THE JOURNAL OF ALTERNATIVE AND COMPLEMENTARY MEDICINE
Volume 15, Number 9, 2009, pp. 1–6

DOI: 10.1089/acm.2008.0489

Rosen Method Bodywork: An Exploratory Study of an Uncharted Complementary Therapy

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Abstract

Objectives: This exploratory study examines the Rosen Method Bodywork (RMB), a complementary (CAM) therapy method that previously lacked scientific documentation. The objectives of this study were to describe (1) why clients consult RMB and (2) what kind of help or benefit (if any) the clients perceive.
Methods: The study comprised a survey of 53 Swedish RMB clients sampled from therapists, based on a criterion of personal experience of the therapy method, responding to a questionnaire collecting both qualitative and quantitative data. The quantitative data were analyzed descriptively and the qualitative data were analyzed by applying content analysis.
Results: Reasons to use the therapy method included physical health problems, psychological problems, and a need for personal growth. A majority of the clients reported that the therapy had helped them with their problems to "a very high" or "high" degree. The main finding is five different categories describing the benefits: enhanced psychological health, enhanced physical health, increased awareness of the mind–body connection, support for personal growth, and self-initiated life changes.
Conclusions: Most RMB clients in this study indicated satisfaction with the treatment. The perceived benefits were found to be related to five separate categories. However, the results of this exploratory study cannot be generalized to a target population or to any conclusions about causality, as there is reason to assume that clients with positive experiences were overrepresented in the study population, due to the selection procedure. The results indicate that an analysis focusing on the interaction between client and therapist from a nursing theoretical perspective may increase the knowledge about mechanisms that create perceived benefits, since several aspects of the therapy seem to be related to high-quality nursing.

Introduction

People's interest in complementary and alternative medicine (CAM)[1] has increased in several European and North American countries. A large proportion of the population, 30%–70% depending on country, turn to different CAM therapies to alleviate health problems.[2–7] Clients who consult CAM therapies often declare that they are satisfied with the treatments or even report improvements.[8,9] Few studies, however, have investigated what kind of improvements they perceive or the basis for clients' satisfaction with the treatments.

Rosen Method Bodywork (RMB) is a massage-based CAM therapy method, about which many clients have informally expressed positive treatment effects. It is often described by therapists as a method of "preventive health care" or advertised as a "pleasant relaxation method which can lead to improved self-knowledge." According to The Rosen Institute[10] in the United States, the therapy method is currently practiced in at least 13 countries on three different continents, but to our knowledge has not previously been explored scientifically. The only published study[11] we found indirectly addresses the RMB by focusing on clients' motives to choose a specific CAM therapy. The study shows that clients who use RMB need psychologic support more frequently than do clients who consult practitioners of other manual CAM therapies.

The objective of this study was to describe (1) why clients use RMB and (2) what kind of help or benefit (if any) the

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clients perceive. Such results may serve as a basis for understanding the factors contributing to satisfaction with RMB of relevance for CAM therapies in general.

Rosen Method Bodywork

The therapy method was developed by the German-American physiotherapist Marion Rosen (born in 1914). The fundamental principle behind the treatment is that there is a special connection between the physical body and the mind.[12,13] Bodily problems such as muscle tension are assumed to reflect unresolved emotional problems, suppressed traumatic experiences, or excessive social demands. The treatment focuses on the body, which is seen as a "gate" to reach unconscious emotional causes of muscular tension.[12,13] A typical therapy session is set up in a calm environment and begins with a short conversation, during which the therapist pays particular attention to the client's voice, body posture, and movements. The therapist examines the client's body, looking for areas of unbalances, and initiates the treatment by slowly and gently touching the client's body, applying light pressure on tense areas. In most cases, the touching causes the client to relax deeply. The therapist observes continually subtle changes in muscle tension, shifts in breathing, or other reactions, and responds to every change by touching the client or by responding verbally. During the process, hidden memories or emotions may come to mind, something that is assumed to provide valuable insights and assist the client in understanding the connection between body and mind.[12,13]

According to the Rosen Institute, the training of RMB therapists is structured in a similar way all over the world.[10] It consists of approximately 365 hours of workshops and intensive courses over a period of 3 years or more. The program includes anatomy studies, demonstrations by certified teachers, training sessions under supervision, and sharing experiences with other students. After this basic training, the trainee is required to conduct 350 hours of supervised client sessions, individually and in a group, and take at least 25 treatments themselves before becoming certified by the Rosen Institute in the United States.

Methods

Study design

The design was exploratory and descriptive, using both qualitative and quantitative data from a questionnaire survey on 53 Swedish RMB clients. The questionnaire was developed from two validated questionnaires.[14,15] It was pretested for clarity and comprehension on 10 people of different ages and educational backgrounds, and revised in accordance with their comments, which were few and minor.

The questionnaire contained 20 closed and open questions. A first group of questions covered sociodemographic variables such as education and age, reasons for using the therapy method, and contacts with conventional health care. These questions were answered using fixed response alternatives, usually in combination with one open alternative to be used if none of the given alternatives were suitable. A second group of questions related to attitudes toward RMB and CAM in general, perceived everyday problems they were experiencing and that may have brought them to this therapy method, as well as their assessment of any perceived benefits from RMB. These questions were answered on nonmetric 7-point scales, the response alternatives being "to a very high degree," "to a high degree," "to a fairly high degree," "to a moderate degree," "to some degree," "almost none," and "none/not at all." Finally, the questionnaire contained three open questions with space for the clients to describe perceived benefits, reactions to the treatment in their own words, and to provide additional comments regarding the therapy method. The open question focusing on benefits from the therapy method was answered by those clients who in response to an earlier question had reported being helped by the treatment.

Sampling procedure

There is no formal requirement for Rosen therapists to register or document their treatments and no informal source that defines the population of RMB clients in Sweden. Therefore, a random sample was not possible to obtain. Hence, one feasible way to recruit clients to the study was through therapists, based on a sampling criterion of personal experience of RMB. In 2006, 17 therapists with differing backgrounds in terms of length of experience as therapists, education, sex, and age (Table 1) were contacted. They were purposively selected from a list of approximately 240 members of the Swedish Rosen Therapist Member Association to represent a variation in background and experience and have the potential to be likely to generate a large enough group of clients. The task of the therapists was to provide their clients with written information about the study during a period of approximately 2 months, and to refer the names and phone numbers of those who were interested in participating to the researchers. Most of the therapists worked part-time or offered RMB as one of several CAM therapies. Therefore, the therapist treated only a small number (2–5) of RMB clients per week on average, many of them returning for longer

Table 1. The Therapists' Background and Number of Referred Clients

Sex	*Age*	*Education*	*Experience of RMB as therapist (years)*	*Referred clients*
Female	54	Compulsory school	5	4
Female	65	Compulsory school	>20	8
Male	51	University	2	1
Female	48	University	11	7
Female	61	University	>20	4
Female	59	Upper secondary	12	3
Female	61	Upper secondary	>20	3
Female	38	University	2	5
Male	63	Upper secondary	2	1
Female	72	Upper secondary	17	3
Female	53	University	–	2
Female	49	Upper secondary	–	1
Female	62	University	7	2
Female	63	Upper secondary	15	3
Female	49	Upper secondary	18	7
Female	61	University	5	2
Female	–	University	–	4

RMB, Rosen Method Bodywork.

periods. This means that same client could visit the therapist two to three times during the sampling period. In this way, we made contact with 60 clients (52 women and 8 men).

All 60 clients were informed verbally about the study and it was emphasized that all kinds of experiences and reactions related to the treatment were of interest, whether positive or negative. After the information was given, two clients declined to participate. The remaining 58 clients received a letter including additional information, the questionnaire, and an informed consent form to be signed and sent back to the researchers together with the anonymously answered (coded) questionnaire. Fifty-three (53) clients returned the questionnaire (response rate 88%).

Neither the clients nor the therapists received any financial remuneration for participating. The study was approved by the Regional Ethical Review Board in Stockholm (diary number 2005/1038-31/2).

Data analysis

Data from the questions covering sociodemographic variables, motives, attitudes, and assessments from the therapy were analyzed descriptively. The analysis of reasons for using the therapy method were based both on data from the question with fixed alternatives and from the three open questions, which in many cases contained detailed information that expanded and exemplified the answer to the structured question.

The three open questions asking the clients to describe their perceived experiences of the treatments generated a rich amount of data. In written text, the answers encompassed 7078 words. The data were analyzed by two of the authors (RH-L and BG) on the basis of qualitative content analysis,[16] pursuing the following steps. First, both authors separately read through the transcripts. This first reading provided some overall ideas of how to categorize responses on the issue of perceived help or benefits from the treatment. The second step included several additional readings to mark sentences and words that seemed to match the first tentative categories. The third step included a comparison between the authors' categorizations. The tentative categories were then revised until full agreement about the categories and their subcategories was reached. The categories were labeled by describing themes, and then supporting quotations were chosen from the text. Finally, additional readings and analyses were made until the whole variation of the material was accounted for by the categories and their contents.

Results

Characteristics of the clients

Most of the clients in this study were women, and half of them were married or cohabitating with someone. Professionally, 23% of the clients were conventional caregivers such as nurses and assistant nurses. Other common occupations were office workers such as secretaries and administrators, academics such as assistant professors and Ph.D. students, and technicians. The characteristics of the clients are described more thoroughly in Table 2.

The group with >30 RMB treatments had received therapy regularly for more than 1 year, and in the extreme case (140 sessions), the client reported having used the therapy once a month for 12 years. In addition, the clients reported a high degree of utilization of other CAM therapies. On average, every client had previous experience of five different CAM therapies, RMB not included. The problems that brought the clients to Rosen therapists bothered a majority of them to a very high or high degree. One third of the clients (37%) had seen conventional health care practitioners (mainly psychologists or physicians), either before or in parallel with RMB for the same problems. Those who had also seen a conventional caregiver experienced only "moderate" or "less-than-moderate" levels of help. In contrast, the reported perceived degree of help by RMB was high.

Reasons for using RMB

Most clients reported several reasons for using RMB. In the analysis, these could in be reduced to three main categories of reasons: physical health problems, psychological problems, and a need for personal growth.

The category *physical health problems* included reasons such as "muscle tension" ($n = 18$), "pain" ($n = 18$), and "physical disease" ($n = 10$). The following quotations from the clients' reports exemplify this category.

> The stiffness in my chest made it difficult to find the support and airflow needed when I play the oboe.

> I had migraine once or twice every week.

> I have "Sjögren's syndrome" [a rheumatic disease], which affects my whole body.

The category *psychological problems* included the reasons "stress or burnout" ($n = 19$) and "a need for improved psychological well-being" ($n = 20$) as well as "mental health

Table 2. Sociodemographic Data and Other Characteristics of the Clients

Sex	*Age*	*Education*	*No. of treatments*	*Degree of perceived everyday problems that had brought the client to RMB*	*Degree of perceived benefit/help from RMB*
45 women 8 men	M = 46 Min: 27 Max: 67	65% University 23% Upper secondary 12% Compulsory or vocational training	Min: 1 Max: 140 Mean = 29 Median = 17	Very high (40%) High (23%) Fairly high (27%) Moderate (4%) Some (2%) Almost none (0%) Not at all (4%)	Very high (38%) High (34%) Fairly high (16%) Moderate (10%) Some (0%) Almost none (0%) Not at all (2%)

RMB, Rosen Method Bodywork.

problems" ($n = 8$) such as anxiety, depressive feelings, and suicidal thoughts.

> [I used the therapy] after I got burnt out.
>
> I have used it [RMB] to stop experiencing anxiety.
>
> I have been extremely depressed and tired, and thought about committing suicide.

The category *need for personal growth* was reported by 19 clients and included reasons such as a need to understand oneself better in order to develop or to find new strategies for action.

> [RMB] is a way of getting in contact with oneself, with my body, to go deeper into my innate nature and to get rid of old habits, to raise my level of consciousness.

Perceived benefits

In response to the open questions, 48 clients described how they had been helped by RMB. Only 1 client reported no benefits. No negative effects were described in the answers. In the qualitative analysis of these data, five main categories of perceived benefits were identified.

The first category was labeled as *enhanced psychological health* and included the subcategories "positive emotions" and "mental health improvements." Positive emotions such as increased happiness, feelings of harmony and well-being, as well as improved self-confidence were described by almost all clients. Fourteen (14) clients described mental health improvements such as reduced anxiety ($n = 4$), fewer feelings of moodiness/depression ($n = 7$) and suicidal thoughts ($n = 3$). The category is illustrated by the following representative quotations.

> [I am] happier and have got increased self-confidence and more trust in life.
>
> It has been relaxing, [I am] not so worried anymore.
>
> My thoughts of committing suicide have disappeared almost completely.

The second category, *enhanced physical health*, included subcategories such as "improved bodily function" and "reduced pain." The improved bodily function included reduced tension in muscles ($n = 35$), improved capacity to breathe ($n = 8$), improved intestinal function ($n = 3$), and increased energy ($n = 4$). Reduced pain such as migraine, headache, back pain, and pain in the neck or the muscles were also mentioned by 17 clients:

> After the therapy session, I was able to breathe deeply and fill my lungs with air. This is something I have not been able to do for several years after my accident.
>
> My back pain has disappeared.

The third category, *increased awareness of the mind–body connection,* was mentioned by 26 clients. It included reports of a new awareness of the body but also an understanding of how emotions influence the body. In addition, this increased awareness caused them to direct their attention toward their body, making it easier to identify where their health problems were located.

> My awareness of my body is totally different compared to when I started the therapy. Previously, I was sort of absent-minded, as though I was cut off from my body. Now I have realized how much emotions and things like that are situated in my body.
>
> I do understand better now how I feel and what my body tells me.
>
> I have learned to pay more attention to the tensions that have had an influence on my body. As a result of this awareness, I have learned to relax in different situations in my daily life.

The fourth category, *support for personal growth,* was mentioned by 24 clients. The clients reported that previously repressed painful events, memories, or problems in their social lives became conscious during the therapy. But it is not the experiences of these events itself that constitute the core of this category, but rather the confirming support from the therapist that made them feel safe to relive and process the events.

> Through the massage and the supportive conversation with the therapist, I have started to analyze and reflect upon myself—how I react and experience things.
>
> In the safe and respectful environment, I have gained the courage and support to experience things that I never before dared to "know" that I experienced. It is a great support that someone can stand to be there when I react to feelings that have been forbidden to me.
>
> I am having a divorce. This means that I don't get any "deeper" treatment, but mostly confirmation and support. It is extremely nice and supportive to get this confirmation. I go there [to the Rosen therapist] as a wreck and come out as a new and whole human being.

The fifth category, *self-initiated life changes,* was supported by new insights and knowledge obtained from the therapy. This was reported by 18 clients and includes an increased understanding of suppressed needs and personal behavior in social situations that made it possible to change circumstances that caused problems in their present lives.

> [In the treatment] I realized that my job was not suitable for me. I quit and got a new job, which was much better. I started my own business which suited me perfectly.
>
> My relationships are healthier today because I am no longer attracted to men with addiction problems [to alcohol].
>
> I have a will of my own and I am better at 'elbowing' my way forward. I know more about what I want and what I need and take this more into account.

Discussion

This study investigates a complementary therapy method that to our knowledge has not previously been studied in detail. Even though the objective of this study was not to obtain a representative sample, the recruited clients' sociodemographic characteristics correspond to what has been

found in previous studies of CAM users[2–7] (e.g., women and highly educated people are overrepresented). For example, the percentage of participants with a university education was 65% as compared to 35% in the Swedish population.[17] However, this study was different from others in that most of the professional clients themselves were conventional health caregivers. Many of the clients, in particular members of this group, reported having contact with the conventional health care system, either before or during their RMB treatments (i.e., a simultaneous use of both systems). This is interesting because in Sweden, there is still a clear barrier between the conventional health care system and CAM (e.g., in terms of legal aspects that define the basic responsibilities of health care personnel and to some degree regulate the CAM area). Certified health care personnel are generally prohibited from practicing CAM therapies themselves if the method lacks evidence, documentation, and is not based on experiential knowledge (e.g., RMB).

Most clients reported several reasons for using RMB, and a majority of them were very bothered by these problems. Forty-eight (48) of 53 clients had experienced help from RMB. An analysis of the data found five separate categories of perceived benefits. Most of the benefits seem not to be related exclusively to the physical touching, but to a combination of physical touching and client–therapist interaction. This interaction has been discussed as being a significant factor for the outcomes of many CAM therapies.[18] It is pointed out as an active and necessary aspect that increases patients' empowerment[19] and hence contributes to the overall treatment effect[18–20] but has probably still been underestimated until now. Rather, it has been regarded as an unspecific effect or a placebo phenomenon[18] and has consequently been controlled for in clinical trials aiming to assess the specific efficacy of a—preferably isolated—chemical compound or technique. The clients' reports from the therapy include aspects such as establishing a secure environment, confirming support, and learning about the causes of their health problems. All these interactive aspects of the treatment are fundamental in high-quality nursing[21–23] where the ambition is to help patients to, for example, cope with health problems or strengthen their will to master them. Our conclusion is that the interaction between client and therapist in RMB plays a very important role in the overall treatment satisfaction and outcome. Nursing theories that focus on interaction (for example, the SAUC Model for Confirming Nursing[23]), might be used in future studies to gain a deeper understanding of which aspects of RMB create perceived benefits.

Bias consideration

Our purpose was to study perceived benefits from treatments in an unknown target population. Therefore, a criterion-based sampling method[24] via therapists was one realistic way to reach RMB clients. However, this sampling process reduced the control of the selection procedure. We recruited 60 clients from 17 therapists. Introductory consultations with new clients during the period, where the treatment was planned for and agreed upon, was not included in the study and in most cases the therapists did not ask their new clients who started the therapy to participate. According to the data on the clients who used this therapy method, most of those who participated in the study were experienced RMB users (returning clients). The number of individuals (potential study participants) who visited the therapists is significantly lower than the number of consultations. However, we have no reliable information about the exact number of clients who consulted the therapists during the sampling period, and we have reason to believe that we sampled only a limited number of the total clients who visited the practitioners. Therefore, the sampled clients must be regarded as "self-selected" (selection bias). Since many clients had used the therapy regularly for a long time, they probably had established a good relation with their therapists. We have reason to assume that clients with positive experiences were overrepresented in the study population. The art of relationship might influence, for example, the clients' reports being positively influenced (reporting bias).

Furthermore, four clients did not answer the specific open question about benefits from treatments, and 1 declared no benefits. The number of clients who did not perceive benefits or might have post-therapeutic health problems is not known, but a follow-up on 4 of the 5 clients who did not return the questionnaire showed that one of them had actual psychologic health problems, and the rest indicated that they had not perceived benefits of the treatment. Therefore, we assume that data from less positive clients might have been lost in the data collection process, which must be taken in consideration. The results of this exploratory study cannot therefore be generalized to a target population or inform any conclusions about causality. However, as the purpose of this study was to obtain information about perceived benefits, the data offered a possibility to analyze the basis for the clients' satisfaction.

Conclusions

Most RMB clients in this study indicated satisfaction with the treatment. The perceived satisfaction was related to five separate categories of reported benefits, aspects that could serve as a theoretical foundation for a deeper understanding of those aspects of RMB that are deemed satisfactory. An analysis focusing on the interaction between client and therapist from a nursing theoretical perspective may increase the knowledge about mechanisms that create perceived benefits in RMB but also generally in other CAM therapies as well.

Acknowledgments

None of the authors had any previous experience with this modality of therapy. During the study, the authors RH-L and TF received one RMB treatment each and observed one treatment. The authors wish to thank the scientific referee board including professors Kerstin Uvnäs-Moberg, Karl Arlfors, and Regina Wredling. David Finer, Seija Hoffrén, Johanna Hök, and Maria Niemi contributed to the language revisions.

RH-L drafted the original manuscript, contributed to and refined the general research design, collected all empirical material, and analyzed the main bulk of the data. BG acted as co-investigator and participated in analyzing the qualitative data, critically read the manuscript, and participated in

redrafting and rewriting. TF acted as principal investigator and conceived the general research design, critically read the manuscript, and participated in redrafting and rewriting.

Disclosure Statement

The authors declare that we have no competing interest. This study was supported financially by Axelsons Gymnastiska Institut, Stockholm, Sweden and Ekhagastiftelsen, Sweden. Axelsons Gymnastiska Institut offers training courses for Rosen therapists in Sweden, Norway, and Finland. However, this sponsor had no influence on the study design, data collection, results, or on the decision to publish the results. In order to avoid any competing financial interests, a scientific referee board with three professors in medicine or nursing ensured objectivity and transparency during the different steps of the study.

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