is struggling with a painful memory. They thought that it must be painful to watch someone relive trauma.

The challenges of receiving RMB are significant and they seem to vary, depending upon the individual’s internal and external resources and on the priming experiences they have had. The experiences of these participants highlight possible challenges that recipients may experience such as: experiencing things they don’t understand, having lingering feelings of confusion, and experiencing difficult emotions that are intense (possibly to the degree of eliciting dissociation) or embarrassing. The practitioner assists the recipient in staying within their window of tolerance for their experience.

**Participant Opinions about RMB and Psychotherapy.**

Participants compared RMB and talk therapy. Their opinions about talk therapy and about combining talk therapy with RMB varied. All participants found the combination of touch
and talk in RMB uniquely helpful. Several said that RMB is more transformational than talk therapy, while others said the two approaches complement each other or that talk therapy is an essential piece of processing RMB. They all found the combination of touch and talk within RMB helpful.

One participant spoke to the benefit of the combined touch and talk in RMB. The combination in RMB was:

“…like the shortcut. I don’t know if my work with [my RMB practitioner] would be as effective if there wasn’t some talk there…She is better than any therapist I’ve ever talked to as far as really being able to hear and zero-in on what’s essential and be able to feed it back in a very concise way, so that I get a whole different view of it and feel like it is something I can deal with, and I have an idea of how I’m going to handle it now. So that’s very valuable, and I wouldn’t get that from just the touch. But the touch is something that no amount of talking can accomplish. It just cuts through all the verbal, mental… the thoughts, the fears… And it just like a door opening onto this peacefulness.”

Some participants said that talk therapy failed to reach places that bodywork can contact and that RMB had helped them with trauma recovery in a way that typical talk therapy had not. “It’s like therapist can help with coping with anxiety and depression, but they don’t have a way to alleviate the effects of trauma, at least not that I’ve seen.” One participant who had tried RMB in the past, returned to RMB after years of talk therapy in order to “do another layer of healing”:

“I had done a million years of talking therapy, and it just felt like there was something that needed to be moved that only working somatically through the body - not just the
breath, sitting in a [talk therapy] session … I felt like I had talked enough. And I wanted something that would kind of move me to a different level of healing.”

Several participants found RMB more transforming than talk therapy alone and believed the body needs to be included in therapy in order to make change. Some had experiences with talk therapy that felt like “spinning wheels”, or that previous talk therapy did not get to the same level of depth, despite years of it. Participants valued learning to feel and hear the body in RMB. They valued the combination of touch and talk in RMB: “touch and language can meld… The touch is profound and combining it with the language is very useful.” One said, “Rosen method has been so effective for me as trauma releaser… Talking is not. You have to feel it in the body.”

One participant discontinued psychotherapy after getting RMB for a while. It happened that her RMB practitioner was also trained in psychotherapy, and they would typically talk for about 20 minutes before the hands-on part of the session. She stated that because of discontinuing psychotherapy, she could afford to come for RMB more frequently.

“For me it’s more about releasing stuck emotions that are in my body and can’t really be accessed through regular therapy. The practitioner listens… listens with their hands, which doesn’t really make any sense when I say that, and together we kind of go to where things seem to be… Where I am noticing certain things and she might notice something, and after that it’s kind of it like a dialogue.”

Several participants observed a synergy between RMB and talk therapy. For some, talk therapy helped them process what they experienced in RMB sessions and put experiences into context. In contrast, for one participant, the talk therapy was central and more frequent than RMB; for this participant, RMB sessions supported relaxation about issues addressed in the talk therapy. For several others, previous talk therapy had seeded ideas that were explored further in
RMB, such as the ideas of an inner peace beneath the suffering or of being kinder to oneself. Participants stated that RMB provided a means to directly experience a felt-sense of those ideas so that they were not simply intellectual concepts.

RMB helped participants access their issues in a different and complimentary way from talk therapy. One participant had years of psychotherapy for trauma prior to RMB. Discovering through that work that she had a “deeper peaceful core within me” helped her:

“…because you understand that it is okay to feel that past trauma because underneath, there is a base there of peace and calmness….For me,…Rosen brings up … images …I could imagine my whole body as a soft, heart. Where before, the talk therapy got me in touch with the feeling, but … Rosen gives you access to your unconscious visualizations of that trauma, and you’re able to transform that. I don’t know if talk therapy gets to that unconscious brain as effectively.”

Another participant strongly advocated for RMB in conjunction with talk therapy. She said,

“Make sure you have a good therapist because, I mean stuff comes up, I mean real trauma. Stuff that you’ve locked away and …. I don’t know how I maybe could’ve handed that if I didn’t have a good therapist because sometimes you need to process a little bit more or talk about it a little bit more and have the support that you need.”

Two participants had training in psychotherapy. They said that it would be ideal to have a RMB practitioner who is also trained in psychotherapy to help with issues that come up such as transference. As one stated:

“It’s so individual about who we are when we are working with people’s psyche. For me, that was definitely something that was missing in the work, and I know often people do
bodywork and they are also seeing and talking to a therapist, so they get to be held by both … I have a big bugaboo about people who harm people. And I was never harmed by a psychotherapist that directly as some people with heinous stories, but I’m very aware of that I think there is some way that people don’t really understand the power of, someone’s on your table, fully clothed and yet this is so intimate. And do you really understand what is really going on, on another energy level that is not just about the body work but, ‘You are my mommy… You’re my sister’, you know what I mean?”

In summary, participants described being changed through their RMB. The practitioner’s words or touch elicited awareness and they felt different. As tensions were explored or let go, something they might not have known became clearer. They made links between body sensations, emotions, thoughts, images, and memories. They gained a different perspective on themselves and their issues. Whether they sought RMB for trauma recovery or otherwise, learning, change, and transformation happened for these participants. They had the sense that “this is working.” They felt that they could get “to the heart of things” through the work. They were able to feel more, both in their bodies as well as in their emotions. They experienced progress in healing their trauma. They reported reduced stress and improvements in daily function, such as reduced “procrastination” and increased confidence. RMB helped them to “continue in a way that is not so debilitating physically or emotionally.” They felt more grounded and able to navigate stressful circumstances or events with less anxiety or depression. Some sessions were a “tune-up” and provided a place for “learning how to be.” Participants described finding their voice and learning to trust themselves more. They became more kind toward themselves and others, and they came to believe they were worthy of regard and gentleness. RMB helped them recover from traumatic experiences. Their learning was
transformational and included connecting to their experience in new ways, as described in the major category, Connecting.

**Feeling Connection**

The main category of *Feeling Connection* represents the fulfillment of participants’ purpose in getting Rosen Method bodywork. The category includes a feeling of connection in various ways: connection to the body, to emotions, to thoughts, to self, to wholeness, and to others. Participants accessed an experience of peace and spiritual connection. For participants, these experiences of connection reflected that RMB was “working” and motivated them to continue receiving the work. Participants felt they could explore themselves in RMB. One participant’s account exemplifies how comprehensive the scope of this connection can be:

“Even though I’ve been on the spiritual path for 40 years. I still make fun of ‘woo-woo’, and if something feels to ‘woo-woo’ for me, which means just too insubstantial. … I like to experience things emotionally, physically, mentally, completely. I don’t want something that’s just airy fairy … I felt that this [RMB] met the test for me, which was that it got to all of those levels, deep emotional, physical, spiritual, mental. … I felt like all of those aspects of my psyche were met.”

**Connecting to Body, Emotions, and Embodied Self.**

Participants described feeling more connected to themselves in various ways through RMB. They felt more connected to their bodies; they were more aware of the connection between their thoughts, emotions, and bodies. Sessions helped them make connections with their past experiences and current emotional responses.
Participants reconnected with their bodies through RMB. For several, this resulted in decreases in physical pain. In addition, they observed that, “The sore part isn’t always just physical, there is an emotional complement.”

Some used the word “embodied” to describe coming into closer relationship with their bodily experience of emotions and self. One participant said that RMB helped her “to be in my body, to feel my body, my feet on the floor.” They described a “cohesive sense” of the body and feeling “whole”. Several participants referred to “being comfortable in their skin” through RMB.

“I notice how embodied I feel. I just feel so in my body in a way that feels really good and trustable and grounding...like a feeling of home, like being at home in your own skin or comfortable in your own skin.”

Another participant echoed this sentiment when he said that the experience in sessions “felt like a coming home”. Still another said:

“It’s like we get pulled in so many different directions in our lives, and when I go and have a Rosen session, however difficult it might be... It might be a lot of painful feelings or it might be really positive feelings. It doesn’t matter. It’s a way of coming home to myself so I feel more in my body and just more centered.”

Participants used words like “whole” and connected when describing their sense of the body and they greeted this experience with enthusiasm. For example, one participant marveled that in sessions, the chronic tremor he attributed to past trauma stopped. He recalled a session in which:

“My whole body went to a time before all this tremor settled in. Before the tremor experiences came into my body, before that, right? Like five years old. Maybe four
years old. My whole body was one whole piece. There was no tightness in between like in my low back or shoulder. Everything is like one whole body. I was on the table. So, this is a new level.”

Another was exhilarated to feel “free” and “open” and added that the practitioner “was working on my body, psyche, and soul at the same time”. A participant who experienced chronic physical pain appreciated finding “spots of peace” in the body and connected these sensations to experiences of peace, both physical and psychological. When feeling connected to self-compassion after exploring a traumatic memory, one participant spontaneously visualized “my whole body as a soft heart”; together, the bodily sensation, self-compassion, and visual image gave an integrated experience.

The experience of slowing down was linked to a quieting of the mind – a disconnection from the usual activities of thought. The “brain shuts off”. Sessions “allow spirit and body to connect without the mind chatter” – a time to “unhook” from anxious thoughts.

Participants described being more connected with their emotional experience through RMB. They valued connecting to their emotions. One participant said that “It’s harder to be in denial and in rationalization when you are in Rosen work”, and the practitioner’s supportive presence was part of what made it possible for her to connect with her emotions rather than deny them. In contrast to denial, “Rosen encourages being present during that emotional connection. It doesn’t just brush it off. It doesn’t move on…It stays with it. It moves towards it instead of away from it”. Another participant said, “The sessions where I cry or really get emotional seem like the best ones to me because I feel like there is proof that I felt something. It feels more cleansing”.

Connection with emotions happens over time and in layers. There are “layers of feelings and deeper feelings that continue to emerge over time. That’s why I keep going, … because I do feel like I’m always discovering more depth of feeling within myself”. Participants connected with a range of emotions: “It might be a lot of painful feelings or it might be really positive feelings” … [the practitioner] has a way of connecting me also to positive feelings like strength or joy. It’s not all just misery and sadness.”

Connecting to Self and Sense of Wholeness.

Participants described getting in touch with an experience of their wholeness in sessions. They connected with qualities within themselves, such as trust or self-confidence as well as a “softer side” of self. Participants felt more whole through their RMB, leaving a session feeling “put back together again”. They said that while they released some pain in sessions, the work also made their life “more full”. As one participant described it:

“Before, … I just knew that there is a part of me that was missing, and I didn’t know what that was, and I didn’t know how to find that, like, but then Rosen has really helped me to find all those pieces that allow for feeling whole and fulfilled and complete.”

A vivid description of the experience of connecting with oneself came from a participant who experienced RMB while receiving “arduous” medical treatment.

“I had to go to the hospital fairly regularly….the cancer was a thing, my body was a thing, and they were killing the thing and they were addressing the thing. It wasn’t about me. And yet me was so much bigger than the thing. And yet I wasn’t part of it. The thing was what they were working on. And that’s their job, and I appreciate that and feel grateful. What the Rosen Method did was it brought me into a quiet space where I was …The “I” of me was talked to … the “me” of me was addressed quietly, patiently, sweetly, and then
bodywork towards the part of me that was hurt and sore from all of this effort. It’s profound. Profound … Instead of being a thing, … actually being…. being part of nature. Being part of what is evolving, being part of what is growing and changing, is different from being a number.”

**Connecting with Others.**

Participants described experiencing interpersonal connection in sessions and appreciating that RMB “is a wonderful way for human beings to be in contact with each other”. Their sense of connection seemed to derive in part from feeling listened to, not manipulated, by the practitioner. One participant said,

“Just the pure fact of the human touch, just having someone place their hand on your body and just feel you. They’re not doing something to you; they’re just feeling you, and you are feeling them feeling you. There’s just an incredible sense of connection and intimacy purely in that.”

Participants felt connected to their practitioners. Several participants were moved to tears when describing their appreciation for the caring they felt from their practitioners. They deeply appreciated the respectful, non-manipulative and attentive touch, encouragement, and presence of the practitioner. They sometimes needed the practitioner. One participant described initially feeling dependent upon the practitioner for the experience of ease. This participant noticed a “real thirst” for sessions in the early months of RMB, “feeling like a dry sponge and soaking up the experience [and thinking], ‘Oh don’t take it away’”. This participant later developed confidence with separation and came to feel “robust” and resilient: “Robust, like, “I can handle this. I’d still really like it [RMB], and I am okay” when the practitioner is away.
Participants described greater quality of connection with other people in their lives, such as spouses and coworkers, and greater hope for loving connections with others in the future. A teacher noted connecting differently with her students; she can “sit a moment” and “wait” rather than impose something on them.

**Connecting Spiritually.**

Participants described connecting to experiences of peace, calm, relaxation and spirituality. RMB helped participants connect with the state of being, rather than doing: “I could just go with who I was in the moment and be accepted for that...There is no doing involved. It was more being.” Despite the stress of their lives, RMB “would take me back into that spacious, resting place of quiet where the brain actually goes to stillness”.

After a time, as these participants became able to relax, the focus of sessions shifted toward lingering in a calm, peaceful state of being. At this stage, one participant described entertaining existential thoughts such as, “Who am I on this planet?” Another reflected that she gets so relaxed that she accesses “that still point”; she believes this state of being may be “what meditation should feel like”, where her breathing felt “like seaweed floating”. They described feeling spiritually transformed.

“I think it is a feeling of getting in touch with your true self, your higher self, … [RMB] allows you to open to your own self … and to expand your understanding of who you are. I mean, to me that is a spiritual experience. When I come away from something feeling transformed, it’s almost like the field around me gets bigger. It’s almost like I can feel the top of my head open, and I can feel everything expand and I know I have been changed in some way.”
Sometimes these transforming experiences are moving. One person said, “I would sit in my car and just cry after the session because it was so profound … like going back to original innocence”. One described a euphoric feeling of relaxation:

“She was working on my jaw, and I suddenly just disappeared. I just, whoosh. That was surprising and really relaxing … I was really surprised at the end of it, when I came back. I was like, ‘Wow, I just was clear. I was here and present, but I was also … everywhere else’. It was real nice.”

Participants described the importance of accessing inner peace through RMB and likened RMB to meditation. It is a “a body meditation” and “transcendental”. One participant said the work brings her to a “deeper meditative state” where she feels “awake” to her experience. Another said that RMB takes her beyond the limits of meditation. She stated that “in meditation you are alone [and] it’s very easy to stay in your head and not necessarily really feel what’s going on or be in connection with your body”. She experienced that Rosen Method bodywork “allows you to open up … in ways that you probably couldn’t by yourself”.

Some participants who had done Rosen Method bodywork for an extended period of time described a shift in their focus over the course of sessions from a physical and psychological focus on “throwing off tension” to a spiritual focus. The work became a spiritual exploration of “what meditation should feel like”. One said that in sessions, she is:

“I’m going straight to that still point in becoming so incredibly relaxed … I feel like I could just be as still as a tree for several days and not move a centimeter… [Now sessions are] to move forward in my spiritual evolution.”
Participants spoke about RMB as a spiritual process. One said, there is “something very holy about the work”. When describing RMB, they used words like, “divine awakening”, “faith walk”, and “spiritual evolution”. Describing the process of unfoldment, one participant added:

“There’s kind of a deeper, quiet, knowing that there are places in me that I’m not even aware of ... And it’s almost like they are pathways into the spirit, or a pathway into a very deep, hidden self.”

In summary, for these participants, RMB facilitated feeling connected in multiple ways. Participants described becoming more aware of their bodies and embodied experiences, including emotions. They became more aware of the body-mind connection. They connected with themselves and feelings of wholeness. They connected more deeply and compassionately with others in their lives. They connected with a felt-sense of inner peace and calm and with their spiritual evolution. Their experiences of being unconditionally accepted seemed to lead to a connection with the practitioner which in turn contributed to their being open to exploring, transforming, and connecting with themselves. Participants described the RMB process as ongoing. As one stated: “I’m always discovering more depth of feeling within myself, more capacity to function in the world”. Participants acknowledged that RMB is not for everyone. One said it is a “niche treatment”, because “There are some people who … are not body-oriented, mind-body connected at all…[they] wouldn’t feel a thing”. For these participants however, RMB is a process of becoming, and they are “still a work in progress”. For them, RMB is a “journey” through which “the whole world is different”.
Chapter 5: Discussion

Overview of the Model

The overall process of RMB identified in this study is a non-linear, multi-directional, integrative, and iterative process. In grounded theory research, a process identified in the data involves progressive phases or steps that are not necessarily orderly (Strauss & Corbin, 1990, 156). The data in this study indicate that the experience of receiving RMB is not an orderly process in which the recipient moves through each phase in a sequential manner but instead is a fluid process where phases sometimes overlap and are iterative. Bidirectional arrows in the diagram illustrate this integrative nature (Appendix K). Concepts within subcategories sometimes fell into more than one main category. For example, “being present” is part of being open and it is also part of exploring and learning. For purposes of simplicity, such overlapping concepts and sub-categories were ultimately placed within the main category that held the most data (evidence in these transcripts) for them.

A goal of this study was to advance the understanding of the processes involved in Rosen Method Bodywork through interviews with RMB recipients and to develop a model representing their experiences of the process. The theoretical framework was then used to answer the research questions: what interpersonal (between the recipient and the practitioner) processes occur with RMB as perceived by these participants, and what intrapersonal (within the participant) processes occur with RMB as perceived by recipients? Just as the concepts in the model are interrelated, the intrapersonal and interpersonal processes at play in RMB are also intertwined. RMB is an activity involving two people with the focus on one individual’s experience. The practitioner touches the recipient with hands and with words. This touch influences how the recipient experiences themselves: their physical sensations, thoughts, and
emotions. This discussion presents these integrated processes (interpersonal and intrapersonal) together as they occur throughout the overall process. The main aspects of the process are discussed below, illuminated by attachment theory and mindfulness theory, and by a discussion of trauma therapy. Below is a brief description of each category.

**Feeling Stuck and Disconnected** motivated most of these participants to enter the RMB process and continue to get sessions. Their reports echo RMB literature in which feeling stuck is a motivator for getting sessions (Rosen & Brenner, 2003). Some got first sessions because they were experimenting, but they continued because they noticed the work brought benefit. In some way, they felt stuck and disconnected. They experienced being “dis-integrated” – having a body, but not feeling it, knowing they had emotions but not feeling them, wanting to access inner peace but being unable. They sensed a disconnect between their body and their mind, and they felt there were aspects of themselves that they did not know, see, or understand. It is not clear that people who come for RMB are anymore stuck than people who don’t; however, these findings suggest that people who come to RMB are willing and able to sense their stuckness and to respond to it.

**Being Open and Trusting** are both states of willingness. Trust involves an openness to influences from another with the assumption that comfort, safety, and connection will be provided (Siegel, 2010). Participants described being both open and trusting and being vulnerable. They had various anxieties such as about being seen in ways they themselves judged, or concerns about what to expect, or about surprising or disquieting experiences. They found the attuned presence, acceptance, and the gentleness of the practitioner comforting. The practitioner helped set the stage for resonance between them, thereby creating an environment in which trust could grow (Siegel, 2010). As they relaxed they were coached by the practitioner to
attend to their felt-experience rather than analyze or talk from the head; they were open to being coached to attend to their felt experience. They experienced uncertainties about what the work was and whether they were “doing it right”. They had unexpected experiences that were sometimes novel, sometimes uncomfortable, and sometimes alarming. With some exceptions, they felt adequate safety and containment in the session to remain open to these experiences.

In the *Exploring* phase, participants became aware of sensations, thoughts, images, and memories. They were coached to be present, listen to the body, and to explore what was held in their tensions. They explored their emotions, thoughts, and embodied experience. The practitioner reflected their experience back to them with few words and with lingering touch and attention, so that these recipients could pause to deeply feel. Exploring was a sometimes-difficult process for most participants, and painful for several. Participants wanted reassurance that their experiences were typical, and that they were doing it right. Some participants felt little or tended to dissociate; they valued how sessions helped them feel more of themselves. Others felt a lot and sometimes were overwhelmed with sessions and exhausted afterward. Participants noticed heightened awareness of themselves during and after sessions.

*Learning and Transforming* occurred on multiple levels. Participants felt changed; many described being transformed. They learned how to receive RMB with its unique touch and interpersonal dynamic. Some learned through experience to relax more deeply in sessions than they had initially be able. Many carried memories of relaxation with them into their daily lives to rekindle some ease, outside of sessions. They felt different during and after sessions, in body and mind. Sometimes there was a decrease in physical tension. Sometimes they had a shift in their perspective. They felt “altered”. Sometimes they journaled about these experiences; often these shifts were beyond verbalizing. They noticed psychological ease and feelings of greater
interpersonal trust over time. They came to feel feelings more keenly and to linger with feelings they might otherwise miss, including pleasant ones. Through exploring their embodied experience and memories, some gained fresh insight about their family’s dynamics and patterns. They became less harsh and more compassionate with themselves and others. Some participants described feeling dependent upon their practitioners. Nearly all voiced gratitude and were sometimes moved to tears of appreciation for their practitioners’ willingness and ability to be with them, offering consistent, caring, listening presence. They described how their learnings continued after sessions. On occasion, trust was strained or eroded during the RMB process when participants’ needs were not met.

Participants described *Feeling Connected* with themselves through the RMB process. Their connections occurred in moments during sessions or between sessions. These participants often felt more grounded and at home in their skin – more whole and complete. During sessions and afterward they often felt connected to their practitioners, internalizing the messages of encouragement, kindness, and patience that they experienced in that relationship. Several participants noticed improvements in their other relationships with others, and two had increased hope that future romantic relationships would benefit from the work they were doing in RMB. Participants accessed spiritual experiences in sessions which they likened to meditation. For some, accessing a state of simply “being” became a focus. Participants connected with their whole selves – including their physical and psychological pain. In addition to positive connections, they connected to memories of past abuse, neglect, or trauma. As they described, through their RMB, they experienced glimpses of peace beyond their pain and were sometimes able to let their pain go.
Participants took time between sessions to integrate the work and returned to RMB to continue to explore in an ongoing process of being open, exploring, being transformed, and coming into connection. These participants did not choose standard treatment (e.g. psychotherapy), at all or alone, because they believed it would not address the wholistic nature of their experiences. They sought therapeutic engagement that was not founded on the notion that there was something wrong with them that needed to be fixed. They sought a therapeutic engagement in which they would be viewed as whole so that they could experience wholeness within themselves.

Participants described RMB as a cyclical, integrative, non-linear, and iterative process of self-discovery and becoming. For example, a recipient may feel open to exploring, and then encounter feelings of being stuck in difficult emotions, and then experience a shift into relaxation that is accompanied by a feeling of peace and connection to the present, and therefore feel more trusting and open to the process and willing to revisit and explore the stuck feelings. The RMB process of these participants involved trusting the experience enough to explore themselves, learning from the experience and being transformed, and feeling connection on multiple levels. The psychosocial process was ongoing as the individual returned for sessions to continue the journey of discovery.

In this study, when asked to describe their RMB experience, participants universally said that it was difficult to put their RMB experience to words. That said, this model emerged from their verbal accounts. As they report, a verbal description of RMB, no matter how thorough, cannot wholly capture this experience which profoundly influenced their lives.

“You can ask me to describe it and I can put words on it but I am really, I am painting a picture of the thing that we could actually just touch … it’s hard for me to put words to it.”
I can’t say, ‘I am profoundly changed because of this, and this has changed’, but I can say that I am more awake and sensitive and less threatened in the world, as a result of the work.”

For these participants, the motivation for RMB is found in the outcomes they experienced. The desire to get unstuck and to connect with oneself sets the process of Rosen Method bodywork in motion. Being open to Rosen Method bodywork was driven in part by a desire to be more in touch with oneself and to trust oneself – to feel oneself better and to connect more.

The ways that participants described feeling connected from RMB point to the ways they were disconnected prior to RMB. Participants described working on certain personal goals. Their goals were the antithesis of their disconnection. They sought to internalize and remember feelings of calm in daily life. They sought to be more emotionally resilient and “robust”. They wanted to be able to settle into the safety and comfort of relaxation more quickly. They wanted to experience themselves as spiritual beings and to access their inner peace. They wanted to trust more in relationships. They wanted to feel whole and cohesive.

RMB is a process fundamentally led by the recipient, and it progresses at the recipient’s pace. Although these participants named goals that they had, the practitioner’s role was not to direct that process but rather to follow and reflect. The process cannot be externally regulated, and it is not possible to predict what, how, or when an individual will respond. Similar to many psychotherapies (other than goal-driven, time-limited short-term therapies), RMB supports the recipient in exploring and learning in their own time and in their own way.
Interpersonal and Intrapersonal Processes in RMB

The interpersonal and intrapersonal processes in RMB are not separable. This study provides evidence about these processes. As the model illustrates, these processes are interdependent, integrative, and iterative. The interpersonal processes in RMB create the safety and conditions for the intrapersonal processes to unfold. The interpersonal dynamics in RMB aid the capacity of the recipient to develop interoception which in turn leads to a mindful awareness of self that supports self-compassion, healing of psychological wounds, and spiritual evolution. This discussion of these processes begins with interpersonal processes as illuminated by attachment theory. Intrapersonal processes are then discussed, including how RMB appears to improve capacities for interoception, mindfulness, and self-compassion, and its role in healing as described by these participants.

Interpersonal Processes Between Practitioner and Participant.

The interpersonal processes in RMB began when these participants first encountered their practitioners. Their intrapersonal processes (within the individual) were dependent upon the relationship with the practitioner. Successful RMB relies on the depth of connection between the practitioner and the recipient (Bernard, 2016; Green, 2016; Hoffren-Larrson, 2013; Salibian, 2015).

Being open and trusting developed over time through participants’ experiences of the practitioner, of the sessions, and of changes that they noticed within themselves. The touch of the practitioner brought comfort which contributed to feeling open. The touch conveyed no agenda and supported recipients in being present. They experienced their practitioners as beneficent, present, and responsive. Participants experienced being listened to by the practitioner and found themselves open to listening more deeply than they might when alone, even in
meditation. Participants felt nurtured and cared for. They sensed the attunement of the practitioner and a resonance was established between them. Being comforted creates an experience of safety and relaxation. By being present they could observe what was happening in their experience, explore themselves, and learn. Within a safe container, it becomes possible to explore the unknown and to be vulnerable. For these participants, trust depended upon experiencing the practitioner as both caring and knowledgeable – a reliable guide on a journey into the unknown (Salibian, 2015; Nichols, 2006).

The interpersonal relationship between practitioner and participant was characterized by the practitioner listening and attuning to the bodily and emotional experiences participant. As one participant said, the practitioner sometimes sensed things about the them before they did. In addition, participants sensed their practitioners; they noticed if they had an “off” day. This non-verbal communication is possible through attunement and resonance in which both individuals are sensing themselves as well as each other. (Siegel, 2012).

Participants perceived their practitioners as caring. They used the words “compassion”, “kindness”, and “caring” as they described their RMB experience with their practitioners and as they described their evolving relationship with themselves. For these participants, the practitioners were not simply non-judgmental, attentive, and open to listening to them, but they also had their best intentions. Clearly, it was of central importance that the practitioner came to the table with good will. As one participant said, he learned through the modeling of the practitioner, “If there’s one central tenant that I could express verbally about the experience it is that - being kind and gentle with yourself is it!” It seems that the strength of the work is not only about paying close attention to the shifts of tension in body and mind, but rather the kindness that is brought to this attention. It is not a neutral awareness. It is a caring awareness,
that does not take care of or seek to manipulate for the good, but is listening, patient, and loving. It is “intelligent touch”, informed by the heart. These findings support findings of the Hoffren-Larrison (2013) study in which participants cited the caring practitioner as pivotal to their experience of RMB.

Participants described the rapport and attachment that they came to feel with their practitioners. Several noted that they felt dependent on their practitioners: they expressed needing their practitioner’s attentive listening in order to listen to themselves. Participants valued the practitioner’s touch and words for stimulating awareness where there might be numbness, lack of awareness, or hypoarousal as well as the comfort and reassurance the practitioner provided when the exploration encountered tension or distress.

To borrow from Winnicott’s concept of a “good enough” mother, when trust is “good enough”, when there is sufficient trust that the recipient is able to settle into the process and let down defenses; then, exploration, learning and connection can follow. Trust is not either 100% or not at all; there are gradations. Trusting involves physiological and psychological aspects. Physiologic aspects described by participants have to do with physical relaxation, reduction in muscle bracing, and autonomic shifts towards relaxation functions. Psychological aspects of being at ease include being able to be present and observe moment-by-moment experiences. (Porges, 2011; Siegel, 2010). According to attachment theory, a good enough interpersonal attachment creates feelings of safety and supports exploring (Nichols, 2006). As predicted by attachment theory, participants felt safe to explore as their attachment to their practitioners grew.

For the most part, practitioners served as loyal and trusted guides in participants’ self-exploration. They counted on the practitioner not abandoning them. Most expressed deep appreciation for practitioners. In psychotherapy, therapists function as attachment figures in
their client’s development (Siegel, 2010). For these participants, practitioners served as “attachment figures” and thereby influenced their learning and transformation (Siegel, 2010, p. 154.) As described by the participants in this study, their RMB practitioners seemed to provide many of these therapeutic functions. They said that the reassuring and orienting presence of their practitioners helped them find even difficult sessions helpful. Over time, some reported an internalized experience of confidence and wholeness. As their window of tolerance expanded, some described being able to cope with arousal that would previously been overwhelming. They grew to be more able to tolerate and respond when feeling distress.

As predicted by attachment theory, when the relationship between the practitioner and participant was adequately safe, the participant felt secure to explore deeper within. Building safety and encouraging exploring is dependent upon the attuned practitioner who mirrors and resonates to the participant’s experience. When the recipient of RMB experiences the practitioner as present in this way, they can open more to their internal experience, including experiences that were previously excluded from their awareness (Green, 2016; Siegel, 2012). Emotions, thoughts, images, and memories that were shut away from awareness can come into view.

The practitioner provided a mirroring function, helping these recipients feel themselves and their experience. As expressed by participants, knowing that the practitioner was responsive to boundaries helped them feel safe; this would be particularly important to individuals whose boundaries had been violated in abusive early relationships. Several participants said that the care and attention they received in the RMB relationship exceeded that in their childhood relationships with care-givers. Although attachment theory holds that early relationships result in templates being formed for later relationships, the theory also allows that relational templates
can be altered through subsequent life experience (Crowell, & Treboux, 1995). The data suggest that these participants experienced changes in their capabilities for attachment.

Attachment experience shape one’s relationship to emotions. If primary care givers do not accept emotions, the child learns that certain emotions are not acceptable (Siegel, 2012). Some participants described having learned from earlier life relationships to avoid their emotions. They discovered in RMB that they had difficulty feeling and putting words to their emotions, and that they tended to speak from their cognitive experience. Over the course of time they became able to recognize these preferences and to explore feelings rather than thinking about feelings. It appears that experiences in RMB can be corrective, helping recipients experience positive attachment patterns as well as capacities to feel and communicate their experience (Green, 2016).

These participants verbalized the importance of the humanity and approachability of their practitioners. Several participants expressed discomfort with traditional therapy which they perceived as objectifying and judging them. They were attracted to the RMB relationship in which the practitioner was seen as another human being with their own struggles.

Even though participants relied on the practitioner, they came to RMB with the intention to participate in the process: They saw themselves as an active participant in their RMB. This study supports the findings by Bernard that RMB recipients seek partnership with their practitioners and that the recipient of RMB is both receiving touch and “meeting the practitioner’s hands from the inside” (2014).

Participants noted changes in their capacity for compassion toward others. They described being kinder to themselves and to others. They attributed this change to their having received kindness and non-judgment from their practitioners. It seems that, the touch and select
words of the practitioner reached these participants at an experiential level that changed them. They cited the compassion of the touch itself as an important factor in this transformation.

The Hoffren-Larrson (2013) RMB study found that perceptions of caring were foundational to the success of RMB for recipients. A lack of caring from the practitioner resulted in dissatisfaction with RMB (Hoffren-Larrson, 2013). None of the participants in the current study explicitly described a lack of caring from their practitioner, but two descriptions provide negative cases in which there were instances in which RMB did not feel validating. One participant stopped weeping when the practitioner ended the session in a manner that felt abrupt; that individual noted the absence of further weeping in later sessions. That participant also became disinterested in sessions after several suggestions by the practitioner to include activities, such as reading, which were for this participant, beyond the scope of expectations for RMB sessions and were not of interest. Another participant experienced a practitioner ignoring her distress by suggesting that she return for sessions despite increased depression and suicidal thoughts.

Feelings of openness and trust can erode, and the relationship becomes less secure when the practitioner somehow disappoints. This can occur when a boundary is overlooked as described by some participants accounts. The practitioner’s sensitivity to the overall, universal boundaries of the work (such as non-sexual touch) and the unique personal boundaries of the individual is important. For example, some participants found it helpful to be given a focus (such as a word) or recommended activity between sessions; however, such recommendations did not fit some client’s expectations. This is an example of the uniquely individual aspects of interpersonal boundaries to which the practitioner must attune. Another disappointment was when a practitioner was unable to respond to transference issues that arose in session; the
participant understood this limitation as the practitioner was not trained in psychotherapy but would have appreciated if the practitioner had been able to respond at this level of interpersonal work.

In the “intimate” activity of RMB, it was particularly important to these participants that boundaries between themselves and the practitioner feel safe, demonstrating respect for the person receiving the work. Overall, participants appreciated the way that practitioners offered attention and touched in a non-invasive manner. For example, one participant noted that the practitioner did not invade her limit when the practitioner was “barking up the wrong tree”. Participants noted that their practitioners followed rather than led them; this was important to them. Maintaining these interpersonal boundaries continues to build safety, trust, and openness.

These participants stated that RMB is not for everyone. Those who come for multiple sessions of RMB need to have or to develop enough resilience to tolerate the interpersonal intimacy of being seen by another as well as the intrapersonal capacity to witness themselves and accept their experience. Without the trusted relationship with the practitioner, the process would be foreshortened, and the recipient would likely not return. As noted by Green, those with secure-enough attachment may find sessions easier to tolerate while those with insecure attachment may find it difficult to gain from RMB. That said, the data suggest that capacities for attachment change over the course of receiving RMB as suggested by previous research (Bernard, 2014) and theoretical literature (Green, 2016).

**Intrapersonal Processes Within the Participant.**

Participants described changes in their relationship with aspects of themselves, such as their body-mind connection, their felt-sense of their body-mind experience, and their relationship
to themselves. They described an embodied experience in which they felt “at home in my skin”. They appeared to learn interoceptive capabilities.

Interoception includes awareness of one’s embodied experiences and internal responses to the world. It is essential for development of a sense of self and integral to navigating one’s relationship with the world (Siegel, 2010; Porges, 2011). For these participants, the relationship to self was deepened as they became more aware of their embodied experience. Participants described increased ability to sense bodily and emotional experiences within themselves suggesting that their interoceptive capacities increased over time. As Ogden notes, the capacity for interoception can be increased with activities such as self-touch or movement (2006). It follows that it may also be increased by touch from another, in a bodywork setting.

Several participants described difficulty feeling their muscle tension and/or difficulty identifying emotions. They were not attuned to sensing these sensations from within the body, suggesting gaps in interoceptive capacity (Porges, 2011). Over the course of RMB sessions, participants became more aware of subtle bodily sensations. It seems that their capacity for interoception increased over the course of sessions. Touch seems to have played an important role in their development of interoception capacities.

The RMB training of practitioners involves detailed training in the nuances of touch and how it makes contact with the tensions held in tissues. In contrast, these participants most noticed the quality of the touch and the attitude that it conveyed to them, such as kindness or non-judgment. Rather than focusing on the breath or touch per se, they were captivated by the experiences within, engendered by the touch. Although participants observed the emotional and attitudinal qualities of the RMB touch, few could describe the mechanics of the touch (except for a bodyworker who described the touch in more detail). When asked how the touch felt, some
participants seemed unable to recall much about the touch itself; instead, they noticed what emerged for them when touched - their thoughts, images, memories and emotions, sense of the practitioner, or their sense of interpersonal relationship with the practitioner. Participants’ experiences of touch fit with the theoretical understanding of RMB as working with the unconscious. Touch and words are not meant to stimulate cognitive activity but rather to awaken a felt-sense of the holding and relaxing within the body-mind (Rosen and Brenner, 2003; Wooten, 1995). The RMB touch is intended to be non-invasive and is given in a skillful manner in order to bring the recipient’s awareness to the internal experience their body and all that may be associated with the area being touched in terms of thoughts, sensations, and emotions. RMB touch fulfills its intended purpose if the recipient is less aware of it than of his or her inner experience.

For practitioners, breathing is central to RMB. Breathing is a spontaneous, autonomic activity and it is also volitional, coming under limited conscious control. RMB theory and training focuses around the breath – the unconscious, uncontrolled breath. Rosen Method Bodywork theory views the spontaneous, unregulated breath as a reflection of the embodied experience (Green, 2016; Rosen & Brenner, 2003; Wooten, 1995). The practitioner observes changes in the spontaneous pattern of the breath. These changes signal changes elsewhere, such as in thoughts or emotional states. As reflected in participant responses, the recipient of RMB may not be aware of the breath so much as of the other internal experiences, such as thought or memory. Some of these participants learned to be observers of their breathing and to sense when it let go more deeply. Others felt largely unaware of their breathing, except for habits such as sometimes holding their breath. These data fit with the theoretical framework of RMB in which the practitioner observes the “unconscious breath” rather than intentional or controlled breathing,
and the touch is intended to be reflective enough to closely track the recipient’s body while allowing body to be unencumbered by manual directives.

Important outcomes of the RMB experience for many of these participants were the capacity to be kinder to themselves than previously and their ability to be open to new perspectives. Their descriptions suggest that the embodied, felt-experience of receiving kindness in sessions grew their capacity for kindness toward themselves. Apparently, they learned self-compassion on an experiential, rather than cognitive level, and this increased their capacity. Participants noted that as they relaxed, physical tensions eased and rigidity in thinking loosened; they were more open to shifting their perspective and seeing things in a new way. These experiences may be understood in part by reflecting on the nature of perception. As Porges and Siegel each describe, if the body and mind are guarded and tense, a neutral gesture by someone else may be interpreted as a threat. In a state of autonomic relaxation, the gesture may be accepted as neutral or even positive. (Porges, 2011; Siegel, 2010). On the RMB table, in the safety and relaxation of the session, a fresh perspective on a stressful life circumstance may be possible.

Participants shared that not only did they connect deeply with themselves, but they experienced transpersonal experiences that were spiritual to them. This finding is in keeping with previous research that correlated use of CAM with spirituality (Thomson etc, 2014). Sometimes with coaching from their practitioners, they lingered in these positive, connecting, and spiritual feelings. Like lingering in meditation and loving kindness, these moments presumably change the brain through neuroplasticity and make returning to this state more possible (Siegel (2014; Porges, 2011) outside of sessions.
In summary, RMB deepened these participants’ relationships with themselves and with others. Within themselves it seems that RMB was a vehicle for developing interoception which is a necessary part of knowing oneself. Interpersonally, RMB provided positive interpersonal experiences which may have been corrective for some participants and may have altered their capacities for attachment. These participants noted that their capacity for compassion and kindness for self and others grew through their RMB. For these participants, it seems that RMB was a vehicle for developing interoception which is a necessary part of becoming aware of oneself, in the moment. Increased interoception is an ingredient in mindfulness. The following discussion focuses on RMB and mindfulness, including how RMB may be a useful tool for developing mindfulness skills.

**RMB and Mindfulness**

In keeping with the inductive practice of exploring what occurs for recipients without biasing them with the researcher's assumptions, the participants were not asked about “mindfulness”. Of the 20 participants interviewed, only one used “mindful” when describing the attentive awareness that she and the practitioner brought to sessions, and yet their accounts are full of examples of mindfulness attributes. In addition, the descriptions of their experiences reflect mindfulness throughout the RMB process.

Participants described the RMB experience as non-judgmental. They noted the absence of an imposed agenda; they observed how touch and words were used to guide their attention back to their experience in the moment. They described the acceptance they felt from their practitioners and their own growing self-acceptance. The practitioner coached them to stay present and listen to the moment-by-moment experience without judgment. Participants likened RMB to a meditative experience. Their descriptions fit with descriptions of mindfulness in the
literature. During the phase of Connecting, participants described transcendent and spiritual experiences of simply being, in profound peace. They likened these experiences to meditation, and they voiced either wanting to stay in this state or to be able to return at will. They described attaining a mindful state of awareness.

Comparing their RMB accounts with the definition of mindfulness offered by Kabat-Zinn (1990), participants practiced being present, in the moment, with the support of the practitioner whose gentle and sometimes reassuring touch helped them stay within their window of tolerance, and thus stay present. They engaged in the process in a particular way. This attention to witnessing experience was done on purpose and was approached non-judgmentally as they recognized and released internal judgments, as modeled by the practitioner.

Referencing Bishop’s operational definition of mindfulness, RMB qualifies as a mindfulness activity. It is a process involving sustained attention facilitated by the practitioner. Working closely with the practitioner, the participant learns to volitionally switch attention. For example, participants described becoming aware of how they talked from their head; they learned through the tactile and verbal cueing of their practitioners how to switch their attention to their embodied experience, feeling what was occurring in the body in the moment, and thereby inhibiting elaborative processing. The RMB process occurs in an atmosphere of curiosity, openness, and acceptance, created in part by the practitioner.

Participants described how their RMB practitioners approached them with unconditional willingness to be with their experience, without seeking to control or direct it. In turn, this influenced how the participants related to their own experiences. In addition to reflecting participants’ experiences, practitioners sometimes suggested different perspectives; this behavior may be viewed as cueing a shift in attention from one perspective to a possible other, and to
being open and curious about another view. These participants observed changes in themselves over time – changes that occurred not because they prescribed themselves goals to meet, but because the dialectical tension between acceptance and transformation was held lightly in the hands of their practitioners.

The descriptions by these participants affirm the relationship between RMB and mindfulness found in the RMB literature. This is not surprising because the authors of RMB theoretical literature have also received RMB extensively and have first-hand experience of being guided in this mindfulness process. In addition, most RMB authors have experience with meditation.

**Mindfulness, RMB and Psychotherapy.**

Mindfulness is an accepted element in modern psychotherapy. If RMB facilitates mindfulness, and if RMB helps recipients tolerate, explore and transform emotional experiences, then RMB would seem to be useful tool for psychotherapy. RMB coaches the recipient to approach themselves with compassion and may be helpful for persons who avoid their painful, difficult emotions or for whom these emotions evoke overwhelming anxiety. RMB seems to provide safety and reassurance needed to tolerate distress, helpful ingredients for psychotherapy. In their RMB, these participants learned to attend to sensations they had previously not noticed, to distinguish between talking from the head and from speaking from the embodied experience, and they learned to observe rather than react to internal phenomena (such as emotions). These outcomes align with common psychotherapeutic goals.

The role of the RMB practitioner has similarities to a teacher of meditation or the guidance of a mindfulness-based psychotherapist. Tara Brach, mindfulness and Buddhist meditation teacher and clinical psychologist, describes the therapist or meditation teacher as a
mindful container for the recipient’s experiences (Kory, 2018). Brach acknowledges that meditation brings people closer to their internal experience. As meditators open to their interoceptive experiences, they can move closer to encountering past experiences that they have pushed down and out of their awareness. As they move closer, they risk becoming overwhelmed. According to Brach, the meditation teacher or mindfulness-based therapist provides a stabilizing, caring force that helps create safety so that the meditation student can continue to be open to their experience at their own pace, rather than shutting down or becoming overwhelmed. The student can move closer to the difficult remembered experience and move away, as needed, to manage the degree of stimulation and exposure to the material. According to Brach, without the company of a teacher, or therapist, the temptation can be to either continue into the overwhelm and be retraumatized or to back away and resist the pain, leaving the experience dormant and leaving the defenses against it intact.

In the case of RMB as described by the participants in this study, the practitioner holds the space for the recipient’s experiences. This container reduced participants’ distress and paired the difficult exploration with experiences of being cared for, which they say enabled them to stay with the distress and to come through the experience having “let it go”. Participants also described a known RMB intervention of gently encouraging recipients to open their eyes to reorient to the safety of the present (Green, 2016).

**Mindfulness and compassion.**

Mindfulness is an important element of self-compassion (Neff, 2003b). According to Neff, self-compassion involves three ingredients: kindness, mindfulness, and a sense of shared humanity (not being alone in suffering). Each of these ingredients is described in the accounts of these RMB participants. Self-compassion has positive influences on relationships and it can be
taught and learned (Neff & Beretvas, 2012; Neff and Germer, 2012). Several RMB participants reported that they became more self-compassionate over the course of receiving RMB and that they had compassion for others as well as improved relationships in their lives. Two participants voiced increased hope for their future relationships, based on their RMB experiences. These findings fit with the research on compassion and they suggest that RMB may be a process whereby recipients can develop mindfulness and self-compassion, and perhaps improve relationships.

In summary, participants’ descriptions indicate that mindfulness is a key element throughout the RMB process. The practitioner brings attention, curiosity, openness, and non-judgment to the encounter with the participant. The participant is similarly curious and open and willing to explore themselves. Self-judgments are tempered by the awareness that the practitioner is welcoming and non-judging. Over time, the participant learns to embody openness to his or her experience, transforming avoidance, overwhelm, or judgment into mindful awareness, kindness, acceptance, and compassion.

RMB and Trauma Recovery

The interview questions for this study did not ask about trauma. Participants initiated the topic of trauma and volunteered that they view RMB as helpful for trauma. Some participants in this study sought RMB in part for recovery from trauma. Some were aware of past difficult experiences but had not anticipated revisiting them in RMB. In a qualitative study on trauma and RMB, Bernard observed that RMB clients sometimes did not realize their stress or symptoms (physical or psychological) were related to past trauma. Instead, they felt that “something is missing or needs to change” (Bernard, 2016, p. 26). For the participants in the current study, facing the pain of traumatic memories and feeling those experiences in the body
was difficult. Participants came to RMB curious about themselves and feeling stuck. They wanted assistance in teasing apart their experiences and integrating them.

Participants described appreciating aspects of RMB in their recovery from trauma. They were reassured by the kind presence of the practitioner that provided safety. The practitioners helped them feel themselves better – feel and take in their experience of the moment more fully, including building awareness of positive experiences. When exploring traumatic memories and distress, participants appreciated that the practitioner assisted them in accessing the painful material more fully than usual. The practitioner re-oriented them to the present experience of safety when distressing recollections became vivid and threatened their orientation to the present. Each of these are important elements in successful processing of trauma (Ogden, 2006). They viewed the practitioner as a guide and an expert at helping them.

Avoidance of traumatic memories is a coping strategy, but avoidance also impedes function by reducing awareness of the present (Levine, 2010; Ogden, 2006; Porges, 2010). Mechanisms of avoidance include the narrowing of interoception which shrinks the traumatized individual’s perception. Unfortunately, this narrowing of perception also reduces function by limiting perception and by preventing integration of full experience (Ogden, 2006; Siegel, 2010). These participants appreciated how RMB helped them move from avoidance toward feeling their experiences. In a given moment of a RMB session, the safety created by the practitioner appears to render a widening effect on the recipient’s window of tolerance. This seems to help the recipient expand their awareness of the distress while keeping the experience within the window of tolerance.

Participants described how RMB began to expand the detail and breadth of their sensations and inner experience; their interoceptive capacities grew. Developing increased
interoception and integrating it, leads to an ability to intervene in previously reactive behaviors and in the healing of traumatic responses (Ogden, 2006). As RMB sessions increased their interoceptive abilities, participants gained control of their responses. For example, as one RMB participant became more aware of his interoceptive experience of anger (including the associated thoughts, sensations, memories, and images), he learned to recognize internal precursors to his previously habitual outbursts. He learned to feel the emotions beneath the anger and to empathize with them. He observed increased kindness and compassion for himself and for others. Participants learned how to witness their memories with less reactivity, thereby integrating them.

Building interoception is facilitated with touch. As found in this study, RMB amplifies bodily experience. Ogden utilizes this effect of touch in trauma work when she has clients touch themselves or do simple movements to increase interoception (2006). While some individuals in recovery may not tolerate touch from another person, participants in this study found touch tolerable, reassuring, and at times, needed.

Blending top-down awareness with bottom-up experience helps integration and expansion of the window of tolerance (Ogden, 2006). These participants described how their practitioner’s touch mirrored and highlighted their inner sensations. The reflective words of the practitioner were few. As postulated in RMB literature, this brevity of verbal stimulation seems to assist deepened awareness of the inner felt-experience while minimizing cognitive engagement. The few and selected words of the practitioner also engage the top-down neural systems in witnessing the inner experience. When the practitioner, orients the participant to the here-and-now by asking them to open eyes or with reminders that what is being remembered is
in the past and not happening now, the top-down faculties are also engaged, aiding integration of the previously-resisted material (Ogden, 2006).

Building capacities for experiencing positive interoceptive experiences and positive experiences of safety is an early step in trauma recovery (Levine, 2010). As described by these participants, building interoceptive capacities is aided by the practitioner’s coaching to feel pleasant feelings of safety, reassurance, and comfort. Without awareness of these safety reminders, accessing traumatic material could be overwhelming. Recipients are given time in sessions to savor these sensations. Experiencing positive sensations in this slow manner is a building block for developing the capacity to witness and accept positive experiences and provides hope for managing less pleasant feelings. This process of tuning in helps in both accepting feelings and recognizing positive feelings.

Participants described accessing peaceful feelings with RMB. They gained access to a felt sense of inner strength, confidence, peacefulness, self-compassion and trust of both themselves and others. As noted by Fogel (2009), spiritual experiences may have a role in trauma recovery. Several of these participants described the spiritual aspect of their RMB experiences, which may contribute to their recovery. These benefits contrast to their wounds from trauma. They are building positive experiences which give them further strength to continue recovery as well as to move forward in life.

According to Levine (2010), oscillating between the pleasant, safe feelings and the unsettling, threatened feelings is important step in recovery. RMB provides this through touch that is both reassuring and comforting while also stimulating awareness of physical and psychological holding. The RMB recipient attends to the gentle, soothing sensation of the touch while also noticing the discomfort within, as a trauma-related sensation arises. The shifting back
and forth between these contrasting experiences seems to build tolerance through gradual exposure.

Trauma-related reactions are not in conscious control and often have no words (Green, 2016; Levine, 2010; Salibian, 2015). The ability to self-regulate within the window of tolerable experience, as well as the ability to regulate while in relationship with another, are skills that develop initially without words (Ogden; Siegel). The rich inner experiences of interoception are largely without words. RMB uses few words. Participants appreciated the focus on their felt-experience rather than complex verbalizations that might obscure their insight about their feelings. They described how their experiences were hard to put to words, and how powerful it was for them to feel them fully. As one put it, “the things that I’m curious about for me are largely nonverbal and preverbal.” They did not feel the need to verbalize experience in detail. They felt the need to feel it, live through it, and witness it in the safety of relationship with their practitioner; then they could “let it go”. These accounts further suggest the value of RMB in trauma recovery.

Recovery from trauma involves coming to recognize how the constellation of trauma-related sensations and emotions can become triggered by present-time events that are not threatening. This recognition is a top-down processing that aids integration of the traumatic experience. In RMB sessions, the surroundings are quiet and minimally stimulating. The touch is gentle, slow, and often with little movement. The helpful aspect of the slowness of sessions was highlighted in a previous RMB study (Bernard, 2016). In the case of revisiting traumatic experiences, RMB seems to allow time to slow down. This may help recipients distinguish if something is threatening or if they are indeed safe now. Slow attention to the interoceptive
experience would also allow one to tune in to the subtle, somatic sensations that precede hyper- or hypo-arousal.

In RMB, the fearful memories of trauma are met, with the practitioner’s attunement and resonance, in a delicate balance of staying present to distress while bringing gentle, grounding touch - a tactile reminder of safety and acceptance. The neural pathways for the memory become reorganized. This process not only brings the intolerable memory within the window of tolerance, but it assists in changing the memory through new associations. (Salibian, 2015). This change in the memory and its effect may be part of what Marion Rosen meant when she wrote that RMB opens one up to new possibilities and leads to transformation (Rosen & Brenner, 2003). A possible mechanism for this transformation may be found in the relationship between explicit (conceptual) and implicit (sensation-based experiences) memory, and mindfulness. Mindfulness attends to the interoceptive, moment-by-moment experience which is related to implicit memory formation (Siegel, 2010). Mindfulness of a distressing memory without conceptual elaboration, may allow room for new appraisals (Farb, 2010). In RMB sessions, mindfulness to distressful memories, while simultaneously sensing safety and comfort, may alter the traumatic memory (Salibian, 2015).

In her article on RMB and trauma recovery, Salibian quotes a RMB client’s observation that RMB may or may not fit the individual’s needs: “Some people need solvent, and some need glue.” (Salibian, 2015, p7). While RMB seems to have the beneficial influences on trauma recovery as described above, the unique needs of the individual determine whether RMB is helpful or whether a different therapeutic intervention would be indicated.

Several participants value the complementary relationship between RMB and psychotherapy in their recovery. Green describes this relationship as: RMB facilitates bringing
experiences to awareness, while psychotherapy facilitates bringing the awareness into words (Green, 2016). It makes sense that RMB be given serious consideration in the treatment of trauma, in conjunction with psychotherapy, and that further research be done.

In summary, participants found RMB helpful in their own trauma recovery or they imagined it would be helpful to others with trauma experience. As Daniel Siegel writes, we are relational - the mind is relational. We are not really separate from one another. When participants recalled what they learned in a session, they also reflected on the role that the practitioner played in that moment of learning and they often reflected on their relationship with the practitioner. For example, when a participant said she has become kinder to herself through her RMB experiences, she recalled how her practitioner was part of that learning; she carried the memory of that relationship with her beyond sessions. The accounts of these participants describe processes found in the literature on trauma, and their accounts echoed those of another study on RMB (Bernard, 2014). As anticipated from the literature, and like the findings of the Barnard study, these participants experienced reduced physical pain, anxiety and depression, and improved abilities to relax and to recognize and feel safe with emotions. They observed relief from symptoms associated with trauma. They noticed changes in their relationships with others, greater acceptance and confidence within themselves, and a deepening of their spiritual experience.

**Implications for Clinicians in Psychotherapy and for RMB Practitioners**

In this study, RMB was helpful with experiences of physical pain including chronic intermittent pain. It helped the participants cope with stress and associated physical and psychological symptoms. It was helpful to them in the face of depression and anxiety. Given these findings, RMB may be a useful component in treatment of these conditions.
Participants reported that RMB is helpful for issues involving the emotions and for resolving trauma. Since emotions are felt in the body, it makes sense that a body-based therapy can assist with ways of relating with emotions. Participants said that the combination of words and touch is a powerful way for them to access their wholistic, body-mind experience. Since trauma is a body-mind experience, RMB may play an important role in treatment of trauma recovery.

Mindfulness is taught in individual and group psychotherapy using verbal instruction and facilitated practice. Ideally in clinical practice, mindfulness training approaches are varied in response to patient preferences and tolerances. For example, some patients become anxious when instructed to attend to their breathing but can tolerate walking meditation or observing an object (Germer, Siegel, & Fulton, 2005). RMB appears to be a potential tool to facilitate mindfulness training for individuals whose learning preferences include a touch modality.

The advanced practice psychiatric mental health nurse (APRN) role includes psychotherapy. Common psychotherapy goals include educating patients about relaxation, working with mood and thoughts, and gaining insight (Tusaie & Fitzpatrick, 2013). Additional goals are self-awareness, self-soothing, acceptance, awareness of patterns of behavior, and coping with and recovering from distress (Linehan, 2014). The findings from this study indicate that RMB facilitates these goals. The provision of RMB is consistent and appropriate for mental health nursing as a potential tool for assisting patients in this learning process.

Training for RMB has traditionally recommended against working with individuals experiencing suicidal thoughts (Green, 2016; Rosen Institute, 2017); it does not prepare the practitioner to work with such symptoms. This study reinforces theoretical and clinical knowledge within RMB literature that recognizes the potentially helpful role of RMB for
individuals with low suicidal risk, when precautions are taken (Green, 2016). It also clarifies the fact that for some persons in psychological distress, the work may be decompensating. Ideally, concurrent psychotherapy would both support integration of learnings from RMB and allow for monitoring and responding to suicidal thoughts – functions outside the expected purview of a RMB practitioner without psychiatric training.

Traditionally RMB is not recommended for individuals using substances in an addictive manner. However, because RMB seems to be a mindfulness coaching process, and since mindfulness training is part of some recovery programs, RMB may have a place in the overall process of recovery, presumably when sobriety is established.

Based on this study, some considerations for RMB practitioners include:

- Recipients may experience distress if they lack a cognitive context for their experiences. Consider closely tracking a client’s comfort with the process, validating the desire to understand and providing context for their experiences, to the degree requested. For individuals needing cognitive processing of their RMB experience, or experiencing overwhelm or suicidal ideation, consider requiring concurrent talk therapy.

- Consider additional professional education in trauma recovery and interpersonal dynamics in therapy to gain a broader understanding of topics such as transference and countertransference. Resources include articles in the Rosen Method International Journal and elsewhere on working with trauma.

- The meaning of the practitioner-recipient connection can be profound, and recipients can go through phases of significant dependence. Finding inner and external resources for practitioner support (peer support or supervision) can be helpful in maintaining a stable,
compassionate container as well as in evaluating the need for additional resources for clients, such as therapy.

- Recipients may feel embarrassed by their vulnerability in sessions. They may have concerns about being a burden to the practitioner. They may or may not be able to verbalize these experiences or may seek reassurance that the practitioner is able to stay with them and not abandon them.

- Recipients with a trauma history may experience dissociation and may experience the practitioner as hurting them. Working closely and frequently checking with the recipient about how the touch is sensed or preferred may help reduce distress and empower the individual.

**Limitations**

These participants self-selected in several ways. They represent a population of individuals who were willing to receive at least five RMB sessions. As indicated by participants, RMB does not appeal to everyone. Some people who try RMB may not return (Bernard, 2016). Findings from this study may be applied to the population of individuals who choose to receive multiple sessions. Self-selection in the study includes those recipients of RMB who were willing and able to be interviewed online.

Unfortunately, this study does not give voice to those individuals who tried RMB and chose not to return. This sample drew from practitioners’ client bases. It is likely that practitioners selected individuals they believed would be willing and able to describe their experience. It is likely that the self-selection of participants yielded more positive clients than those who felt more ambivalent. Although participants were not identified to practitioners, participants may have felt their practitioners would recognize some of their comments; this may
have influenced their accounts. Recipients who had more fondness for their practitioners may have been more motivated to participate than those with less connected feelings.

Due to the logistical constraints of the study, participants were limited to those with online interviewing capability. All participants had to have adequate internet capacity and ability to access Skype or Facetime. Regrettably, individuals who were not able or did not wish to do online interviewing were excluded.

Qualitative research methods, as compared with quantitative research methods, have the benefit of most closely reflecting the human nuances of meaning in the data. Even with this advantage, the analysis process of coding and categorizing is inherently dissecting; it removes the data from its greater context. Many comments, when extracted because they fit in one category, lose their greater meaning when removed from context.

**Future Research**

Although the European psychotherapy field recognizes body-based psychotherapies, the United States lags in integrating somatic approaches, including touch approaches, into psychotherapy (Marlock, Weiss, Young, C. & Soth, 2015). According to NCCIH (2018e), touch therapies are not listed among the mind-body practices studied for depression treatment. There is a need for research on hands-on therapies for depression. Several participants described the benefits of RMB on their mood and anxiety. Research on RMB as an intervention for depression and anxiety is warranted.

Mindfulness appears to be a central part of the RMB experience. Since participants appear to be developing mindfulness capacities through RMB, it would be reasonable to hypothesize that RMB might be a useful teaching tool in individualized mindfulness training. Rather than relying on verbal cues for instruction, RMB would add a dimension of tactile aid to
the process. As a mindfulness intervention, RMB may be useful as part of psychotherapy. Intervention studies measuring mindfulness outcomes would help identify the capacity of RMB to facilitate mindfulness training. Mixed methods research could combine qualitative data on outcomes with qualitative data to enrich the meaning of outcome measures. Prospective research on RMB could explore how many sessions are needed to develop an embodied awareness, a key to identifying inner experiences as well as central to developing mindfulness skills.

Given the apparent usefulness of RMB for trauma, as noted by these participants as well as those the Bernard study (2016), research on RMB in trauma recovery is indicated. Studies measuring symptom change could demonstrate outcomes when RMB is included within trauma recovery programs. Case studies of individuals receiving RMB and psychotherapy might explore the dynamic between these two disciplines, including whether and how a psychotherapist trained in RMB might provide these two typically distinct functions. Future research might explore how RMB may be used in phases of addiction recovery in programs utilizing mindfulness training for recovery.

Outcomes of RMB may be studied with measures of compassion and relational satisfaction. Quantitative measures of attachment style changes combined with qualitative data would help to demonstrate if and how RMB may assist individuals in developing secure attachment. Future studies could identify which kind of individual would be most receptive to RMB and would help to establish the safety, efficacy, and appropriate application of RMB for specific applications.

Findings from this study indicate that RMB helped alleviate both physical and psychological pain. This information is important for advanced practice nurses who may subsequently include RMB treatment in their practice or may refer to practitioners.
As noted above, research is inherently dissecting; it removes the data from its greater context, losing some of the meaning contained in the integral wholeness of the raw data. This researcher observed that within a single transcript, the interrelationship between the concepts stands out more clearly than when analysis included input from all the participants or when an individual transcript was dissected. For this reason, a future, follow-up analysis might focus on single case studies from these transcripts. A case study approach, perhaps using this model as a framework, could explore one individual’s experiences in greater depth and might provide a deeper reflection on the usefulness of the model as well as its integrative nature.
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Appendix A

Kent State University Institutional Review Board Approval Letter

From: "Holbrook, Victoria" <vholbroo@kent.edu> on behalf of RAGS Research Compliance <researchcompliance@kent.edu>
Date: Tuesday, May 10, 2016 at 10:17 AM
To: Barb Drew <bdrew@kent.edu>
Cc: Susanna Smart <ssmart1@kent.edu>
Subject: IRB approval for protocol #16-251 - retain this email for your records

RE: IRB # 16-251 entitled “Grounded Theory of Rosen Method Bodywork”

Hello,
I am pleased to inform you that the Kent State University Institutional Review Board reviewed and approved your Application for Approval to Use Human Research Participants as a Level II/Expedited, category 7 project. **Approval is effective for a twelve-month period:**

May 9, 2016 through May 8, 2017

*If applicable, a copy of the IRB approved consent form is attached to this email. This “stamped” copy is the consent form that you must use for your research participants. It is important for you to also keep an unstamped text copy (i.e., Microsoft Word version) of your consent form for subsequent submissions.

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB tries to send you annual review reminder notice by email as a courtesy. **However, please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials.** Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date. Visit our website for forms.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact the Office of Research Compliance at Researchcompliance@kent.edu or 330-672-2704 or 330-672-8058.
Appendix B

Diagram of Recruitment Procedure

General email to practitioners to inform of study and encourage their assistance in recruiting potential participants from their clients (Appendix B). Repeated 1-3 emails.

Email script to willing practitioners for informing clients (Appendix C) and send flyer to post or email to clients (Appendix D). Maintain personal contact with practitioners.

Interested potential participants contact Principle Investigator directly or provide allow practitioner to give their phone number and email information to the researcher

Inform potential participants of the study (Appendix E). Initiate Participant Data Form (Appendix F) for new participants.

Email consent form for online interviews and schedule interviews (Appendix H)
Appendix C

Email to Practitioners Introducing Them to the Study

Dear Rosen Method Bodywork Practitioners:

Fortunately, we have several published research studies on Rosen Method Bodywork! Now, with your help, we will have another! This new study will use in-depth interviews of Rosen Method Bodywork clients to identify processes occurring within the client and between the client and practitioner, as experienced from the client’s perspective.

During a Rosen Method Bodywork session, we stand at the table and listen for the client's truth. This study will use the systematic, qualitative method of grounded theory research to listen to the client’s truth. Grounded theory is rooted in the accounts clients and specifically focuses on processes that occur in the work.

Currently, we have books and articles that tell about theoretical aspects of Rosen Method Bodywork as understood by trained Rosen practitioners. This study will explore the accounts of clients. Their accounts may help substantiate what we believe happens in Rosen Method Bodywork and may provide surprising and important new information that will help us understand what happens over the course of time with this remarkable bodywork.

Clients who have had positive experiences may be the first to volunteer to be interviewed, but people who have been dissatisfied at some point would also offer important information.

Interviews will begin in the Summer of 2016. (Due to constraints of my doctoral program, this study is limited to the USA.)

In the next weeks, I will send details about how you can invite your clients to participate in this study of Rosen Method Bodywork. Meanwhile, please consider sending me a quick reply to indicate that you got this message and are interested in hearing more details.

Thank you,
Susanna Smart
Rosen Method Bodywork Practitioner
Doctoral Candidate, Kent State University College of Nursing
330-998-0933 Ssmart1@kent.edu
Appendix D

Script for Practitioners Informing Clients of Study

Research Study: Receiving Rosen Method Bodywork
This study is designed to learn about the processes involved in Rosen Method Bodywork as described by recipients of the bodywork. Hopefully in the future, accumulated research on Rosen Method Bodywork may help health care providers understand how to possibly integrate the bodywork into health care.

This study will explore what happens in Rosen Method Bodywork sessions from the perspective of the clients who have received at least 5 sessions of RMB.

If you agree to participate, you will be interviewed by a nurse researcher who is responsible for this project. She is also a Rosen Method Bodywork practitioner.

Interviews are confidential.

As your practitioner, I will not be informed by the researcher about whether you choose to participate in the study and your decision to participate or not will not influence the care you receive from me as your practitioner.

If participating in this study sounds interesting, please contact Susanna Smart directly (see below) or give me your permission to give her your phone number or email. She will go over any questions and then you can decide if you want to be interviewed.

If you would like me to communicate your interest to Susanna and have her contact you:
Your best telephone number? ________________________________ (time zone)
Email: ______________________________________________________
May Susanna leave a message on an answering machine about the study? Yes No
Participant’s name ________________________________________________
Practitioner (recruiter) name________________________________________

Contact: Susanna Smart, APRN-BC, Rosen Method Bodywork practitioner 330-998-0933
Ssmart1@kent.edu Doctoral Student: College of Nursing, Kent State University
Appendix E

Recruitment Flyer

RESEARCH STUDY ON ROSEN METHOD BODYWORK

HAVE YOU:

- Received 5 or more Rosen Method Bodywork sessions?
- Not taken training in Rosen Method Bodywork beyond the introductory weekend?

Research can help health care providers understand if and how Rosen Method Bodywork might be included in health care. This study will explore what happens in sessions from the client's perspective.

PARTICIPATION INVOLVES:

- **Confidential** interview (approx. 60 minute) via Skype, Face Time, or face-to-face
- $35.00 compensation for participation

Contact:
Susanna Smart, RN, MSN, PhDc, APRN-BC, Rosen Method Practitioner
Doctoral candidate, College of Nursing, Kent State University
(330) 998-0933 or email Ssmart1@kent.edu

This study is reviewed by a University IRB for adherence to ethical standards.
Appendix F

Script - Principle Investigator's Recruitment Script (for Phone or Email) for Participants

Study Name: Grounded Theory of Rosen Method Bodywork

Thank you for your interest in knowing more about this study on Rosen Method Bodywork.

This study is designed to learn about the experiences of recipients in receiving Rosen Method Bodywork. This study will explore what happens in Rosen Method Bodywork sessions from the perspective of the clients who have received at least 5 sessions of RMB. This research study relies upon the feedback from Rosen Method Bodywork clients.

An ultimate goal of this study is to raise awareness of RMB among health care providers and inform their decisions about if and how RMB may be helpful for their patients. If the method is shown to be helpful to people, health care providers may be encouraged to include RMB in their therapeutic treatment for physical and/or emotional health and this may eventually lead to insurance coverage of Rosen Method Bodywork.

I am a nurse researcher and a Rosen Method Bodywork practitioner. I am responsible for this project and will be doing the interviews.

I will interview participants to explore what they experience over the course of time in their relationship with the practitioner and in their relationship with themselves through the bodywork.

Criteria for adult participants:
- At least 5 sessions of Rosen Method Bodywork
- Is able to meet for interview (online)
- English language capability sufficient to give informed consent and engage in interview
- No RMB training beyond the introductory weekend workshop

Interviews will be held online via Skype or Face Time. Interviews will last about an hour and will be recorded to maintain an accurate account of participant experiences. You may also agree to be contacted in the future for other studies on Rosen Method.

Rosen Method Bodywork can help us access our feelings. Talking about the experience of receiving RMB may also put you in touch with feelings. Sometimes, talking about feelings can feel helpful. Sometimes it can be tiring, or it may bring up thoughts or feelings that are distressing. If at any time during the interview you should feel unwanted distress, you would be free to stop the interview, and have the option to reschedule or to stop participating in the study.

It is important to have a quiet and private place to share your experiences. The interview will be held online.
You will receive a $35 compensation for participating in the study as a token of respect for your time. After the interview, there may be follow-up questions for clarification. You may choose at that time whether to respond.

This study is reviewed by a University IRB (Institutional Review Board) for adherence to ethical standards. Interviews are confidential, and data will be protected according to standards of ethical research practice.

Your practitioner will not be informed by me about whether you choose to participate in the study or not so as not to influence what you choose to share and in order to maintain your confidentiality.

Are there any questions that you have that I can answer to help you make your decision about whether to participate in this research study?

Most referrals for this study come from Rosen Method practitioners, but some come from clients who know of other clients. For example, you may know of someone who might like to participate in this study.

Do you think you would be interested in participating in this study? Yes__ No__

Contact: Susanna Smart, APRN-BC, Rosen Method Bodywork practitioner 330-998-0933
Ssmart1@kent.edu  Doctoral Student: College of Nursing, Kent State University
Appendix G
Sample - Informed Consent to Participate in a Research Study

Study Title:  *A Grounded Theory of Rosen Method Bodywork*

**Principal Investigator:** Susanna Smart, PhDC, Barbara Drew PhD, Faculty Advisor

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Your participation is voluntary. Please read this form carefully. It is important that you ask questions and fully understand the research in order to make an informed decision. You will receive a copy of this document to take with you.

**Purpose:**
This study will use grounded theory research methodology to explore the processes involved in Rosen Method Bodywork from the perspective of people who have received at least 5 sessions. If you choose to participate, you will be interviewed about your experiences. As a recipient of Rosen Method Bodywork, you are the authority on your experience of the work. There are no right or wrong responses. Your experiences of what happens for you, both during sessions and between sessions, will contribute to an understanding of what Rosen Method Bodywork is and how it works.

**Procedures**
Using Grounded Theory research methodology, interviews of Rosen Method Bodywork (RMB) recipients who have had a least 5 sessions will be conducted face-to-face interviews or online (Skype or Face Time) for the purposes of constructing a theoretical framework describing the processes involved in RMB over time.

Interviews will last approximately 1 hour. Face-to-face interviews will be held in participant's home, at offices of The Rosen Berkeley Center (see attached letter from Rosen Berkeley Center), or online.

Prior to initiating face-to-face interviews, participants will be compensated (see proposal for details). For online interviews, compensation will be sent by regular mail following the interview.

Data collected: digital audio interviews; email correspondences related to setting up interviews and any comments participants volunteer via email; principle investigator memos; participant data form (age, number of sessions, RMB providers, willingness to be contacted for follow-up questions during data analysis, etc.).

**Audio and Video Recording and Photography**
Participant interviews will be recorded using digital audio recorder which is not linked to the internet. Face-to-face interviews and online (Skype or Face Time) interviews will be recorded. Participant Data Forms will be stored separately from digital interview data and will link the participant's name with a code to de-identify the data.
Digital files will be labeled according to participant code and downloaded to a password-protected Blackboard site where all other digital data, such as transcriptions and ongoing data coding for analysis will also be stored and available only to research team.

Data will be used for purposes of this dissertation and potential articles for publication.

Benefits
The potential benefits of participating in this study may include benefit from reflecting on experiences of Rosen Method bodywork and why you choose to engage in this activity. Your participation in this study will help us to better understand Rosen Method Bodywork and may help health care providers determine whether to use it in their work with patients.

Risks and Discomforts
The interview questions are about your experiences with Rosen Method Bodywork and may touch on personal topics which may cause you embarrassment or stress. You may ask to see the questions before deciding whether or not to participate in the study. You may choose to skip questions if you find them too personal. Sometimes, when remembering one's experiences of discomfort or distress, feelings of discomfort or distress may be triggered. It is important to have support person(s) available to debrief after the interview, in the event that something arises for you that is distressing. The principle investigator will ask if you have a support person with whom you can talk and will provide you resources for counseling assistance at the beginning of the interview.

Privacy and Confidentiality
Your information will be kept confidential. Your Rosen Practitioner will not be informed about whether or not you choose to participate in the study. Your personal information (name, contact information, signed consent form, etc.) will be stored under lock, separately from the interview data. Interview files will be identified by a code number and not by your name, so that the interview data is not linked to you. Interview data will be stored under password protection. Interviews will be held in the privacy of your home or at the Rosen Berkeley Center when other staff are not present or online using Skype or Face Time. Your study related information will be kept confidential within the limits of the law. Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results; only aggregate data will be used. Your research information may, in certain circumstances, be disclosed to the Institutional Review Board (IRB), which oversees research at Kent State University, or to certain federal agencies. Confidentiality may not be maintained if you indicate that you may do harm to yourself or others.

Compensation
Participants will receive $35 compensation for participating in the study.
Voluntary Participation
Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of compensation to which you are otherwise entitled.

Contact Information
If you have any questions or concerns about this research, you may contact Susanna Smart at 330-998-0933 or Barb Drew, Faculty Advisor at 330-672-8821. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at 330.672.2704.

Consent Statement and Signature
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

If

Participant Signature ___________________________ Date ___________________________
Appendix H
Participant Data Form

This form is stored separately from the interview data to de-identify the data.

Name: __________________________ Study Code #: __________________

Date of initial contact: __________ Practitioner (recruiter): _________________________

Date that informed consent form was signed: ____________

Date of birth: Age in years: _____

Gender: ___ Ethnicity: ______ Level of Education in years: __________________________

Other wellness practices experienced (bodywork, meditation, etc.):
_____________________________________________________________________________

Contact information:

Phone: __________________________

Email: __________________________

Emergency contact (name & phone): ________________________________

Previous Rosen Method Bodywork: # of sessions ________

Date of first RMB session: ________ Date of most recent RMB session: ________

Practitioner name(s) ______________________________________________________

Any training in RMB: ______________________________________________________

Location of planned interview: __________ Date of planned interview: __________

Actual location and date of interview: _________________________________________

Compensation given: ______________________________________________________

Willing to be contacted again: _____Y _______ N Date contacted again: ___________

Notes:
Appendix I
Interview Guide
(Interview Guide (original), Day of Interview-Script and Details, and Modified Interview Guide)

Day of Interview-Script and Details

Environment and Supplies:
- Ensure appropriate lighting, two chairs and flat surface (for signing consent), copy of flyer for the study (for reference), tissue box
- Ensure privacy during interview, i.e. sign for door indicating “Session in Progress – Please do not disturb”
- Blank consent forms and pens.
- Participant Data Form with coding # for participant: preselected
- Water for refreshment
- Access to bathroom

Orientation Script for Day of Interview:
Thank you for your willingness to share about your experiences of receiving Rosen Method Bodywork. Your contribution will help build an understanding of what occurs in sessions, within the person receiving as well as between the receiver and the recipient.
This kind of study views you as the authority on your experience. There are no right or wrong responses. What matters most is that your answer reflects your experience.
Your interview is kept confidential and safe-guarded according to the ethical and legal standards for research in the U.S.A.
Please read the consent form which includes permission to audiotape the interview. If you agree, please sign the form. Please let me know if you have any questions or concerns. When you are ready, we will begin the interview.
Hand the participant the form, retrieve it, and place it with interviewer’s materials (to ensure not leaving it at the interview site).

Procedure for interviews:
Thank the participant
Ensure informed consent – obtained prior to interview. Obtain a signed copy for face-to-face interviews. Receive an email copy for online interviews. Provide a copy of the consent form to the participant.
Provide compensation at start of interview.
Complete Participant Data Form
Provide support resources and ensure participant has support person, if needed.
Offer contact information if participant has further information to share post interview

After Interview
Record memo and field notes immediately
Arrange with team member to debrief after interview
Back up data. Store original data and back-up copy of electronic data in locked closet and secure, password-protected internet location.
Locked storage of coded data is kept separate from locked storage of coding identifiers of participants.
Transcription by interviewer within 48 hours of interview.
Preparatory statements for the interview: Audio taping so I am able to really listen to you...hear things in your own words. Questions are a guide for us. Feel free to talk about other things that I don't ask. Any time you want to stop or pause the interview, let me know and we can do that. I wonder if you would start by sharing about what made you want to do this interview?

Grand Question: Tell me about... Tell me about a specific time when…
The first time you experienced Rosen Method Bodywork.

Describing the RMB experience: What is a RMB session? ...what happens? What motivates you to get sessions? Is there something you expect during a session? How would you describe the touch? ... the talking?

Experience with practitioner(s): How it is for you to work with your practitioner.
If you have received from other practitioners; what are some differences?
Tell about a time when your practitioner did something helpful, unhelpful
How do you communicate needs during a session? …tell about a time when you needed something during the session.

Within yourself: What happens inside you during a session? Would you share an example? Helpful? Unhelpful?

Best, Worst, "ideal" session: Please tell me something about the "best session" you experienced. What happens in a session?

Distress in session: Tell about a time when something was difficult, like painful thoughts, emotions or body sensations, how did you respond? How did your practitioner respond?
If someone were going to receive a RMB session for the first time, what would you tell them?

Between sessions: Do sessions influence you in your life between sessions?

Differences from other experiences: How is RMB different or similar to other bodywork, yoga, massage, meditation, psychotherapy?

Change that has occurred: Tell me about any changes you’ve noticed in yourself since doing RMB. Example?

Open question: How has this discussion been for you? Is there anything else that I haven't asked that I should know about...you would like to share?
Modified Interview Guide

Preparatory statements for the interview: Audio taping so I am able to really listen to you… hear things in your own words. Questions are a guide for us. Feel free to talk about other things that I don't ask. Any time you want to stop or pause the interview, let me know and we can do that. I wonder if you would start by sharing about what made you want to do this interview?

Grand Tour question (open): What is Rosen Method Bodywork? What is a RMB session? …what happens?
   How would you describe the touch? … the talking?
   Tell me about a specific time when…
   The first time you experienced Rosen Method Bodywork.

Modification added during data collection: It’s possible that people are drawn to Rosen in part because of life experiences. What kinds of background do you think has influenced you to be interested in getting Rosen (to address question about how people might be primed for Rosen)

Describing the RMB experience: What motivates you to get sessions? Is there something you expect during a session?

Experience with practitioner(s): How it is for you to work with your practitioner?
   If you have received from other practitioners, what are some differences?
   Tell about a time when your practitioner did something helpful, unhelpful.
   How do you communicate needs during a session? Tell about a time when you needed something during the session.

Within yourself: What happens inside you during a session? Would you share an example? Helpful? Unhelpful?

Best, worst, "ideal" session: Please tell me something about the "best session" you experienced. What happens in a session? Tell me about the worst session you experienced. What makes an ideal RMB session?

Distress in session: Tell about a time when something was difficult, like painful thoughts, emotions or body sensations. How did you respond? How did your practitioner respond?
   If someone were going to receive a RMB session for the first time, what would you tell them?
   When something is hard, what helps you stay there or how do you go through that? What positive experiences drew you back?

Between sessions: Do sessions influence you in your life between sessions?

Differences from other experiences: How is RMB different of similar to other bodywork: yoga, massage, meditation, psychotherapy?

Change that has occurred: Tell me about any changes you’ve noticed in yourself since doing RMB. Example?

Open question: How has this discussion been for you? Is there anything else that I haven't asked that I should know about... you would like to share?

If they mention spiritual: what do they mean by spiritual? What does spiritual mean to them. How do they recognize it?
Appendix J
Demographics of 20 Participants

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Appendix K
Model of the Process of Rosen Method Bodywork

Feeling Stuck & Disconnected
Holding Tension
Feeling Disconnected from Emotions, Self, and Relationships
Being Stuck in Trauma

Being Open & Trusting
Sensing the Practitioner as Caring
Being Listened to
Feeling Comforted and Accepted
Being Open to Uncertainty
Being Ready
Not Being Open or Trusting

Feeling Connected
Connecting to Body, Emotions & Whole Self
Connecting with Others
Connecting Spiritually

Mindfulness
Becoming Aware
Listening to Body
Feeling, Thinking & Embodying
Exploring the Unexpected
Dealing with Discomfort/Distress
Being Present
Exploring After & Between Sessions

Exploring
Relaxing, Releasing, and Letting Go
Feeling Different in Body and Mind
Emotional Learning
Interpersonal Learning
Learning How to Receive RMB
Transforming In & Between Sessions
Transforming Trauma

Learning & Transforming
Priming Experiences:
Appendix L
Interview Mapping Sample

ID: X

**Priming experiences:** value being open; bullied for being different; psychologist has preconceived notions; studied stress, believe antidepressants are not refined tools; have to go through pain in order to shine; no previous bodywork

**Feeling Stuck & Disconnected:** physical tension, panic attacks, holding breathing, body shutting down, body – thing that kept my brain alive, brain on stick, not interested in antidepressant, not believe standard treatment could help

**Being Open & Trusting:** skeptical, value direct evidence, body did things not in my control; it didn’t make sense but I couldn’t deny; not understanding but it works; attracted to online picture of practitioner; practitioner’s balance of letting me lead sessions and session unfolds naturally

**Feeling Connected:** feeling relaxed; now sessions are spiritual technique, what meditation should feel like; want to just be in sessions, not needing verbal as much as in past; brain shuts off; breathing feels so good, like seaweed moving; goal: dissolve ego

**Exploring:** observing body shaking; better for me not to know in advance; maybe scary, but real; extremely tired after session; psychological tension is retained in muscles; touch is gentle and insistent; Practitioner’s questions helped; not analyzing or explaining; not feeling “studied”; early sessions throwing off tension; off sessions when not in my body; take time after sessions to be quiet.

**Learning &Transforming:** able to feel and hear body; recall practitioner’s simple sayings; fascinating things I don’t expect; I don’t want to stop; opening even more; body doing it on its own between sessions; journaling; grounding self between sessions; learning to be gentle, not judging, more compassion

**Antithesis:** talk therapy experience of spinning wheels.
## Appendix

### Snippets for Checking Theory Credibility

#### Feeling Stuck and Disconnected (DC)

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## Snippets for Checking Theory Credibility

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Snippets for Checking Theory Credibility
Learning and Transforming

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<th>Trscept</th>
<th>Relaxing, Releasing, and Letting Go</th>
<th>Feeling Different in Body and Mind</th>
<th>Emotional Learning</th>
<th>Interpersonal Learning</th>
<th>Learning How to Receive RMB</th>
<th>Transforming In &amp; Between Session</th>
<th>Transforming Trauma</th>
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### Snippets for Checking Theory Credibility
### Connecting

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<th>Transcript</th>
<th>Connecting to Body</th>
<th>Connecting to Emotions</th>
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