

SOMATIC COUNTERTRANSFERENCE EXPERIENCES
OF NURSE THERAPEUTIC TOUCH PRACTITIONERS:
A CONTENT ANALYSIS

by

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A Dissertation submitted to the
Graduate School–Newark
Rutgers, The State University of New Jersey
in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Graduate Program in Nursing

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Newark, New Jersey

May, 2014

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ABSTRACT OF THE DISSERTATION

Somatic countertransference experiences
of nurse Therapeutic Touch practitioners:

A content analysis.

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This qualitative study describes somatic countertransference (SCT) experiences of nurse Therapeutic Touch (TT) practitioners during their work with traumatized clients. Increased understanding of SCT can further promote the role of TT in trauma therapy. Orbach and Carroll (2006) define SCT as “the therapist’s awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the client’s healing process” (p. 64). The study is timely and aligned with current state of the science on use of Complementary and Alternative Medicine (CAM; WHCCAMP, 2000; Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). Its findings pose an alternative to current exposure-based psychotherapies. Following IRB approval, purposeful sampling was used to recruit and interview eight expert nurse TT practitioners. After signing the informed consent, sixty-minute face-to-face in-depth interviews were conducted in a private setting of the participants’ choice, and audio taped. A semi-structured interview guide with six open-ended questions was used to collect sufficient narrative data to answer the main research question: “What is the experience of SCT as described by nurse TT practitioners

who have cared for traumatized patients within the previous 6 to 12 months?” Qualitative data from verbatim transcription of interviews were analyzed using the preferred method of latent content analysis described by Sandelowski (1993, 1995, 2000, 2010). Codes and subcategories were grounded exclusively in the data (Patton, 2002; Krippendorff, 2004). Categories and one major theme were inductively generated to reveal the underlying meaning in the communication (Chang, 2001). Data saturation was reached (Sandelowski, 1995). Consensus on coding and results of data analysis was achieved to produce a credible research report. Ten subcategories and three categories led to the emergent theme, “A Language for Healing Trauma.” Consistent with communication research in the social sciences (Krippendorff, 1989), SCT was found to be a factor in the healing of trauma that emanated from the verbal and nonverbal communication of one group of nurse TT practitioners in their interaction with their traumatized clients.

Dedication

This dissertation manuscript is dedicated to my family: to my late parents, Catherine and Edward Jirak, whose legacy of perseverance amidst adversity I honor; to my twin sister, Patricia Anne Jirak, who taught me to communicate; to my sister, Carolyn Jirak, whose nonlanguage ways of knowing helped me to survive; and, to my husband, Dr. Steven A. Monetti, whose love, devotion, and protection allow me to thrive.

Acknowledgements

The limits of language and the confines of these pages permit only a mere rendering of those to whom I am indebted.

First, I would like to express my sincerest appreciation to the Robert Wood Johnson Foundation and leaders of the New Jersey Nursing Initiative for the educational opportunity afforded me. Without their support, the enterprise of doctoral education would have been untenable. Dr. Diane Billings, Dr. Susan Bakewell-Sachs, and Dr. Maryjoan Ladden are chief among benefactors. Following closely is Dr. Lucille Joel whose tenacious leadership guaranteed a vigilant eye.

Next, I would like to thank the members of my dissertation committee; namely, for her willingness to serve as chairperson, and her determination, Dr. Deanna Gray-Miceli; for her methodological expertise, Dr. Mary Grace Amendola; for her insight, Dr. Jeanne Ruggiero; and, for his kindness and encouragement, Dr. Earl Goldberg.

Without the early endorsement of the professional organizations, Therapeutic Touch International Association and the American Holistic Nurses Association, my confidence would have waned. The courage, dedication, and trust of the expert nurse Therapeutic Touch practitioners who participated in this study both inspired and sustained me throughout the dissertation process. They continue to do so. Guiding lights, it was a rare privilege to glimpse their experiences, and empower them by giving voice to them.

Throughout my life there were many mentors whose paths I emulated. These include the late Marion V. Keckeisen, a World War II army nurse, who befriended me

and guided my career; Dr. Neil Smith, a spiritual clinical Gestalt psychologist who healed me personally and trained me professionally; and, the late Ann Teachworth, a beloved friend and founder of the Gestalt Institute of New Orleans, who inspired me. Knowing you watch from above, I thank you. Over long years Dr. Maureen Esteves, Associate Dean for Undergraduate Education at Rutgers, College of Nursing, continuously entrusted me with the clinical education of many future nurses, an honor always.

I would like to also acknowledge Dr. Noreen Cerino and Dr. Leslie Nicoll for their editorial assistance in the preparation of this dissertation research manuscript. Their positive feedback came at times most needed. For the camaraderie of fellow doctoral students, Shanda Johnson and Karen Moosvi, the emotional support they proffered kept me afloat. Lifelong friendships with Ellie Zairis, Anna Masiorski, Donna Reale, Janice DeMadona, and Donna Palmer continuously reminded me of who I really am.

Finally, to my late and dear friend, Ruth Dente Saar, we did it. I have become “Dr. Cat.” You are forever our dragonfly...

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CHAPTER I

INTRODUCTION AND THEORETICAL PERSPECTIVE

The Concerns Addressed

Germane to the field of trauma therapy, the concerns addressed in this study are: 1) the occurrence of vicarious traumatization (VT) in health care providers; 2) the ever-growing clinical population of patients with trauma histories and commensurate and increasing health care expenditures; 3) the predominance of exposure-based therapies; and, 4) the impact of energy healing from the practitioner's point of view (Potter, 2003). Further discussion ensues.

Vicarious Traumatization (VT) in Health Care Providers

First, when health care providers working with patients who have experienced trauma experience vicarious traumatization (VT), an even greater societal burden is posed. Energy healing - not requiring a patient's re-traumatization – holds important implications for both patients and clinicians. The residual effects of trauma are removed (Janet, 1925/1973), in part, by the practitioner's experience and somatic countertransference (SCT) phenomenon. Also called embodied empathy, SCT contains inherent self-regulatory processes that help to diminish VT in the healthcare provider (Raingruber & Robinson, 2007). These self-regulatory processes include increased attunement, creation of appropriate boundaries, facilitation of self-care, and more accurate assessment (Jakubowski, 2012).

Trauma Histories and Related Health Care Expenditures

Second, trauma is any experience that has threatened the health or well-being of an individual, and need not involve a catastrophic event (Brewin, Dalgleish, & Joseph,

1996; Scott & Stradling, 1994, 2011). Traumatic experiences involve the whole person's emotions and feelings (mind, body, and spirit) (van der Kolk, 1994). These experiences can include an event such as a natural disaster or accident; an illness; bereavement; or, loss of an interpersonal relationship. Patients with trauma histories are therefore widespread in clinical practice (van der Kolk, Spinazzola, Blaustein, Hopper, Hopper, Korn, & Simpson, 2007).

Veterans are among those who have experienced trauma. The 2007 overall projected cost of their health care was between \$350 to \$660 billion (Kanter, 2007; Bilmes, 2007). The Veterans Health Administration spent \$48 billion in 2010 alone for health care for those of all ages and all conflicts (Congressional Budget Office, 2012). Ivanova, Birnbaum, Chen, Duhig, Dayoub, Kantor, Schiller, and Phillips (2011) attribute the substantial healthcare costs among veterans with posttraumatic stress disorder (PTSD) to both the high use of medical services associated with it and the psychiatric and non-mental health comorbidity burden. Values for mental health care treatment for FY 2014 to FY 2020 have been forecasted by Bernal (2006) to be between \$1.79 billion and \$1.94 billion. Further research to understand the effect of PTSD psychotherapy and medication treatment on costs and this burden has been recommended.

Kanter (2007) noted that poor occupational and social functioning is a hallmark of chronic PTSD. Psychiatric disorders associated with depression, PTSD, anxiety, substance use, and head injury contribute to difficult maintenance of employment (Adler, Possemato, Mavandadi, Lerner, Change, Klaus, Tew, Barrett, Ingram, & Oslin, 2011; Bilmes, 2007). Disability compensation for PTSD alone increased from \$1.72 billion in 1999 to \$4.28 billion in 2004 (Institute of Medicine, 2007). The cost of lost work productivity is therefore high.

Trauma-focused treatment includes psychotherapeutic approaches that require clients' re-exposure to a traumatic event. Current therapies include cognitive behavioral therapy (CBT), virtual reality exposure (VRE), and eye movement desensitization reprocessing (EMDR; Shapiro, 2001). Pharmacotherapy, notably, the selective serotonin reuptake inhibitors (SSRIs) and selective norepinephrine reuptake inhibitors (SNRIs), is also used. van der Kolk (1994) recommends that trauma treatments integrate cognitive-based narrative therapy (psychotherapy/counseling) with somatic body memory treatment.

Exposure-based Therapies vs. Energy Healing

Third, standard treatment approaches for PTSD are currently exposure-based (Foa, Keane, & Friedman, 2000). Conventional psychotherapy has been critiqued for bringing memories to consciousness without resolution (Csordas, 1994; Johnson, 1999). Experts confirm that re-exposure of trauma deters patients from treatment. Nor has confronting memories been found to be universally effective (Lewis, 2003).

Non-exposure-based complementary and alternative medicine (CAM) modalities such as energy healing (e.g., Therapeutic Touch) have been posited as a welcome alternative for treatment of PTSD (Bleiberg & Markowitz, 2005). Eisenberg, Kessler, Foster, Norlock, Calkins, and Delbanco (1993) conducted one of the initial surveys of CAM use by adults ($n = 1539$), aged 18 or over, in the United States. More than 33% of respondents used one or more of the 16 modalities on the questionnaire, including touch therapies. A follow-up national survey ($n = 2055$) of CAM use in the United States, 1990 to 1997 (Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay, & Kessler, 1998) demonstrated that participation had increased to 42% by 1997. In particular, the

prevalence of energy healing increased to 3.8%, or 1.2 million people, in 1997 (Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay, & Kessler, 1998) with an estimate of nearly 40,000 visits to providers (Engelbreton & Wind Wardell, 2007).

In a large survey (N = 31,000) conducted in 2002 by the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS), more than 1% of 62% of adults using CAM within the past 12 months had used touch therapies (Barnes, Powell-Griner, McFann, & Nahin, 2002, 2004; Engelbreton & Wind Wardell, 2007). A study of sampled adults aged 18 years and over ($n = 23,393$), conducted by Barnes, Bloom, and Nahin (2008) under the auspices of the National Center for Complementary and Alternative Medicine (NCCAM), National Institutes of Health (NIH), found that American Indian or Alaska Native adults (50.3%) and white adults (43.1%) were more likely to use CAM than Asian adults (39.9%) or black adults (25.5%) (Engelbreton & Wind Wardell, 2007). Since veterans are also among those widely using CAM therapies, including Therapeutic Touch Energy Medicine (TT; Krieger, 1979a, 1979b, 1987), Slater (2004) states it is reasonable to assume that TT holds promise as adjunctive treatment of PTSD.

Fostering the Evidence Base

In addition, future research on the impact of energy healing on practitioners was recommended by Potter (2003). Further description of TT practitioners' experiences of somatic countertransference (SCT) during their work with traumatized patients will provide further evidence, while shedding greater light on the beneficial role of TT in trauma therapy.

Summary

In summary, issues regarding trauma therapy that warrant further address are: the frequent encounter in clinical practice of patients with trauma histories; significant costs to patients and clinicians; and, the prevalent use of exposure-based therapies and pharmacotherapy that are not universally effective. Since current trauma treatment is only palliative and does not cure, more efficient, cost-effective approaches that do not re-traumatize the client are needed.

The Phenomenon of Interest

The phenomenon of somatic countertransference (SCT), as experienced and described by nurse TT practitioners, is the one of interest in this study.

Therapeutic Touch (TT) Energy Medicine

To provide context for TT, energy medicine is recognized by the healthcare system as a subspecialty of CAM. As defined by Maret (2009), it is the diagnostic and therapeutic application of “energetic and information interactions resulting from self-regulation, brought about by interactions between mind and body” (p. 4). Integrative, or CAM, practices such as TT (Krieger, 1973) involve putative energy fields (i.e., subtle forms of energy), and comprise, in part, the field of energy medicine.

Micozzi, Kronenberg, and Jobst (1995) estimated 80% of the world’s population uses some form of alternative therapy such as energy healing (Engebretson, 1999). According to Micozzi and colleagues (1995), alternative therapies encompass healing paradigms and practices that are routine for much of the world though not commonly embraced by Western allopathic medicine. In Europe and the United States these therapies are generally used to complement, rather than replace, biomedical therapy.

Many people use energy healing for the promotion of health and prevention of disease (Engebretson, 1999).

To introduce TT, human touch or laying-on of hands for the purpose of healing has been used for centuries. For almost forty years nursing, the discipline in which TT originated, has led in recognizing the effectiveness of touch therapies (Engebretson & Wardell, 2007; Vitale, 2007). TT was originally developed in the 1970s by Dolores Krieger, a clinical nurse, and Dora Kunz, a clairvoyant and energy healer. It is based on the premise that the human body, mind, emotions, and intuition form a complex, dynamic energy field (Macrae, 1987; Robinson, Biley, & Dolk, 2007; Zolfaghari, Eybpoosh, & Hazrati, 2012).

Krieger (1979) describes TT as utilizing the hands “to direct human energies to heal illness” (p. 1) that results in a modification of the human energy field. TT is comprised of four phases: 1) Centering (e.g., locating calm through focused attention); 2) Assessment (e.g., using the hands to assess the quality of the client’s energy field; 3) Mobilization (e.g., re-directing the client’s perceived ineffective energy field elsewhere); and, 4) Repatterning (e.g., realignment of the client’s energy field with the hands creating energy transfer) (Krieger, 1979, as cited in Smyth, 1995, p. 15).

Krieger (1979) believes that TT can be practiced by anyone willing to learn and aspiring to help another (Smyth, 1995). Conceptualized as a secular modality, it can be practiced by people of any or no religious faith (Hemsley, 2003). It is used to complement medical, nursing, and psychotherapy skills, and not replace them (Smyth, 1995). An extension of professional nursing skills, TT is analogous to autonomous nursing interventions such as touch, massage, stress management, counseling, the

provision of comfort measures, and the teaching of coping activities (Engebretson, 1999; Fazzino, Quinn Griffin, McNulty, & Fitzpatrick, 2010).

The Therapeutic Touch International Association (TTIA; 2013) reports that TT is now taught in educational institutions, health care facilities, and community-based agencies and groups around the globe. Worldwide, it has been taught to over 200,000 people in 104 countries. More than 70 universities in North America include TT in their curricula. TT was the first holistic healing method to be taught at the doctoral level; over 50 doctoral dissertations on it have been completed. Overall, TT is the most extensively researched CAM modality in that over 1,000 research reports have been published. TT is also currently practiced in over 50 medical centers (Fazzino, Quinn Griffin, McNulty, & Fitzpatrick, 2010).

Therapeutic Touch & the Science of Unitary Human Beings

Malinski (1993) noted, “TT has long been recognized as a health patterning modality consistent with Rogerian nursing science” (Abstract). Many studies on TT have been framed within Martha Rogers’ Science of Unitary Human Beings (SUHB; Rogers, 1970; 1980, 1990). However, many of the theoretical explanations of TT have not always been consistent with the SUHB because of the concept of energy transfer or energy exchange (Malinski, 1993).

In her revision of the principles of homeodynamics, Rogers (1990) re-named the four building blocks in the SUHB as postulates: energy fields, a universe of open systems, pandimensionality, and pattern or patterning (Malinski, 1993). Meehan (1988) suggested that the concept of energy transfer should be substituted with human-environmental field process. This latter term disavows TT as an alternative or holistic

medicine technique, with consideration of it as a nursing health patterning modality more appropriate.

While Rogers' SUHB (1990) is one theoretical approach to underwrite studies on TT, it does not include the concept of nurse-client interaction. Additionally, Rogers (1990) viewed TT as a technique, rather than a body of knowledge (Malinski, 1993). Meehan's (1988) definition of TT was more aligned with Rogerian nursing science: "a knowledgeable and purposive patterning of patient-environmental energy field process in which the nurse assumes a meditative form of awareness and uses her hands as a focus for the patterning of the mutual patient-environmental energy field process" (p. 6).

Questioning the appropriateness of the phrase "purposive patterning," Malinski (1993) offered an alternative definition: "TT is a health patterning modality whereby nurse and client participate knowingly in the changing human-environmental field process" (p. 6). During this modality, the nurse assumes a meditative, pandimensional form of awareness to experience integrality (Rogers, 1990), and uses the hands as a focus. Malinski (1993) noted that while the client may or may not experience pandimensional awareness, he/she does participate knowingly in the process.

Noting an inconsistency in her study with Rogers' (1990) conceptual system, Samarel (1992) attributed it to the difference between a linear versus a multidimensional perspective. She conjectured that while the experience of TT is non-linear, the expression of it is limited by language. Her conclusion was the nature and memory of human experience are difficult to express in a non-linear fashion.

Somatic Countertransference (SCT)

A newly articulated phenomenon (Shaw, 2003, 2004), SCT is distinct from the traditional notion of countertransference (Freud, 1910; Schroder, 1985).

Countertransference is now viewed as a natural part of the therapeutic relationship that yields deeper empathetic understanding of the patient (Puckey, 2001). When used intentionally, the therapist's inherent self-knowledge, attunement, reflection, and analysis are tools used in the healing process (Ens, 1998). The therapist's body actively participates in the therapeutic interaction (Diamond, 2001; Orbach, 2004, 2006; Shaw, 2003).

SCT is defined by Orbach and Carroll (2006) as "the therapist's awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the client's healing process and the intersubjective field" (p. 64) (Rumble, 2010). In systems theory, the intersubjective field is defined as the relationship between client and psychotherapist, and the contained space (Macecevic, 2008).

Aligned with the traditional perspective of negative countertransference, Jakubowski (2012) found that negative personal effects of working with trauma survivors included an increased experience of countertransference. These include increased feelings similar to anxiety; negative effect on therapist's physical health (e.g., physical symptoms such as feeling sick to the stomach, muscle tension, tearing, fatigue, depression, decreased body awareness, and tingling in the hands); negative modulation of feelings of emotional pain; increased need to practice self-care; and, negative effects on personal relationships. A negative impact on professional life included burnout and fatigue; increased need for therapist support and supervision; and, negative effect on therapists' finances and time schedule (Jakubowski, 2012).

In contrast to the negative effects of countertransference, SCT can positively affect both the clinician and the client (Puckey, 2001). The construct of SCT is drawn on infant studies and the work of the phenomenological philosopher, Merleau-Ponty (1962).

As initially conceptualized, trauma is stored in somatic memory - at the receptor level of cells (Pert, 1997). Cellular intelligence is connected to the conscious and unconscious processes of mind and emotions. The body can reveal the forgotten areas of experience embedded within it. When the bodymind (Pert, 1997) is approached, wisdom is revealed by surrendering and listening to that which is sometimes beyond rational (Hartley, 2004, p. 186, as cited in Macecevic, 2008).

Memory processes that are emotionally driven and unconscious can sometimes be made conscious through SCT experienced by the therapist. Merleau-Ponty (1962) considered the therapist's body a surrogate for the client's trauma-related thoughts and images in search of a body. Hence, TT allows access to bodily-stored memory and cellular intelligence. Unresolved trauma need not predominate in one's life.

According to Ogden (1994), during TT the interpersonal relationship between clinician and patient there is "an unconscious intersubjectivity" (p. 11). Hence, therapeutic interpretation should be made about the interaction "at an intrapsychic level" (O'Shaughnessy, 1983, p. 281, as cited in Ogden, 1994, p. 4). The mutual dialogue between clinician and client (Grotstein, 2005) allows the client's body to communicate. Macecevic (2008) contends that taking notice of it enables more subtle material to emerge (p. 182).

Yontef (1979) indicated that through sensory awareness in the Gestalt here-and-now (p. 30), the client's and therapist's wisdom is revealed. This is especially true in a supportive environment, such as the energy exchange occurring during TT, where there is a willingness to let go of preconceived ideas or plans (Macecevic, 2008). Inherent spontaneity manifests SCT phenomenon and imagery of a revelatory nature. In

attachment research, this communication has been deemed analogous to mother–infant communication (Schore, 2003; Seligman, 1993, 1994).

The untapped healing potential of the human brain has relevance for SCT. “Deputy perception” has been used to describe SCT (Stoerig & Cowey, 1997). Gallese and Goldman (1998) and Gallese (2001) accounts for this by their discovery of the “mirror neuron,” which allows for a simulation theory of mind-reading and empathy (Grotstein, 2005). Stern (2004) described the process as “a nonvoluntary act of experiencing as if one’s center of orientation and perspective were centered in the other. Rather than knowledge of the other, it is participation in their experience – a capacity that makes imitation and empathy possible. The inherent trait of empathy refines with development” (pp. 241-242).

However, these processes have received little attention, with a paucity of empirical studies on SCT noted (Vulcan, 2009). An impediment to investigation has been the perceived inadequacy of language to depict precise renderings. Furthermore, classically-trained psychodynamic therapists have been taught to regard countertransference reactions as detrimental to healing (Hart, 1997). Hence, therapists may have felt reticent to speak about them (Shaw, 2004).

When information is reacted to without awareness, avoidance through objective detachment is the response. In contrast, when SCT awareness in therapists is cultivated, reactions stimulated by the client become a source of understanding (Macecevic, 2008). It is therefore crucial to find ways of articulating and researching the language of the body (Vulcan, 2009). Immersion in non-verbal relating can bypass language and lead to new and deeper dimensions that allow the client’s body to tell its story, rather than putting words to the client’s experience (Lude, 2003).

Articulation of the body's language may be particularly productive in clinical work with clients who have experienced trauma (Vulcan, 2009). In parallel, Macecevic (2008) posits, "the ability to perceive our clients in a way that encompasses their mind, body, and spirit, using our own mind, body, and spirit is the most comprehensive means to assess for holistic well-being" (p. 184). Therefore, SCT phenomenon in TT practitioners can be used as a source of direct and intuitive information; thus, guiding the therapeutic process (Shaw, 2003, 2004). Given the degree of trauma in the clinical population, TT is a significant resource.

Finally, Shaw (2004) emphasized that SCT phenomenon described by therapists arose from experiences within their own bodies, and not from their clients' bodies. Using an example given by one therapist (e.g., "I think what I was doing was picking up the unconscious body memory of the client."), he emphasizes verification with the client. SCT phenomenon experienced by TT practitioners might indeed be attributed to the client's unconscious, bodily-stored material.

Embodied Empathy

In the nursing literature, the term embodiment, now used interchangeably with SCT, has replaced "mind-body connection" (Wilde, 1999; Paley, 2004). The terms "embodied empathy" and "embodied transcendental empathy" (Husserl, 1929/1967; Hart, 1997; Macecevic, 2008) have been used synonymously with SCT (Macecevic, 2008). A link between kinesthetic empathy and SCT has also been presented (Pallaro, 2007). Hence, empathy in an embodied TT practitioner consists of understanding by perceiving another's experience in their own body (Shaw, 2003).

Concerned with the phenomenology of perception, Wilde (1999) describes embodiment as "how we experience the world – perception, emotion, language and

movement through our bodies” (p. 27) (Merleau-Ponty, 1962, 1968). It is the phenomenological lived body/self (Gale, 2011). The term “body-talk” means the body can communicate its distress and need. In bodywork, or embodied psychotherapy, the practitioner does not necessarily touch a client (Shaw, 2003, 2004). Instead, in understanding their countertransferential responses, therapists assume the roles of “witness” and “mover”; thus, enabling mutual responses and projections that engender the emergence of unconscious contents (Vulcan, 2009). The simultaneous perception of practitioners’ and clients’ own body experience is therefore integral to “no-touch” energy field therapies, such as TT.

Therapists draw on their own experiences with pain, anxiety, and memories of profoundly upsetting life experiences in hopes of understanding the client’s psychic trauma. Empathy enters the phenomenal reality of the trauma victim to understand the internal working schema of the trauma experience and its effects on intrapsychic processes (Wilson & Thomas, 2004). Studies are needed to test treatment approaches for PTSD, especially those incorporating embodied healing (Ray, 2009). As such, CAM practitioners (e.g., TT practitioners) are an interesting way to investigate the concept of body work (Gale, 2011).

Furthermore, the body is a resource that often goes underused in trauma therapy (Ray, 2009). Discourse on healing often overlooks the importance of embodiment. The body’s storage of traumatic memories and their impact on the body are essential features of psychological trauma and must not be overlooked by nurses (Ray, 2009). Thus, the use of non-touch techniques such as TT can help access this resource (Ogden & Minton, 2000). Embodiment and embodied engagement needs to be especially incorporated into

best practice guidelines for the nursing care of patients with trauma histories (Ray, 2009), especially veterans.

Imagery

Experience of spontaneous imagery in the healer is an aspect of SCT and is an important focus of this study. It is distinct from guided imagery (GI) that is evidence-based and has been used as an independent nursing intervention in all clinical settings, including chemical dependency (Reed, 2007). To inform the reader, guided affective imagery (GAI) is already available as an effective treatment in psychotherapy.

The type of imagery explored in this study differs from the type commonly found in the complementary therapy lexicon (Engebretson, 1999). SCT-related imagery is the effect on the therapist's body of the patient's material (Forester, 2007). Sometimes recognized by feelings, moods or thoughts, SCT may manifest in spontaneous imagery that appears to embody something that "belongs" to the patient (Casement, 1985). For example, Csordas (1994) found that TT practitioners experience revelatory imagery with links to clients' healing processes. Findings from this empirical literature will be presented in greater depth in chapter two.

As contact with a client deepens, and "linking" occurs, subtle body sensations, feelings and thoughts are frequently sensed in deep empathy (Hart, 1997). For example, a therapist may see an image and respond as the client does. In forms of psychological resonance, during SCT there is a less direct impact on the self; instead, the occurrence of a more detached witnessing of the other's world occurs. From a phenomenological perspective, information is often encountered as if it were coming from another source. As this field of consciousness is opened, material may emerge in the practitioner that is

unavailable to the client's immediate awareness (Hart, 1997). This non-retraumatizing, or non-exposure based, aspect is significant for patients undergoing treatment for trauma.

The process of SCT-related imagery is both an intrapsychic and an intersubjective event. The term "catathymic imagery" refers to inner vision that occurs in accordance with and is related to affect and emotions (Leuner, 1966/1969). An experiential receptive mode is most effective when dealing with the world of sensation, emotion, and imagery which are nonverbal intrapsychic events (Dosamantes-Alperson, 1979). Movement occurring in this mode is associated with more vivid imagery and a greater number of memories (Berdach & Bakan, 1967).

Images which occur while the person is in the receptive mode (i.e., relaxed but conscious) are called hypnagogic images (Leuner, 1966/1969; Horowitz, 1970). They are preconscious, preverbal, visual symbols that have a motion picture quality (Shorr, 1974) and can be watched with the mind's eyes. In other words, a state of relaxation, such as that encountered during TT, may facilitate the spontaneous emergence of imagery in the practitioner that promotes emotional healing in the client. Hence, TT practitioners' images may serve to bypass, and compensate for, blocked images and affect in the client. This is significant for trauma therapy.

Some aspects of mental imagery arise from knowledge acquired through other than normal perceptual experience (Finke, 1985). Distinct neural systems carry out visual and motor processing in the absence of conscious awareness (Milner & Goodale, 1995). They are based on the subjective difference between sensing and seeing (Rensink, 2004). "Metaperception," a mode of "deputy perception", might also be called "mindsight," and involves more than a pickup of transient signals (Stoerig & Cowey, 1997). Hence, TT practitioners may sense without eyesight. Furthermore, their use of intention and

empathic attunement may enhance metaperceptive ability, predisposing them to the hypnagogic imagery of the client's bodily-stored material. Given the limited reporting, TT practitioners' descriptions of imagery experienced during SCT would add significantly to the literature.

Integrating somatic body memory treatment with cognitive-based narrative therapy is recommended in PTSD (van der Kolk, 1994). Resulting imagery during energy healing may be revelatory for verbally inaccessible content. Charismatic imagery in the TT practitioner is therefore clinically significant in treating PTSD (van der Kolk, 1994). Consideration of TT practitioners' experience of imagery, the role of the nonordinary state of consciousness in healing, and the nurse's presence is needed (Heinschel, 2002).

At this time, this type of imagery has been minimally investigated in both the nursing literature and that external to it (Csordas, 1994). This research study addresses this noted gap by exploring this type of SCT-related imagery in nurse TT practitioners.

For purposes of this qualitative study, it is important to emphasize that the researcher's a priori knowledge, aforementioned, was bracketed. Prior to each interview, I examined, and then put aside, my own interpretations and presuppositions regarding the SCT phenomenon under study (Beck, 1994, 1996). This resulted in an unbiased listening of the participants' descriptions of SCT without any preconceived notions or ideas.

Purpose of the Research

Pursuant to the researcher's professional experiences, and noted gaps in the literature, this study qualitatively describes SCT experiences of nurse TT practitioners during their work with patients who have been traumatized. This study is based on the premise that somatically attuned and aware clinicians such as nurse TT practitioners are better able to identify and work with bodily aspects of experienced trauma (Pert, 1997;

Reed, 2007). The study offers further validation and lends support to the beneficial role TT plays in trauma therapy.

This study has also been undertaken because somatic phenomena in the countertransference (i.e., SCT) have historically received minimal attention, remaining largely unexplored. This is despite evidence of their common occurrence in the therapeutic relationship (Shaw, 2003, 2004; Rumble, 2009, 2010). Furthermore, while there has been discussion from a theoretical perspective (Samuels, 1985; Meekums, 2007), only recently has qualitative research on it (Athanasiadou & Halewood, 2011; Jakubowski, 2012) contributed to psychological theory and clinical practice (Macecevic, 2008). To this researcher's knowledge, this study is the first of its kind to deliberately explore the SCT phenomenon in nurses.

Foundational Assumptions

Undertaken within the interpretive paradigm (Sandelowski, 2010), a qualitative descriptive research design was employed to conduct an inductive content analysis, the preferred method to produce a theme (Sandelowski, 2000). Deductive content analysis was also used initially to code the narrative data, and to identify subcategories (Patton, 2002; Polit & Beck, 2008). In other words, as produced in the data, a content analysis of participants' descriptions of their own sensations and perceptions experienced during the healing process of TT with patients who have been traumatized led to the development of subcategories, categories, and an emergent theme. These, in turn, further described the minimally researched and articulated aspects of SCT experiences, the targeted phenomenon (Macecevic, 2008).

In summary, these foundational assumptions lent support for this research study, and an exploration of the main research question, "Please tell me, what is your

experience of SCT when you have cared for traumatized patients within the previous 6 to 12 months?”

Significance of the Study

TT has typically been withheld from mental health arenas due to uncertainty about its clinical value (Vickers, 2008). Nonetheless, psychotherapists are already incorporating energy-based healing modalities, including TT, into their practices (Macecevic, 2008). Veterans are among those receiving benefit for common conditions such as fatigue, headaches, insomnia, depression, anxiety, sleep disturbances, and relationship problems (Eisenberg, Davis, Ettner, Appel, Wilkey, van Rompay, & Kessler, 1998). As mental health expenditures rise, and more people besides veterans are diagnosed with trauma-related psychiatric and medical disorders, it would behoove nurses to consider the effectiveness of energy-based healing modalities such as TT in their own practices (Vickers, 2008).

This study is therefore timely and is aligned with the current state of the science on CAM use (WHCCAMP, 2000; IOM, 2007; Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). It is also in keeping with the White House Commission on CAM's (2000, 2002) mandate for the provision of further research, and the IOM's (2007) recommendation that alternatives to traditional exposure-based trauma therapies and pharmacotherapy be explored.

Regarding imagery, Tedlock (1997) noted that while the scarce anthropological literature on healing imagery (Tedlock, 1987) focuses on healers' experiences, the psychological literature on imagery in psychotherapy focuses on patients' (Csordas, 1994). Given this gap, TT practitioners' descriptions of SCT-related imagery contribute

to the anthropology, psychology, and nursing literatures; in turn, to the field of trauma therapy.

There is current discourse in the field of psychology about therapists' claim their experience of unsolicited and spontaneous imagery is a manifestation of unconscious material in the client. Shaw (2004) suggested that such experiences should be verified with the client. The findings of this study can contribute to this current discourse by providing nursing's input.

Regarding vicarious traumatization (VT), the concept of helping-induced trauma was in its infancy when Peplau's (1952) interpersonal nursing theory emerged (Puckey, 2001). The common occurrence of VT has now become clinically significant. Stress-related emotional and physical illness occurs more frequently in healthcare providers working with patients with trauma histories (Rand, 2002, 2003). Increased vulnerability exists if a healthcare provider's self-regulatory capacity is inadequate to cope with strong emotions. Therefore, professional and organizational safeguards need to be in place, with employers engaging in risk management for nurses (Puckey, 2001).

In contrast to little prior recognition of VT as an occupational hazard, implications for psychiatric mental health nursing, the therapeutic relationship, the use of self, and the nature of practice have now been explored (Puckey, 2001). Effective use of somatic empathy of both the therapist's and client's bodies helps to prevent and lessen the severity of VT by returning the symptom(s) to the client - instead of the providers taking it on themselves (Rand, 2003). Essentially, an awareness of SCT may produce more effective self-care that, in turn, can lead to greater productivity (Clarke, 2007), while also serving as a guide to clinical work (Davis, 2011).

With paucity noted, more research on the effects of TT in lessening VT is needed. Emerging literature has already demonstrated that mindfulness practice in therapists increases their empathy and ability to stay present in their therapeutic work (Thomas, 2011). Other benefits include increased patience, intentionality, gratitude, sense of connectedness, and body awareness (Rothaupt & Morgan, 2007). Negative countertransference reactions are also managed (Seigel, 2007a, 2007b; Davis, 2011).

Empirical evidence also demonstrates that early childhood trauma confers an added strength to clinicians (Cohen, 2009). The discovery of “mirror neurons” (Gallese, 2004; Rizzolatti, 2005) opened additional empirical routes to independently test that personal experience may confer added sensitivity to therapists’ understanding of similar experiences in their patients (Iacoboni, Woods, Brass, Bekkering, Mazziotta, & Rizzolatti, 1999).

Thomas (2011) also notes that little attention has been paid to intrapsychic variables which may influence therapists’ capacity to sustain a therapeutic presence without succumbing to the detriments of “witnessing the suffering of others” (p. 5). Hence, a promising platform now exists for further examination into the relationship between adverse emotional experience in the psychotherapist’s past and their current empathic capabilities (Thomas, 2011).

In conclusion, significant opportunities for future research on SCT exist. A description of experiences of the phenomenon during TT could address issues of stress and vicarious traumatization in healthcare providers. Through empathy, the firing of mirror neurons, and TT practitioners’ self-regulatory processes negative countertransference reactions are lessened (Raingruber & Robinson, 2007). The study also addresses noted gaps in CAM literature on practitioners’ personal experience (Potter

& Perry, 2003; Gunnarsdottir & Peden-McAlpine, 2004). A foundation for the future development of nursing theory, measures of SCT, and increased empiricism is therefore laid.

CHAPTER II

REVIEW OF SELECTED LITERATURE

Purpose of the Literature Review in Qualitative Inquiry

As delineated in chapter one, the researcher's assumptions and a priori convictions were made explicit. This was done in accordance with Sandelowski's (2010) mandate for the researcher to identify "where she was at the beginning of the study, and her willingness to move away if further investigation is warranted" (p. 80). Sandelowski's (2010) additional recommendation was upheld in that while the researcher may have "begun this qualitative descriptive study with a framework for collecting or analyzing data from prior research on the SCT phenomenon, there was no commitment to stay with it" (p. 80).

As a generic form of qualitative inquiry and data analysis, this content analysis consisted of an atheoretical set of techniques whereby the informational content of the data was relevant (Sandelowski, 2000). The goal of the study was simply to shed further light on the phenomenon of SCT by providing a comprehensive description of it (Sandelowski, 2000).

In this study, Orbach and Carroll's (2006) definition of SCT as "the therapist's awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the client's process" (p. 64) was used for its sensitizing concepts (Patton, 2002). In other words, the concepts of SCT, body experiences, images, and perceptions were brought to the study and used to formulate the main and probe research questions. In this way, as endorsed by Patton (2002), "an examination of how aspects of the SCT

phenomenon was manifest and given meaning” (p. 456) among a sample of nurse TT practitioners unfolded.

Importantly, as Patton (2002) emphasized, “the sensitizing concepts did not replace direct experience with the descriptive data that was the essence of this qualitative inquiry” (p. 457). Rather, they were used to bring focus to the inquiry, and help make sense of and present the data without straining or forcing the analysis (Patton, 2002). Overall, although the qualitative content analysis process began with a preliminary coding system, it was continuously modified and amended. This ensured the best fit of the data (Sandelowski, 2000).

In summary, a preliminary review of the extant theoretical and empirical literature was undertaken to obtain a general grounding and familiarization with the existing knowledge on SCT, and its related terms, embodied empathy and imagery. The purpose was to identify the cutting-edge theoretical issues (Patton, 2002). The researcher’s personal knowledge was also deemed useful and necessary. In this way, a priori presuppositions or knowledge served as a valuable guide to the inquiry. As extrapolated herein, knowledge garnered from a selection of the extant literature added to the inquiry.

Review of the Literature

The purpose of this qualitative descriptive study was to illuminate SCT experiences of nurse TT practitioners, described using their own words. This chapter is divided into five sections which comprise a review of the literature on SCT; on the related phenomena, imagery, embodiment, and embodied empathy; and, that on TT Energy Medicine and PTSD. The chapter concludes with study aims, the main research question, and probe questions.

Theoretical saturation was achieved by undertaking an exhaustive review of the literature on the SCT phenomenon being studied. It is important to note, however, that a relatively small body of empirical research on SCT phenomena, as related to TT practice, in particular, was identified. These gaps in the literature served to guide this inquiry, and the formulation of the main, and probe, research questions.

Background of the Phenomenon

Somatic Countertransference (SCT)

To reiterate, Orbach and Carroll (2006) defined somatic countertransference (SCT) as “the therapist’s awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the client’s process and to the intersubjective field” (p. 64). Miller (2000) had described SCT as a valuable clinical tool whereby body sensation and body knowledge could be used by the therapist as valuable communication from the client’s body manifestations and unconscious messages (Jakubowski, 2012).

Earlier, Casement (1985) stated that the clues to recognizing countertransference reactions are sometimes experienced as feelings, moods, or thoughts; sometimes as unbidden, or spontaneous, images, fantasies, or sounds. The experience of SCT was also described by Casement (1985) as appearing to embody something that “belongs” to the patient. Csordas’ (1994a, 1994b) research findings exemplified the experiences of SCT-related imagery as indicative of clients’ healing processes in charismatic healers who practiced Therapeutic Touch (TT).

SCT has been hypothesized to have links to “mirror neurons” (Gallese, 2001; Macecevic, 2008), is facilitated by empathy, occurs in the middle stages of the therapeutic alliance, and is a hallmark of expertise (Benner, 1984). Nonetheless, despite enthusiastic claims for its effectiveness, a clear theoretical framework that would explain

the effects of mirroring on empathy has not yet been presented, and empirical research on the topic is generally lacking. Hence, qualitative investigation of the phenomenon of SCT and related aspects such as imagery and embodied empathy in energy healers may provide further elucidation.

Recent literature reviews (Vulcan, 2009; Rumble, 2010; Athanasiadou & Halewood, 2011) noted that somatic phenomena in the countertransference, despite evidence of their common occurrence in the therapeutic encounter, have historically received minimal attention. This is true for both literature and practice (Soth, 2006). While a holistic comprehension of the connection between the client's body and mind has been increasingly established, especially in relation to trauma treatment (van der Kolk, 1994; Ogden, Minton, & Pain, 2006), the exploration of the therapist's "being-in-representation" in terms of an intricate psychosomatic system is still quite rare (Soth, 2006, as cited in Athanasiadou & Halewood, 2011, p. 250).

Vulcan (2009) attributed the paucity to controversy surrounding the definition of the concept and the role of the construct in the therapeutic relationship. Much of the initial literature on the therapist's experience was written by clinicians who reported physical responses framed as countertransference, the traditional psychodynamic concept (Freud, 1923; Rumble, 2010). Therefore, a negative stereotype of interference with the therapeutic alliance previously prevailed. A gap in the empirical literature still exists. What follows is a review of the extant empirical literature on SCT currently available.

There have been no randomized clinical, or Phase III, research trials conducted thus far. As germane to the aims of this study, Price (2006) conducted a quantitative study, using a two-group, randomized, repeated measures design, to examine the feasibility and acceptability of body-oriented psychotherapy (e.g., focus on somatic

awareness, involving a combination of massage and emotional processing) for female veterans ($n = 14$) with PTSD and chronic pain. Questionnaire responses suggested that the intervention increased access to emotional experience, increased self-efficacy, and provided new tools for self-care (Price, 2006).

In her exploration of somatic experience in psychoanalysis, Dosamantes-Beaudry (1997) concluded that attending to it in both the patient and therapist has particular relevance. This is especially true for patients who use their internal experience to communicate primarily through various forms of bodily expression.

Forester's (2001) doctoral dissertation research examined the effects of clinicians' body awareness on countertransference management, and also on vicarious traumatization (VT). Moderating factors were: years of ongoing supervision/consultation, hours per month of supervision/consultation, and years of own therapy. Two new measures, the Body Awareness Measure and the Frequency of Practice (of body awareness) Measure, were piloted and tested with good reliability and validity demonstrated. VT was assessed through two measures: the TSI Belief Scale - version L (Pearlman & Mac Ian, 1995), and the Impact of Events Scale-Revised (Weiss & Marmar, 1997). Data analysis occurred using hierarchical multiple regressions. Due to a low response rate, the power for the study was too low, with small effect sizes and few statistically significant results found. Nonetheless, all hypotheses were supported. Frequency of Practice (of body awareness) accounted for more inverse variance in scores for VT than any of the other factors. Its effect exceeded those for other moderating variables combined.

Forester (2007) later explored therapists' SCT experiences during their work with dissociative and traumatized patients. Intending to contribute to the dialogue between

body-oriented and psychoanalytic approaches to the psychotherapy of trauma, Forester (2007) found that SCT plays a central, facilitating role in body and movement psychotherapy. SCT experiences provide a critical window into patients' material and dynamics, and lessen VT of the therapist (Forester, 2007).

Fatter and Hayes (2013) also produced an unpublished doctoral dissertation wherein they investigated factors that facilitated countertransference (CT) management. Measures of meditation experience, mindfulness, and self-differentiation were completed by 78 therapist trainees, while their supervisors rated trainees' CT management qualities. The study findings supported the positive association with psychotherapy outcome; namely, that trainees' meditation experience predicted CT management qualities. The non-reactivity aspect of mindfulness was found to be related to CT management qualities (Fatter & Hayes, 2013).

Only seven qualitative studies conducted on SCT were located: two grounded theory studies (Shaw, 2004; Athanasiadou & Halewood, 2011), one phenomenological study (Rutter, 1989), three narrative case studies (Ross, 2000; Lude, 2003; Clarke, 2007), and one qualitative content analysis (Jakubowski, 2012). No nursing studies were located.

Rutter (1989) noted SCT as being fairly well described in the Dance/Movement Therapy (DMT) literature. In a phenomenological study of SCT and therapist type, it was noted that SCT, or "embodied countertransference," has hypothesized links to mirror neurons and automatic somatic empathy for others due to the actions of these neurons. Since SCT was described as occurring in the middle stages of the therapeutic alliance, Rutter (1989) stated the goal was to move it to the earliest stages of the therapeutic encounter.

Ross (2000) focused on the physical experience of the therapist in the therapy session (i.e., SCT). Using clinical illustrations from her own practice, she related these instances to Dinora Pines' (1993) practice of listening better and trying to understand a patient's pain; to what the patient is not saying, or unable to say; and, noticing how the body has been forced to act out feelings that could not be consciously known or transmitted (Pines, 1993, p. 4; as cited in Ross, 2000). Ross (2000) illustrated, by drawing from the popular literature, how everyday language is sometimes more effective and precise in describing instances of SCT, and making the unconscious link between body and psyche (Vulcan, 2009).

This same idea was also expressed by Orbach (2004) who concluded that "making therapists' bodies available to patients in the therapeutic relationship is akin to making the psyche available" (pp. 148-149). Booth, Egan, and Trimble (2010), like Geller and Greenberg (2002), also concluded that physical reactions in the therapist's body, even if stimulated unconsciously, can provide insight into unconscious processes if attended to (Maroda, 1991).

Lude (2003), a practicing body psychotherapist and humanistic and holistic therapist, saw his role as facilitating a process of discovery of the innate wisdom of the body. Drawing on clinical vignettes from his own practice, he shared that by staying anchored in his own body, effective use of SCT is a two-way process between energetic connection and non-verbal communication. He stressed the importance of not interpreting the client's experience (Lude, 2003).

Shaw's (2004) grounded theory study explored psychotherapists' somatic experiences during the therapeutic encounter. Extolled as a significant contribution to psychological theory and clinical practice by Macecevic (2008), his study was the first in

its exploration of the phenomenon of SCT. Drawing on the philosophical work of Merleau-Ponty (1962), and on Rowan's (1998) concept of "linking", Shaw (2004) viewed the therapeutic encounter as an "intrinsically embodied experience" (p. 15). Based on the lived-body paradigm of phenomenology, a grounded theory of embodiment was generated, indicative of the relationship among first-order themes (e.g., physical reactions, communication, and styles and techniques); second-order themes (e.g., body empathy, body as receiver, body management); and, permeative themes (e.g., psychotherapeutic discourse and researcher embodiment) (Shaw, 2004).

One of Shaw's (2004b) study participants described her experience of SCT. She remarked, "The body is clearly an instrument of physical processes... This sensitive instrument also has the ability to tune in to the psyche: to listen to its subtle voice, hear its silent music and search into its darkness for meaning" (p. 17). Shaw's (2004a) findings therefore suggest that therapists use their somatic experiences to navigate and interpret the therapeutic encounter; specifically, "the therapist's body experience (may provide) invaluable information about the intersubjective space between therapist and client" (p. 273). Shaw (2004) concluded that psychotherapist embodiment, when regarded as a common factor, fits well within the integrative psychotherapy movement that examines the common factors present in all forms of psychotherapy.

For her Master's Thesis, Clarke (2007) addressed a noted gap in the social work literature (e.g., how the body is manifested, used, and understood in social work practice) by asking the research question: "How and to what extent do clinicians experience personal body awareness in sessions and what factors are associated with an increased sense of personal body awareness?" The completion of an online survey by study participants ($n = 310$) revealed that the vast majority of social workers reported being

aware of their bodies and bodily responses in assessment and practice with clients, and of taking these factors into account in sessions (Abstract, Clarke, 2007).

Another Master's Thesis investigated the efficacy of the therapeutic use of touch in psychotherapy with trauma victims (Finneran, 2009). A national purposive expert convenience sample ($n = 76$) was recruited for their self-identification of having experienced a traumatic event(s), or having a current or past diagnosis of PTSD. An anonymous online survey that inquired about the use of direct touch as a method of abreaction for trauma-related symptoms was completed. The study aim was to determine if individuals with a trauma history derived curative aspects from the use of therapeutic touch modalities during the treatment process. The findings revealed that people with significant trauma histories found them to be helpful in the recovery process (Finneran, 2009).

Recently using a grounded theory methodology like Shaw (2004), Athanasiadou and Halewood (2011) explored twelve therapists' somatic experiences in the countertransference. Their analysis revealed how the therapist's body may function as a means of empathic and intuitive connection to the client's internal world within the realm of intersubjectivity, through unconscious mechanisms. Examples of SCT given by the study subjects included phrases such as, "So the body can be a mirror to the client's body, something you identify with, as in SCT"; "I think of it as an unconscious communication of the patient that I was responding to somatically"; and, "It's a sort of empathy" (Athanasiadou & Halewood, 2011).

Most recently, Jakubowski (2012) conducted an exploratory descriptive study to examine eight therapists' use of their physiological responses in work with trauma survivors. The body's role in implicit communication during clinical work was

investigated. Using qualitative content analysis, Jakubowski (2012) sought to build on a relational framework to view SCT as therapists' experiences and use of physiological responses during therapy with trauma survivors. Findings revealed that clinical functions, such as ability to attune, choice of interventions, assessment, ability to maintain boundaries, and prevent vicarious trauma were used by the participants.

To conclude the presentation of research on SCT, Shaw (2004) noted the process of body-oriented communication seems to be an important area to research and incorporate within psychotherapy training because the commonplace occurrence of somatic phenomena are far too important to ignore. As next steps in research, he recommended rigorous scientific investigation in a critical fashion (Shaw, 2004), and an articulation of bodily knowledge in the language of evidence-based research (Vulcan, 2009). Furthermore, pursuant to Shaw's (2004) suggestion that psychotherapy in general embrace other disciplines to investigate and theorize about SCT and embodied empathy, this study aims to offer nursing's unique contribution.

Summary of Research on SCT

To summarize the literature on SCT, more theoretical than empirical research on countertransference (CT) has been conducted. As Vulcan (2009) noted, due consideration has not yet been given to the somatic manifestations of countertransference (CT), or somatic countertransference (SCT). There are currently no measurement tools to measure traditional CT. Two new measurement tools (e.g., the Body Awareness Measure and Frequency of Practice Measure) have been developed and utilized by Forester (2001) to assess use of body awareness by therapists' as a way of managing CT (Jakubowski, 2012). A questionnaire to assess the frequency of somatic/body-centered CT in therapists was also developed by Egan and Carr (2008). This latter tool was used by Booth, Egan,

and Trimble (2010) to quantitatively measure the frequency of body-centered CT in Irish clinical psychologists ($n = 84$). Study findings revealed that almost 80% of the sample reported some form of body-centered CT, especially muscle tension during the previous six months (Jakubowski, 2012).

A current paucity in research on SCT reveals the need for more empiricism. Quantitative studies have yielded inconsistent results; small sample sizes; and, a lack of external validity (Jakubowski, 2012). In order to replicate findings, operationalize and define terms, and provide further support about identified patterns, more quantitative research on SCT is therefore needed (Jakubowski, 2012).

Limited qualitative research on the phenomenon of SCT also exists. A total of seven studies were located by the researcher. To reiterate, only two grounded theory studies (e.g. Shaw, 2004; Athanasiadou & Halewood, 2011), one phenomenological study (e.g. Rutter, 1989), three narrative case studies (e.g. Ross, 2000; Lude, 2003; Clarke, 2007), and one qualitative content analysis (e.g. Jakubowski, 2012) were located.

By qualitatively exploring and describing nurse TT practitioners' SCT experiences, this study using qualitative content analysis (Sandelowski, 1995) can provide further understanding of the SCT phenomenon. Additional elucidation can make an important contribution to the general body of knowledge, and to that for nursing, in particular.

Related Phenomena

Imagery

The type of SCT-related imagery to be explored in this research study is distinct from the traditional use of guided imagery (GI) in nursing. Though a more extensive

review of the empirical literature on GI is beyond the scope of this present study, a brief discussion of that which is germane to this research will be useful to the reader.

Selected Literature on Guided Imagery

The first publication on the use of imagery as a nursing strategy appeared in McCaffrey's (1979) book on pain management. Scientific investigation of guided imagery (GI) began to appear in the nursing literature in 1981 (Heinschel, 2002). Its benefit has since been well established in psychiatric mental health (PMH) nursing, in the areas of: anxiety (e.g., Jallo, Bourguignon, Taylor, & Utz, 2008)); pain (e.g., Swinford, 1987); improved ability to fall and stay asleep (Jallo, Bourguignon, Taylor, & Utz, 2008); and, symptom management (Eller, 1999).

One study on GI was particularly informative to this research study. Farr (1990) developed a specific type of GI, designed to facilitate the generation of spontaneous imagery in clients during counseling. In five female clients she reported that the intervention facilitated exploration and disclosure of deep emotional material that may not have been uncovered for many sessions with verbal interaction alone. Her study findings revealed: 1) the imagery enabled the participants to quickly discover and explore affective material related to important life issues; b) their images were powerfully intense and real; c) their images were perceived as being representative of events and relationships in their lives; and, d) the imagery process facilitated their discovery of personal meaning and increased understanding about their inner and outer lives (Farr, 1990).

Empirical Literature on SCT-related Imagery & TT

An exhaustive review of the literature was conducted in a quest to locate explicit examples of SCT-related spontaneous imagery in the healer. Two qualitative studies outside the field of nursing were located: one in psychology (Samuels, 1985), and one in anthropology (Csordas, 1994). To this researcher's knowledge, there are no studies in the nursing literature that have investigated this aspect of SCT per se. However, in his qualitative study Csordas (1994) provided compelling examples of SCT-related imagery as reported by TT practitioners.

The literature on TT in particular was also carefully scrutinized in an effort to find examples of TT practitioners' report of SCT-related imagery that corresponded with patients' unconscious material. The results were few and deeply embedded in the text. Significant findings from the empirical literature were Heidt's (1990) grounded theory study and Coppa's (2008) descriptive study that used a qualitative design. In her discussion of future directions for TT research, Quinn (1989) also provided a compelling example of an experience of resonant imagery between a TT practitioner and recipient.

Nursing Literature

In the nursing literature, Quinn (1989) gave an example of resonant imagery, saying, "On the other hand, some subjects reported some very meaningful experiences" (p. 24). One client reported, "I can't describe it. I felt like...if I could always feel this way I would be fine...I felt like a little baby being held, totally secure, totally peaceful...peaceful, so calm...it was almost...spiritual. I never felt anything like this before." Prior to any discussion with this recipient, the corresponding TT practitioner had written, "I felt very centered during TT. Suddenly 'saw' a very small baby, an infant, and imagined that I was holding her in my arms. As I held her I allowed her to be surrounded and penetrated with unconditional love and peace. I could feel it pouring out of me, into

her. The baby just slept, filled with love and peace. I allowed this image to fade as I ended the treatment. During the session the patient appeared to be asleep” (p. 24).

Heidt (1990) also alluded to nurses picking up on a client’s unconscious material. Using the constant comparative method, Heidt (1990) generated a grounded theory explaining the process of TT for seven nurses and seven patients. The primary experience of TT for both practitioners and recipients was found to be opening to the flow of the universal life energy. Although Heidt (1990) focused on patients’ involvement in the creative imagery that emerged during TT, she provided significant examples of two of the nurses’ experience.

Heidt (1990) reported that while treating a patient with deep muscle tears after childbirth, one TT practitioner recounted, “I got the feeling that the problem is not in the pelvis. It is higher. It is here (points to the heart). I then asked her if she was afraid that she wouldn’t heal.” (p. 183). Another nurse related that many thoughts kept coming to her as she was treating her patient. Pondering the source, she said, “I began to connect the tension of her shoulders with her life choices and life-style right now” (p. 183).

Other nurse researchers made explicit mention of patients’ imagery. Nebauer’s (1994) study highlighted the significant role of insight imagery in the patient’s healing process (Smyth, 1996). Hemsley, Glass, and Watson (2006) conducted a hermeneutic phenomenologic study to investigate the extraordinary and transformative experiences of nurse healers. They, too, found that the entering of profound or expanded states of consciousness might manifest in unusual insight.

Similarly, using quantum physics, Smyth (1995, 1996) conducted a hermeneutic phenomenological study (van Manen, 1990) to explore the healing phenomenon during TT. Participants in Smyth’s (1995, 1996) study related having insights which sometimes

happened during the TT session, or evolved as the sessions progressed (Smyth, 1996).

These took the form of visual images, feelings, and insights. The imagery seemed to be of a supportive nature directly related to the patient's situation. Specifically, Smyth (1996) reported, "Mobilization of healing seemed to take the form of imagery, warmth and vibration-like sensations, and a generalized presence of energy" (p. 21).

Literature Outside Nursing

Samuels (1985) conducted a research project in which the countertransference experiences of twenty-six psychotherapists, covering a total of fifty-seven cases, were collected, collated and evaluated. Of these, 35 (46%) were held by the respondents to be of embodied countertransference and 41 (54%) of reflective countertransference, reactions regarded as having been stimulated by communications from the patient. Samuels (1985) became aware that all the instances of countertransference could be regarded as images, true even of the bodily or feeling responses because they were active in the psyche in the absence of a direct stimulus which could be said to have caused them. In other words, nothing had been done to the analyst that would explain the presence of such a reaction (Samuels, 1985).

Samuels (1985) essentially identified what Corbin (1972) had earlier described as the *mundus imaginalis*, an archetypal realm of images in the psyche, a level of reality that may link two persons in a certain kind of relationship. In 1989 Samuels again explored the idea of a "*mundus imaginalis*," an imaginal world, a third order of reality between subjective and objective that enables the therapist to gain "in-sight." He described it as an in-between state, where images take the place of language (Corbin, 1969). Further, it is a process wherein imaginal sight emerges, that can be experienced through the eyes, the body, or the emotions (Schwartz-Salant, 1991, p. 211, as cited in Rowan, 1998).

Macecevic (2008) described embodied countertransference as involving the meeting of two individuals in this realm. She noted that based on commonalities noted between the analyst's body and the mundus imaginalis, the analyst's "organ of visionary knowledge" (Corbin, 1972, p. 1) is therefore considered their countertransference (Samuels, 1985, 1989; Macecevic, 2008).

Csordas' (1994) phenomenological study findings revealed compelling examples of imagery related to SCT phenomena in healers; in TT practitioners, specifically. An anthropologist, he distributed questionnaires between 1986 and 1989 to a group of Charismatics ($n = 587$) in southeastern New England. Data was also comprised of interviews with eighty-seven healers of varying degrees of experience and "giftedness," including both laypeople and clergy. Professional training in health or mental health care (e.g., psychology, psychiatry, internal medicine, social work, nursing, and pastoral counseling) was held by twenty-six (30%) of the participants, though not all of these integrated healing into their professional work (Csordas, 1994).

Detailed phenomenological data were also gathered in sixty private sessions with eighteen supplicants conducted by six participating healers. Csordas (1994) based his account on a particular variant of phenomenology in which bodily experience is understood as the existential ground of culture and the sacred. Merleau-Ponty's (1962) philosophical ideas were used to understand an embodied process of perception as "embodied imagery" Csordas (1994).

Csordas (1994) noted the ethnopsychological assumption that any spontaneous imagery in the healer is likely to reflect important unconscious content in the client. He distinguished therapeutic imagery as typically evoked during moments in a healing

session devoted to “openness,” but not during periods of discussion and “counseling.” He indicated that Guided Imagery may take one such form (Csordas, 1994, p. 75).

Csordas (1994) stated that in ritual healing imagery assumes a specific efficacy in transforming other orientations, particularly those associated with illness and distress. He indicated that imagery may be either revelatory or therapeutic in that the content of therapeutic issues may emerge. As germane to this study, when experienced by healers (e.g., TT practitioners), revelatory imagery is invariably spontaneous. In contrast, therapeutic imagery occurs not to the healer but to the patient and constitutes the experiential resolution of a problem.

Csordas (1994) indicated that charismatic healing is relevant for all kinds of emotional problems, and subsumes the “healing of relationships” (p. 40). Inner healing is also referred to as “healing of memories,” a term that reflects its underlying theory of affliction. Emotional “woundedness” or “brokenness” is the result of traumatic life events. Among revelatory acts, vision or imagery may occur to either healer or supplicant, experienced as a nonverbal sensory image. In the healer, imagery signifies that healing is occurring. For example, during administration of TT, one healer in his study shared, “...as I lay down my hands...love energy brings up what needs healing...and that’s when we deal with healing of memories...so it brings it up in the sense of bringing to consciousness and bringing it into what you can talk about” (Csordas, 1994, p. 53).

Of particular note, his study findings described specific modalities of revelatory imagery reported by Charismatic healers: visual (54%) (e.g., mental pictures); intuitive (32%) (e.g., “sense” about person/situation); auditory (28%) (e.g., inner words); and affective (14%) (e.g. specific emotion). Three of the healers, all of whom had some

degree of professional psychotherapeutic training, emphasized the continuity between human intuition and this mode of imagery, described by some as an impression (Csordas, 1994).

Csordas (1994) also provided two hundred eighty-seven examples of specific images reported by healers. Roughly half of the images ($N = 146$) were symbolic signs of persons and situations (e.g., revelations about a patient's problem). Sixty healers experienced imagery of people alone; thirty-nine of objects; and twenty-two experienced imagery in the form of an emotion or an impulse. Overall, the possible interpretation varied depending on whether or not the healer knew the nature of the patient's affliction. If known, then such an image indicated either that healing was taking place; if not known, the image may have specifically revealed a problem to be dealt with (Csordas, 1994).

As related to psychocultural themes, the largest group of interpretants in Csordas' (1994) study had to do with the lack of failure of intimacy, either in childhood or adulthood. Symbolic images were interpreted as the enduring consequences of traumatic events, also subcategorized in terms of origin in childhood or adulthood (Csordas, 1994).

Csordas (1994), like Quinn (1989), noted that charismatic revelatory imagery can be experienced by both healer and suppliant, and that on occasion separate but complementary images may be experienced (i.e., resonant imagery). Imagery emerges from the intersubjective milieu, a view in keeping with Jung's (1921) perspective on the role of imagery as tapping unconscious processes. In contrast to the stereotyped notion of countertransference, a more positive view of the human person involving growth, integration, and individuation evolves (Csordas, 1994).

Empirical Literature on Embodiment

In addition to somatic countertransference, the physiological aspects of countertransference have also been termed body-centered countertransference and embodied countertransference (Jakubowski, 2012). Phenomenological approaches have been used by anthropologists to understand social issues of the body, and to focus on lived experiences - including pain, emotion, violence, and trauma. Nurses have therefore used embodiment as a central paradigm, with the term “mind-body connection” now replacing it (Wilde, 1999). In nursing, embodiment has been studied in relation to emotion (e.g., Benner & Wrubel, 1989; Lawler, 1993), and violence and/or trauma (e.g. Winkler & Wunninger, 1994).

Rich potential exists for interdisciplinary theory development in literature using embodied approaches. Soth (2006) referred to “an ‘embodied’ phenomenology of the therapeutic relationship” (p. 12). He defined embodiment as “a subjective experience, as a sense of being in my body, identifying with the ‘lived body’ moment-to-moment.” (p. 12). Lawler (1993), an Australian nurse, coined the term “somology” to mean the study of the body. She noted the lived experience of nursing the body is hard to describe and communicate through language. Lawler (1993) claimed that in nursing, embodiment is important because embodied knowledge provides much needed theoretical links in practice for living with chronic illness.

A review of literature from the fields of psychotherapy, nursing, and social work demonstrated that embodiment is used as a technique to provide quality treatment with consciously present awareness of the client/patient (Talbot, 1998; Thomas, 2005; Wilde, 1999). Wilde’s (1999) theoretical and Raingruber and Kent’s (2003) empirical work in the field of nursing demonstrate that attendance to embodied responses is an important part of clinical work (Macecevic, 2008).

Wilde (1999) defined embodiment as “an ethical stance in which the nurse makes a conscious choice to be fully aware of his or her own body to remain present to the patient” (p. 25). Raingruber and Kent’s (2003) phenomenological study investigated embodied responses of nurses, social work students, and faculty to traumatic clinical events. They supported their embodied stance, especially with regard to self-care and prevention of burnout. According to participants, “physical sensations served as a Geiger counter of meaning that helped clinicians reflect on and understand the traumatic event in the patient” (p.454). However, the cases studied did not focus on embodiment as a quality to be learned and utilized in therapy as a psychotherapeutic tool (Macecevic, 2008).

In her unpublished doctoral dissertation, Stromsted (1998) originally wrote about the dance and the body in psychotherapy. The holistic process of Authentic Movement, used in individual and group settings in the context of a healing relationship, was later found by Stromsted (2009) to be effective within the contexts of psychotherapy and meditative practices. Through the development of embodied presence, a descent into the inner world of the psyche was found to foster reconnection with deeper instinctual resources and spiritual intelligence in the molecular structures of the body.

Wang (2007) investigated mindfulness meditation (MM) for its personal and professional impact on eight meditating and nonmeditating psychotherapists. Specifically measured by valid instrumentation were the levels of awareness or attention, and empathy. Quantitative data analysis yielded no significant differences on the attention or awareness levels; however, one hypothesis was supported in that meditating psychotherapists scored significantly higher levels of empathy. Semi-structured interviews with the meditating psychotherapists demonstrated enhanced levels of attention and awareness, empathy, nonjudgmental acceptance, love, and compassion.

Ways of verbalizing the embodied experience was researched by Panhofer (2009) in an unpublished doctoral thesis, and then later reported (Panhofer & Payne, 2011). As an inquiry into the subjective undertaking of yielding meaning in movement, practitioners were provided with a language for articulation and description of the embodied experience. Referred to as nonlanguage ways of knowing, words were replaced by movement; metaphors, images and poetry were posited as possible methods of communicating it (Panhofer, 2009; Panhofer & Payne, 2011).

Using an integration of the artistic research methodologies of narrating and perceptual practices, Panhofer (2011) further examined the extent to which the lived, embodied experience can be worded. Building on the idea of an embodied cognition and the embodied mind, and by combining the use of writing and moving, he demonstrated the importance of nonlanguage ways of knowing. Widely applicable to research in counseling and psychotherapy, he concluded that crossing over modalities, and thus brain hemispheres, allows access to valuable, and even unconscious, material from the clinical work. This approach accesses the knowledge of the body beyond the use of words (Panhofer, 2011).

Examining the challenges of doing holistic trauma work, Ben-Shahar (2012) further explored relational perspectives and their relevance for body-oriented psychotherapy. The researcher posited that in work with post-traumatic clients, the therapist's help is elicited in helping clients deal with splitting; in other words, to build bridges between the dissociated aspects of the self.

Empirical Literature on Embodied Empathy

Hirose (1999) explored and interpreted the nurse psychotherapy process with a phenomenological approach (Hirose, 1992, 1992a, 1993). Hirose's (1999) study aim was

to identify types of verbal communication approaches to empathic understanding, and how these contributed to psychological support for forty-six Japanese cancer patients. Hirose (1999) indicated that when both a patient and a nurse psychotherapist have a deep level of empathic understanding, the patient can recover his or her own way of being, with embodiment in the nurse psychotherapist helping the patient to live more in the here and now (a Gestalt perspective). Levels of patient experiencing perceived by the nurse psychotherapist and types of verbal communication approaches to empathic understanding were established. Key points identified were the ways in which a nurse psychotherapist perceives the patient's inner process of experiencing through intuition, and the kind of empathic understanding with which the nurse psychotherapist approaches the patient (Hirose, 1999).

A more recent preference for the term “embodied empathy” over “embodiment” has been endorsed. Regarding clinical supervision, Meekums (2007) notes an awareness of the lived body, of subjectivity and intersubjectivity and of somatic intelligence that might assist the trainee in developing a capacity for creative “not knowing” and “linking” (p. 105).

For her dissertation research Macecevic (2008) conducted a qualitative study of eight psychotherapists’ lived experience of a phenomenon she coined embodied transcendental empathy (ETE). She defined ETE as a truly transpersonal experience where higher levels of consciousness are embodied. She used the term, embodiment, to describe a state of consciousness of the psychotherapist during which a conscious choice to be present in the physical body is made while in session with a client.

Macecevic’s (2008) study participants were eight psychotherapists from the San Francisco Bay area who were either self-selected, or nominated as having experienced

ETE. Five key constituents delineated the essential meaning structure of ETE: 1) the psychotherapist experiences a profound quality of being described as relaxed, calm, open, or spacious, and deeply intimate and accepting. This state of being invites clients to reciprocate by fully engaging in the therapeutic process; 2) psychotherapists' bodies are integral to the ETE experience for information gathering and empathic expression; 3) there is an experience of dropping or settling into a mutual space or field of experience within which interpersonal boundaries are less defined and the psychotherapist perceptually experiences the client's experiences; 4) a transformation or breakthrough occurs on the part of the client; and 5) extraordinary, sacred, and/or transcendent phenomena occur (Abstract, Macecevic, 2008).

Empirical Literature on TT

Qualitative latent content analysis was conducted by Chang (2001) to identify the concept of Ki related to Therapeutic Touch (TT) within the context of caring. The study purpose was to provide information on a culturally sensitive nursing intervention.

Interactive interviews were conducted with nineteen health care professionals, four alternative therapists; ten inpatients; and, thirteen healthy adults. Six categories of Ki related to perceived meanings of Ki emerged: two related to Ki and four related to touch. From these, two themes were postulated: Ki, the interactive energy flow; and touch, the activator of Ki flow (Chang, 2001).

TT has not been investigated in PTSD per se. However, Olson, Sneed, Bonadonna, Ratliff, and Dias (1992) studied TT in post-hurricane Hugo survivors. Using three case examples, Hill and Oliver (1993) recommended the integration of TT into mental health nursing clinical practice; namely, with patients with Obsessive Compulsive Disorder (OCD), symptoms of trichotillomania and chronic dysthymia, and child

molestation. Slater (2004) also reported on human holistic and energetic responses following an F-4 tornado. After administering fifty complementary energy treatments to victims, she discovered that the same energetic, physical, emotional, mental, and spiritual disruption occurred in people whether directly exposed to the tornado or not. Also, the damage did not disappear spontaneously over time. In conclusion, she suggested that energy healing techniques and TT hold promise for victims of PTSD and trauma (Slater, 2004).

Research Question

The interpretive paradigm was viewed most suitable for this qualitative research because of its potential to generate new understandings of the complex multidimensional and human phenomenon of SCT. Content analysis was deemed a suitable research methodology to explore nurse TT practitioners' description of their SCT experiences.

Since illuminating the phenomenon of SCT required the participants to raise their level of awareness, and the main research question (see Appendix G) contained embedded and overlapping phenomena, an attempt was made to understand the targeted phenomenon as a whole (Ajjawi, & Higgs, 2007). Orbach and Carroll's (2006) definition of SCT was used to develop the following additional probe questions:

- "What sort of experiences do you experience in your body during TT, from everything you can think of?"
- "What do you perceive, if anything, during TT sessions?"
- "What do you see, if anything, during TT sessions?"
- "What emotional issues, if any, do you perceive in clients?"
- "What experiences do you consider extraordinary, if any?"

CHAPTER III

METHODS

In Support of the Method

A qualitative research design was chosen for this research study because the nature of the SCT phenomenon being studied is lived human experience. The method of latent content analysis, described by Sandelowski (1993, 1995, 2000, 2010), allowed for a description and preservation of nurse TT practitioners' unique SCT experiences in their own words. Content analysis revealed the underlying meaning in their communication (Chang, 2001). This offered a glimpse into the vast reality that nurse TT practitioners tap into as they bear witness to human suffering (Vaillot, 1966), and attempt to lessen its burden (Thomas & Pollio, 2002).

In this study, the SCT experiences described by nurse TT practitioners during healing sessions with traumatized clients were initially explored with Orbach and Carroll's (2006) definition of SCT. The study participants were asked to provide a description of any thoughts, feelings, body senses or sensations, perceptions, and all other forms of inner life subjectively experienced (Bugental, 1976). The specific aim of the study, therefore, was to obtain a description of SCT phenomenon from a purposive sample of nurse TT practitioners.

Content analysis of the data resulted in a description of their experiences of SCT during clinical practice with patients who have been traumatized. The research question and objectives were based on an assumption of the researcher that the SCT phenomenon involves a therapeutic state of consciousness within the nurse TT practitioner. Further description of the SCT phenomenon during work with traumatized clients can help lay the foundation for future research on the role TT plays in the treatment of trauma. Data

obtained from this study can also be used to inform psychiatric nurses, nurse TT therapists, and psychotherapists in ways to increase effectiveness of trauma therapy.

In Support of Content Analysis

Krippendorff (1980) emphasized the relationship between the content of texts and their institutional, societal, or cultural contexts (Weber, 1990). Krippendorff (1989) later noted that “content analysis is indigenous to communication research and is potentially one of the most important research techniques in the social sciences.” Krippendorff (1989) stated further, “It seeks to analyze data within a specific context in view of the meanings someone, a group or a culture, attributes to them” (p. 403).

Krippendorff (2004) indicated, “Qualitative approaches to content analysis (CA) have their roots in literary theory, the social sciences (e.g. symbolic interactionism, ethnomethodology), and critical scholarship” (p. 17). In common with interpretive approaches, CA requires a close reading of relatively small amounts of textual matter. It involves the re-articulation (interpretation) of given texts into new (analytical, deconstructive, emancipator, or critical) narratives within particular scholarly communities” (p. 23).

As per Downe-Wamboldt’s (1992) and Krippendorff’s (1980, 1989, 2004) definitions, the goal of this qualitative content analysis was “to provide knowledge and understanding of the phenomenon under study” (p. 314); namely, SCT. A systematic classification process of coding and identification of subcategories, categories, and a theme comprised the subjective interpretation of the content of the text data generated from interviews with study participants (Hsieh & Shannon, 2005). However, in a reflexive and interactive manner, treatment of the data was continuously modified to accommodate new data and new insights about it (Sandelowski, 2000).

In this exploration of the distinctly human phenomenon of SCT, the researcher remained as faithful to its essence as possible. The illumination of nurse TT practitioners' subjective descriptions was found to be a valid way of gaining further knowledge about the phenomenon as accurately reflected in the articulation of their experiences. Following Patton's (1980) guidance, "the researcher's pre-existing expectations were not imposed on the research setting" (p. 40).

Participants were allowed to describe what they believed are experiences of SCT; that is, what they experienced in their bodies, what they perceived, what they saw, and what emotional issues they perceived in clients (Raingruber & Kent, 2003). With this attention to their embodied SCT responses, the nurse TT practitioners in this study were able to gain further meaning about their past interactions with clients who have experienced trauma (Raingruber & Kent, 2003).

In this study, analysis of the content of the texts was therefore situated within the institutional, societal, and cultural contexts (Krippendorff, 1980) of current trauma treatment. Content analysis also occurred within the context of nurse TT practitioners' description of the SCT phenomenon and the meanings they attributed to it (Krippendorff, 1989). The use of content analysis was supported in this study.

Description of the Setting

Naturalistic in design, the phenomenon of SCT was described within the context of how it presented within the natural environment of the individual TT healing session. Interviews with participants occurred in a quiet, private setting of their choice.

Characteristics of the Participants

The goal of this study was to acquire a rich or dense description of the SCT phenomenon through in-depth interviews with participants who were purposefully selected (Denzin & Lincoln, 2000; Patton, 2002). This allowed the most to be learned, and further insight gleaned about the SCT phenomenon under investigation (Stella, 2010). Consistent with the interpretive paradigm, a purposeful volunteer sample of twelve TT practitioners was recruited to achieve a minimally adequate sample size of seven (Denzin & Lincoln, 1994; Sandelowski, 1995; Creswell, 2007). In the event of participant drop out, additional participants were recruited to maintain the minimal sample size. The goal of the researcher was to reach a point of saturation; that is, a point in time when a clearer description of the SCT experience was not found through further discussion with participants (Sandelowski, 1986; Sandelowski & Barroso, 2003). This goal was accomplished after qualitative interviews with eight nurse TT practitioners.

Inclusion Criteria

Criterion sampling was utilized for this study (Creswell, 2007). Participants were selected who met the pre-determined criteria of significance (Patton, 2002). The criteria for inclusion included self-identification as having had SCT experiences, willingness to talk about them, and enough diversity from one another to enhance possibilities of rich and unique stories of the particular SCT experience (Creswell, 2007).

Specifically, the four inclusion criteria met were: 1) current licensure as a Registered Professional Nurse; 2) self-identification as a TT practitioner; 3) self-identification of having experienced SCT phenomenon during at least the past six to twelve months when working with patients with trauma histories; and 4) willingness to talk about those experiences to the researcher. These criteria for sample selection

reflected the purpose of the study and research question(s). Rationale for this selection was based on the assumption that these nurse TT practitioners were familiar with the content and process of their minds (Creswell, 2007). That is, they were able to recall, and then articulate, their experiences to the researcher. There was no specific age, racial/ethnic, sexual orientation, or religious criteria to be met (Macecevic, 2008). A conscious decision was made not to require a specified number of years of experience as a TT practitioner, nor proof of qualification (i.e. certification). This was based on the rationale that significant engagement with healing is less a matter of time practicing (Hemsley & Glass, 2006) than intention to do so (Krieger, 1979a, 1979b).

Subject Recruitment

TT practitioners were recruited from: 1) the professional organizations, Therapeutic Touch International Association (TTIA), located in Delmar, NY, and the American Holistic Nurses Association (AHNA), NY/NJ/CT chapters subsequent to receipt of respective Agency Letters of Permission (See Appendices H and I); 2) the Pumpkin Hollow Retreat Center, located in Craryville, NY; 3) public listings on the internet; and, 4) word-of-mouth (snowball sampling) (Thomas & Pollio, 2002). A letter of study recruitment (Appendix A) and a Recruitment Flier (Appendix B) describing SCT and the proposed study was dispersed electronically by the researcher to affiliating members of the aforementioned professional organizations; to publicly-listed TT practitioners; and, those contacting the researcher directly. In the e-mail letter of recruitment, members were asked to either nominate a colleague who fits the description outlined, or to self-identify as an interested, qualifying participant. Persons who replied to the recruitment statement or who were nominated by the professional community were

contacted by telephone or e-mail, given a brief initial interview, and screened for appropriate participation.

Protection of Human Subjects

Ethical approval for protection of human subjects was obtained from the Rutgers University Institutional Review Board (IRB). Ethical considerations took the form of obtaining two Informed Consents: one for study participation (Appendix C) and one for Audio Taping (Appendix D); and, maintaining participant confidentiality. Prior to participation, all subjects were provided with information detailing the aims of the research and the process. Prior to the study, they were given the opportunity to ask questions about the research, and were made aware they can withdraw from the study at any time without negative consequences or repercussion. Written consent was obtained from each volunteer prior to commencement of data collection and conduct of audio taped interviews.

Participants' confidentiality was maintained through the use of a separate, new blank audiotape for each interview, labeled numerically #1, #2, etc. In order to avoid any interpreter bias, verbatim transcriptions were completed by a third party administrative assistant who was unfamiliar with the nature of the study. As a form of member checking, individual transcripts were sent to each study participant for accuracy, and then verified by each. The audio tapes were then erased. All verbatim transcriptions and related notes will be kept in a locked file by the researcher for seven years to maintain confidentiality and protection of human subjects, and then shredded. Specific contextual details in the research report that could potentially reveal the identity of the participant was also changed (Ajjawi & Higgs, 2007).

Protection of Risk and Benefits to Participants

There were no anticipated physical risks to study participants due to the exploratory nature of this study and no invasive intervention. However, as there was a potential risk for emotional distress such as embarrassment or discomfort when answering questions, a statement to this effect was included on the Informed Consent. As per the Rutgers University Office of Research and Sponsored Programs (ORSP), plans for referral to counseling or crisis intervention, if needed, were also included. Specifically, if a subject experienced emotional distress or discomfort during an interview, they had the choice to not answer a question, or immediately stop the interview. They could also choose to continue at a later date, or withdraw from the study entirely. As determined by the subject, if emotional assistance was needed, they were advised to see a counselor of their choice. If immediate assistance was needed, they would have been referred to the free and confidential Safe Horizon Counseling Hotline at (800)621-4673 (HOPE). Payment for any counseling services would have been the responsibility of the subject or their private or public health insurance carrier. During the course of this study, none of the foregoing measures needed to be taken.

Study participants were told verbally and in writing by way of the Informed Consent that benefits of participating in the qualitative interviews may be catharsis, self-awareness, healing, and empowerment (Thomas & Pollio, 2002). Furthermore, knowledge gained from their study participation may promote TT practice in nursing and the health care professions, and will promote a better description of the SCT phenomenon that, in turn, can benefit future patients undergoing trauma-related treatment.

Data Source and Collection

The traditional data collection strategy of the in-depth interview was used to produce a narrative account of the participants' description of their subjective SCT experiences. Once signatures of Informed Consent were obtained from each participant, a demographic questionnaire (Appendix E) was completed. Participants were then asked to describe their SCT experiences while engaging in individual TT sessions during at least the previous six to twelve months with clients with trauma histories.

A semi-structured interview format provided greater breadth or richness in data, and allowed participants freedom to respond to questions and probes without being tied down to specific answers (Morse & Field, 1995). The use of standardized questions decreased the risk of researcher bias, and also conferred the advantage of comparison across interviews (Minichiello, Madison, Hays, Courtney, & St. John, 1999). Each interview lasted up to one hour, depending upon the gathering of sufficient narrative data to answer the main research question. This interview approach was exploratory in nature, and the initial question set the direction of the conversation. Additional questions or prompts (Appendix G) were used as needed throughout the interview for the purpose of clarification, or to facilitate a deepening of the participants' description of their subjective experience. A concerted effort was made by the researcher to allow the participants' experiences to flow naturally and to allow space and time for memory to reveal itself. At no time did she interject her own prior experiences or knowledge of SCT.

During this study the researcher acted as the principal data collector. She is also a member of the same nursing profession as the participants, a Gestalt-trained counselor, and a TT practitioner herself. Being a colleague conferred the advantages of facilitating trust and confidence in the researcher-participant relationship; establishing rapport early

in the data gathering process; and, providing access to the nurse TT practitioners' clinical world and thoughts. Another benefit of this research interview approach was the fostering of a sense of safety to disclose personal information. Given the sensitive nature of SCT experiences, a shared interest in, and knowledge of SCT, ultimately strengthened the validity of the research findings (Whyte, 1992). Reciprocal, positive feelings of curiosity and respect on a cognitive and emotional level between the interviewer and researcher was also fostered (Kvale, 1996).

Overall, a balance between direction and flexibility was the goal of this study (Walker, 2011). In addition to data collected from the semi-structured interview, three types of data were generated during the research process: the transcript file (e.g., raw data), a field notebook (e.g., a detailed chronological account of the participants and their settings, and any thoughts the researcher had about the interview questions and subsequent responses); and, a reflective journal (e.g., on the research experience and methodological issues). This latter journal included observations during participants' recounting of their SCT experiences. This included a detailed, critical examination of ideas that emerged in relation to the research questions; and, reflections and insights related to the research that potentially influenced its directions (Minichiello, Aroni, Timewell, & Alexander, 1995).

Verbatim transcription of the audio taped interviews served as another source of data. In order to avoid interpreter bias, these were transcribed by a third party administrative assistant unfamiliar with the nature of the study. The interviews were typed simply in narrative form. An additional method of proofing the interview involved the process of reading the transcript again alongside the source audio tape (Sandelowski, 1995).

Data Analysis

Qualitative data from verbatim transcription of interviews was content analyzed using the basic and fundamental method of qualitative description described by Sandelowski (2000; 2010). Specifically, 1) The text was naively read several times in an attempt to understand each interview to get a sense of the whole, and to grasp the words or phrases that described the SCT phenomenon (Sandelowski, 1995); 2) The text was initially separated into the research question areas that contained sensitizing concepts (Patton, 2002) from previous research (e.g., Orbach & Carroll, 2006); 3) The text was then inductively separated into meaning units that appeared to share the same content, as guided by the aim of the study (Soderberg, Strand, Haapala, & Lundman, 2003); 4) Each meaning unit was then condensed, labeled and coded, and sorted into subcategories that described the manifest, or surface, content of what the text said; 5) The subcategories were then inductively subsumed into categories and a theme wherein threads of meaning appeared in category after category (Patton, 2004; Graneheim & Lundman, 2004); 6) The interview texts were then re-read to refine and verify the themes and interpretation, and achieve validity of the findings (Maxwell, 1992; Beitz & Goldberg, 2005); and finally, 7) The underlying meaning, the latent content of the categories, was inductively formulated into a theme (Graneheim & Lundman, 2004).

Trustworthiness

Methodological Rigor

According to the qualitative research tradition, methodological rigor ensured trustworthiness, or objectivity and worth of the study findings (Lincoln & Guba, 1985). Specifically, in order to establish trustworthiness of the data, issues of credibility, transferability, dependability, confirmability, and authenticity were addressed (Guba,

1981; Lincoln & Guba, 1985; Denzin & Lincoln, 1994; Morse & Field, 1995; Polit & Beck, 2008).

Credibility was addressed by creating a sample of a minimum of seven nurse TT practitioners recruited from a pool of twelve professional nurses who could represent the SCT phenomenon under study through a vivid and faithful description of their experiences of it. The nurse TT practitioners were informed about the study beforehand so that they could voluntarily consent to participate. All interviews were personally conducted by the researcher. In-depth descriptions, in participants' own words, of SCT experiences during interactions with patients who have been traumatized were included in the final text. In this way, participants' validation of the exhaustive descriptions achieved credibility (Dobbie, 1991).

The researcher's prior research experience in coding qualitative data (Welch, Thomas-Hawkins, Bakas, McLennon, Byers, Monetti, & Decker, 2013) lent some initial support to her qualification as an informed administrator of the method of analysis. The researcher worked closely with members of her dissertation committee to achieve consensus on coding and results of data analysis. In this way, representativeness of the data was ensured. Through this activity, truth, value, and applicability were also achieved (Guba & Lincoln, 1981; Sandelowski, 1986). The ultimate aim was the production of a high quality dissertation study and research report.

Rigor was also demonstrated through clarity in the data collection and data analysis processes. An audit trail was maintained by the researcher, and was reviewed by members of her doctoral dissertation committee with expertise in qualitative inquiry (Beck, 1994). During this "Memoing" phase (Forman & Damschroder, 2008) the researcher's early thoughts and hunches were recorded on the transcripts. Categories and

themes (e.g., core topics or meanings) that begin to emerge were identified, coded, and honed. The memos described subcategories and the connections among them that were developed through inspection of the data. Hence, the memos served as an audit trail of the researchers' analytic processes, adding credibility to the final analysis and conclusions (Forman & Damschroder, 2008).

Descriptions of the SCT experience will be considered credible if after reading the participants' words, the reader recognizes the experience as being similar to something that he or she has encountered themselves (Lincoln & Guba, 1985; Raingruber & Robinson, 2007). Transferability will depend on the degree of similarity, or generalizability, between the context of the interviews in the study and the actual setting. The context was described sufficiently so that readers can judge for themselves the applicability of the research findings to their own contexts (Seale, 1999). The fact that participants are nurse TT practitioners who themselves work individually with clients who have trauma histories will strengthen transferability to others TT practitioners who encounter clients with trauma histories in their practices (Polit & Beck, 2008). When the study findings can be dependably, consistently and reliably applied over time and conditions, their credibility will be strengthened (Polit & Beck, 2008). To further validate the findings, quotations were used to illustrate and provide concrete examples of the TT practitioners' description of the SCT phenomenon. Attempts were made to include their feelings or moods expressed during the interview, as recorded by the researcher in her fieldnotes during the recounting of their experiences.

Confirmability was achieved through the study findings being shaped by the participants' own SCT experiences, as described in their own words. The study results were derived from the participants' characteristics and the context of the study, rather

than from the researcher's biases (Polit & Beck, 2008). Use of or multiple methods and sources of data collection that used different perspectives, strengthened the claim of fairness in the comprehensive description of the SCT phenomenon produced (Polit & Beck, 2008).

In this study, two types of triangulation (e.g. investigator, or analyst; and, methods) were used (Denzin, 1970; Roe, 2013). In order to avoid selective perception, the researcher's analysis of the same qualitative data was read by another researcher, and the findings discussed. This helped reduce the potential for researcher bias inherent in a single person assessing consistency of the data collected (Roe, 2013). Methods triangulation included a variety of different methods to augment the collection of data (Roe, 2013). These methods included the use of fieldnotes and interviews. Copies of the interview transcripts were shared with the participants to verify the accuracy of their content. Upon review of them, each study participant verified their accuracy. In this way, a depth of study; possibility for triangulation of data; and, a better understanding of the concept of SCT was achieved (Creswell, 1994; Hsu, 2006).

Rich description and the use of participants' own words, in quotations, allowed the participants to speak for themselves. Constant cross-checking of interpretations (i.e., categorization and theme formulation) with the original transcripts maintained authenticity (Lincoln & Guba, 2000). In this way, closeness, or faithfulness, to the participants' descriptions grounded interpretations in the data. Ongoing dialogue with the dissertation Chair about emerging findings served to further check the faithfulness or authenticity of the data (Ajjawi & Higgs, 2007).

In summary, a qualitative research approach was chosen because it was particularly useful for studying SCT, a phenomenon about which little is known (Field &

Morse, 1985). This initial exploratory study aimed to illuminate SCT experiences as described by nurse TT practitioners. A focus on the individuals' experiences provided rich and detailed descriptions of this minimally explored SCT phenomenon. The chosen content analysis approach helped to make sense of the somewhat vague concept of SCT, and serve as a catalyst for its conceptualization (Knafl & Howard, 1984). The ultimate goal was the development of knowledge about SCT, and the nurse TT therapists' role in working with traumatized clients.

CHAPTER IV

CONTEXT AND INFORMANTS

Historical and Sociocultural Context of the Research

This study was conducted within the historical and sociocultural context of Energy Medicine, as classified by the National Center for Complementary and Alternative Medicine (NCCAM, 2002, 2004). Therapeutic Touch (TT) is one of the energy-based healing therapies subsumed within the subset of biofield modalities (Engebretson & Wardell, 2007; Rhodes, 2012).

The NCCAM defines “energy healing therapy” as “the channeling of healing energy through the hands of a practitioner into the client’s body to restore a normal energy balance and, therefore, health.” Energy healing therapy has been used to treat a wide variety of ailments and health problems, and is often used in conjunction with other alternative and conventional medical treatments (NCCAM, 2012; Hart, 2012) (<http://nccam.nih.gov/health/providers/camterms.htm>).

The premise behind energy healing is 1) a disruption occurs in a person’s holistic harmony when energy paths of the body are blocked or disturbed; 2) illness, disease, weakness, pain, and/or psychospiritual issues may ensue from this disruption; and 3) realignment of the energy paths during energy healing can alleviate these ensuing issues (Fazzino, Griffin, McNulty, & Fitzpatrick, 2010). The energy-based therapies commonly combine physical touch and non-physical contact to stimulate healing (Hammerschlag, Marx, Yamamoto, & Aickin, 2012). The human energy field is influenced, and the physical, emotional, mental, and spiritual dimensions of the patient are affected (Fazzino, Griffin, McNulty, & Fitzpatrick, 2010).

While energy medicine has long been accepted by many clinicians in the nursing and allied health care professions, it is increasingly accepted as an important healing practice in the medical community. Due to consumer demand, clinician interest, and experienced practitioners, a heightened awareness of the physical, emotional, and spiritual benefits of energy medicine has occurred (Hart, 2012). For example, as part of their training in integrative medicine, some medical residents are being taught about energy medicine, and physicians are writing orders for it in many hospitals (Hart, 2012).

Energy Medicine therapies, such as Therapeutic Touch (TT), are among the most common complementary therapies offered in hospital and community-care settings (Hart, 2012). TT is practiced in a variety of medical settings, including rehabilitation, hospice, palliative care, preoperative, postoperative, oncology, and home care. It is administered to people of all ages (Hart, 2012). Veterans are among those benefiting from TT. Nurse practitioners of TT are the focus of this study.

Therapeutic Touch (TT)

Human touch or laying-on of hands for the purpose of healing has been used historically and cross-culturally for centuries. TT is derived from this ancient practice and is based on the premise that the human body, mind, emotions, and intuition form a complex, dynamic energy field (Macrae, 1987; Zolfaghari, Eybpoosh, & Hazrati, 2012) that can be modified by the TT practitioner.

Nursing has been in the lead of contemporary health care professions in recognizing the influence of touch therapies (Engebretson & Wardell, 2007). TT was originally developed in the 1970s by Dolores Krieger, a clinical nurse, and Dora Kunz, a clairvoyant and energy healer, on the assumption that the human being is an energy field (Robinson, Biley, & Dolk, 2007; Zolfaghari, Eybpoosh, & Hazrati, 2012). They

envisioned TT as a noninvasive intervention that would be acceptable in the medical setting and build on the nursing tradition of compassionate, hands-on-caring (Rhodes, 2012).

Therapeutic Touch is currently defined by the Therapeutic Touch International Association (TTIA; 2013) as, “Therapeutic Touch® is a holistic, evidence- based therapy that incorporates the intentional and compassionate use of universal energy to promote balance and well-being” (<http://www.therapeutic-touch.org>). The TTIA reports that TT is now taught in more than 80 countries around the world in educational institutions, health care facilities, and community-based agencies and groups. For example, patient-centered health care systems, such as Planetree™ facilities, now offer TT training to their employees. Another example is the Veterans Administration (VA) hospital in New Jersey that is currently in the process of training all of its health care providers to become TT practitioners (Hart, 2012) (<http://www.therapeutic-touch.org>).

A TT treatment is a process that is always individualized and usually does not exceed twenty minutes in length. Although the exact method may vary among practitioners, generally their hands are passed over the body from head to toe, front and back, holding them between two to six inches from the skin. The purpose of this is assessment of the condition of the human energy field. Rhythmical, sweeping motions are then done with the hands, as if they are smoothing out wrinkles in the energy field. Physical touch may or may not be used by the practitioner.

The TT process involves five dynamic and interactive phases: Centering, Assessing, Intervention (Unruffling), Balancing, and Evaluation. During Centering, the TT practitioner’s body, mind, and emotions are brought to a quiet, focused state of consciousness. The breath, imagery, meditation and/or visualizations are used to open

one self to find an inner-sense of equilibrium. During the Assessment phase, sensory cues such as warmth, coolness, static, blockage, pulling, and tingling are described by some practitioners. The phase of Unruffling facilitates the symmetrical flow of energy through the field. During the Balancing phase energy is projected, directed, and modulated based on the nature of the living field. The goal is to assist in the re-establishment of order to the system. Evaluation, or Closure, consists of the use of professional, informed, and intuitive judgment as cues to determine when to end the session (<http://therapeutic-touch.org>).

In terms of TT credentialing (qualification), a standardized process now exists under the auspices of TTIA, the international organization representing TT (Hart, 2012). Prior to the year 2000, none existed. However, an application process for Qualified Therapeutic Touch Practitioner (QTTTP) and Qualified Therapeutic Touch Teacher (QTTT) practicing and teaching prior to 2000 was created. Recognition as a QTTT is specific to the level of TT for which one is applying (e.g., Basic, Intermediate and/or Advanced) (<http://therapeutic-touch.org>).

With regard to nursing practice, acceptance of TT by the nursing community has become widespread. In particular, TT has been integrated with mental health nursing approaches, and its use in practice has been demonstrated, for example, through case examples from experiences with students and clients (Hill & Oliver, 1993). As applied to practice, the nursing diagnosis that reflects understanding and use of biofield approaches is defined as follows: “Disturbed Energy Field: disruption in the flow of energy surrounding a person’s being that results in a disharmony of the body, mind, and/or spirit.” Benefitting nursing practice, TT has been studied in relation to facilitated relaxation, pain relief, promotion of healing, decrease in anxiety, and promotion of

mental health (Fazzino, Griffin, McNulty, & Fitzpatrick, 2010). Further research in psychiatric settings is awaiting.

Overall first-line treatments for PTSD with strong evidence bases are cognitive behavioral therapies such as Prolonged Exposure and Cognitive Processing Therapy, as well as Eye Movement Desensitization Reprocessing (EMDR) (Hamblen, Schnurr, Rosenberg, & Eftekhari, 2008). Although TT was developed by Dolores Krieger (1973) as a nursing intervention more than forty years ago, its use with psychiatric patients has been minimally explored. A contributor may have been controversy surrounding the use of any type of touch in psychiatric settings (Hughes, Meize-Grochowski, & Harris, 1996). Now, however, TT is being incorporated into psychotherapy for PTSD. The findings of this study lend further support to this trend.

Introduction to the Participants

The eight participants for this study met the inclusion criteria and were purposefully selected (Denzin & Lincoln, 2000; Patton, 2002). A point of saturation was reached in that a clear description of SCT experiences was obtained through the conduct of eight qualitative interviews (Sandelowski, 1986; Sandelowski & Barroso, 2003). Rich and unique stories told by each participant signified their diversity (Creswell, 2007).

As per the approved methods, and the receipt of Agency Letters of Permission (See Appendices H and I), the nurse TT practitioners were recruited from two professional organizations: the Therapeutic Touch International Association (TTIA), and the American Holistic Nurses Association (AHNA). TTIA is an international organization whose mission is to lead, inspire, and advance excellence in TT as a healing practice and lifeway (<http://therapeutic-touch.org>). Its vision is to expand awareness and access to TT as a process that potentiates and promotes worldwide healing. The TTIA

organization was initially established as Nurse Healers-Professionals Associates in 1977 under the leadership of Dolores Krieger, PhD, RN, and since 2010 has been doing business as Therapeutic Touch International Association. TTIA is a voluntary not-for-profit 501(c)(3) organization and all donations are tax deductible. TTIA serves as the central resource for information on TT. It is an international network for members. TTIA promulgates standards for TT education and practice, viewing the human body as a complex, dynamic whole, and healing as a process of restoring and promoting the integrity of body, mind and spirit (<http://therapeutic-touch.org/bylaws-2012>).

The American Holistic Nurses Association (AHNA) is a non-profit membership association for nurses and other holistic healthcare professionals, serving more than 5,700 members and more than 125 local network chapters across the U.S. and abroad. The AHNA has as its mission the advancement of holistic nursing through community building, advocacy, research, and education. The AHNA is affiliated with the American Holistic Nurses Certification Corporation (AHNCC) (<http://www.ahna.org/About-Us/Mission-Statement>).

Of the eight study participants, six were recruited from TTIA, and one from the AHNA. One participant was recruited through a public listing on the internet. No subjects were recruited through snowball sampling. A letter of study recruitment (Appendix A) and a Recruitment Flier (Appendix B) describing SCT and the proposed study were dispersed electronically by the researcher to affiliating members of the aforementioned professional organizations. Persons who replied to the recruitment statement were contacted by telephone or e-mail, given a brief initial interview, and screened for appropriate study participation.

Sociodemographic Characteristics of the Participants

For the frequency distribution of the selected demographic variables, see Appendix H. Table 1. The participants ranged in age from 61 to 78 years (*M* 67.13, *Md* 66). 100% of the sample was female. Five (62.5%) were married; 3 (37.5%) unmarried. 2, or 25% lived alone; 6, or 75%, lived with a spouse or other. The ethnic background of the sample was predominantly white (75.0%, *n* = 6); with two designating themselves as other (25%), writing "Native American." Every participant had attended some college. Their highest educational levels were: Associate (12.5%, *n* = 1); Baccalaureate (25.0%, *n* = 2); Masters (50.0%, *n* = 4); and, PhD or earned doctorate (12.5%, *n* = 1).

The participants had extensive experience in nursing practice: 12.5% (*n* = 1) worked between 11 and 15 years; 87.5 % (*n* = 7) had more than 16 years. This experience corresponded exactly with their years practicing TT: 12.5% had 11 to 15 years of experience, and 87.5% had more than 16 years, with some indicating 40 years. Regarding TT Certification, 62.5% (*n* = 5) were certified; 37.5% (*n* = 3) were not.

When asked about certifications held other than TT, 75.0% (*n* = 6) said yes; 25.0% (*n* = 2) said no. Other types of certification were the following: Nurse Practitioner (NP), Reiki (Master), Qualified Therapeutic Touch Teacher (QTTT), Guided Imagery (GI), Aromatherapy, Advanced Holistic Nurse Practitioner (AHNP), Clinical Nurse Specialist (CNS), Adult Advanced Practice Nurse (APN), Creative Healing, National Board for Certified Counselor (NBCC), and Registered Nurse, Certified (RNC).

87.5% (*n* = 7) of the sample practiced other holistic modalities; 12.5% (*n* = 1) did not. Other types of holistic practices indicated were: Meditation, Esoteric Studies, Voice & Sound Practices, Vibrational Energy, Aromatherapy, Acupressure, Guided Imagery, Reflexology, Medical Qigong, Massage Therapy (65 modalities), Emotional Counseling,

Biofeedback, Herbs, Homeopathy, Nutrition, Visualization, Emotional Freedom Technique (EFT), and Polarity Therapy.

To summarize the characteristics of the sample, the participants were a predominantly white, older, well-educated and experienced group of all female expert nurse TT practitioners. Although TT Certification was not one of the criteria for study inclusion, 62.5 % of the sample was certified in TT. Additionally, 87.5% practiced a myriad of other holistic modalities. Overall, the study population comprised a homogeneous purposive expert convenience sample of eight nurse TT practitioners who self-identified as having had SCT experiences while working with traumatized patients.

Description of the Audit Trail

An audit trail was used to establish the credibility of this study (Lincoln & Guba, 1985). Following established guidelines (e.g. Rodgers & Cowles, 1993; Creswell & Miller, 2000), its purpose was to contribute to the trustworthiness of the study findings by documenting “both the process and product of the inquiry” (Creswell & Miller, 2000, p. 128). The research process was documented at each stage to explain and justify the researcher’s decisions (Appleton, 1995). By accurately documenting the contextual background of the data; the impetus and rationale for all methodological decisions; the evolution of the findings; and, her particular orientation to the data, the researcher attempted to enhance the confirmability, dependability, and credibility of the study (Lincoln & Guba, 1985).

Five classes of records comprised the systematic collection of materials and documentation (Polit & Beck, 2008). These were: 1) the raw data (e.g. interview transcripts); 2) the data reduction and analysis products (e.g. memos, theoretical notes);

3) process notes (e.g. methodologic notes); 4) reflexive notes (e.g. a reflexive journal); and, 5) a draft of the final report (Halpern, 1983; Polit & Beck, 2008).

While reading the transcripts, memos were kept by the researcher to record her early thoughts and hunches about emerging categories and theme (Forman & Damschroder, 2008). In her field notes, taken during and after each interview, the researcher observed participants' body language, their emotional expression (e.g. crying, laughing); long silences; and, possible reticence to speak about the topic (Goldberg & Beitz, 2010).

In her reflexive journal, the researcher documented her self-awareness, and monitored her personal responses to the data (Rodgers & Cowles, 1993). She also maintained reflexivity through her consideration of the participants' context, and her own role as researcher (Patton, 2002). In keeping with Coffey and Atkinson's (1996) stance, the former was undertaken with the goal of "giving voice" to otherwise silenced individual nurse TT practitioners (p. 78).

Another purpose of the audit trail was to continuously engage in triangulated reflexive inquiry (i.e., self-reflexivity, reflexivity about those studied, and the audience) (Creswell & Miller, 2000). In addition to self-awareness, the researcher attempted to consider both the participants' worldview and the readers'. Credibility in this study was also enhanced by oversight of the researcher's doctoral dissertation committee (Patton, 2002) and an external auditor, Dr. Earl Goldberg, RN. By making an independent assessment of the reported findings, he was able to confirm the findings of the study (Cutcliffe & McKenna, 2004).

The interviews were conducted from August to October, 2013 in a private setting of the participants' choice: two in a private home; two in a private office; and four in a

private hotel room during a TTIA-sponsored week-long conference, “The TT Dialogues.” The TT Dialogues are an annual assemblage of expert TT practitioners who are currently working collaboratively toward development of the theory of TT as a healing process.

For this study all interviews were conducted on a one-to-one basis, and face-to-face between the researcher and the nurse TT practitioners. Since all subjects who were approached agreed to participate, a high response rate occurred. The researcher used effective interpersonal skills during the interview to put the participants at ease. Questions perceived by the subjects as ambiguous or unclear were clarified. Throughout the interviews in this research study, open-ended and standardized questions were used, following a semi-structured format. This enabled the participants to expand on their own SCT experiences, with rich, detailed information being obtained.

Since the researcher was concerned about imposing preconceived perspectives or researcher bias on the participants, the Interview Protocol (see Appendix G) was strictly followed (Goldberg & Beitz, 2010). None of her worldviews about SCT, professional experiences, or pre-understanding (Polit & Hungler, 1999) were shared with the participants. The researcher did not interrupt the participants as they were speaking. In these ways, the participants’ responses were not influenced by the researcher (Goldberg & Beitz, 2010).

No interview exceeded sixty minutes. Each was audio taped using a digital recorder, and then transcribed professionally by a third party unfamiliar with the phenomenon under study. In addition to the audio taping, descriptive validity (Maxwell, 1992) was fostered by comparing the verbatim transcriptions with the digital recordings, and verifying their accuracy with each participant (Beitz & Goldberg, 2005). The audit

trail was developed to correlate the original transcripts with the categories and theme emanating from them.

For the purpose of this study, the researcher completed four pre-pilot interviews in March and April, 2013 to gain experience and prerequisite skills in undertaking qualitative interviewing; and chiefly, to avoid the introduction of researcher bias, potentially strong at the outset of this study. Since the researcher was the one who collected all the data, the impact of her qualifications, professional training and SCT experiences had to be taken into consideration (Patton, 1990). As recommended by Graneheim and Lundman (2004), a balance between the researcher's particular perspective to SCT and "permitting the text to talk without imputing unintended meaning" (p. 11) was sought.

In this study, the qualitative researcher was potentially influenced by her prior learning (Sandelowski, 2010). From the outset of the study, she therefore made explicit her stance as previously presented in her review of the theoretical and empirical literature. This self-disclosure was an important validity procedure to present her position and knowledge, and to consider the influence of the social, cultural, and historical forces in which the study was subsumed (Creswell & Miller, 2000).

The researcher did not share her prior knowledge with the study participants. A definition of SCT from prior research (Orbach & Carroll, 2006) was presented to the participants at the start of the interview. The sensitizing concepts from the definition were used as a framework to formulate the interview questions, and to initially sort the data (Patton, 2002). Thereafter, the codes, subcategories, categories, and theme were inductively generated from the data (Sandelowski, 1995). Overall, the data was allowed to speak for itself (Sandelowski, 2010).

A semi-structured and standardized interview guide, approved by the Rutgers University Institutional Review Board, was employed to facilitate an in-depth exploration of the nurse TT practitioners' description of their experiences of SCT, the phenomenon under study. The interview schedule (see Appendix G) was designed for this study based on previous research in the field of Psychology (Orbach & Carroll, 2006).

In order to guard against researcher bias and to enhance the validity of the categorization method, the assistance of an independent researcher was employed. Dr. Earl Goldberg, RN reviewed and approved the categories to achieve consensus (Cutcliffe & McKenna, 1999). Since there is an absence of theory pertaining to SCT phenomenon, an objective, unbiased analysis of the data rendered a form of analyst triangulation (Woods & Catanzaro, 1988).

Methods triangulation was also utilized in this study to augment the collection of data (Roe, 2013). Different methods included the use of fieldnotes and interviews. When copies of the interview transcripts were shared with the participants to verify the accuracy of their content, all agreed. Triangulation of the interviews with analysis of the documents, and triangulation of the interviews with one another produced a depth of study, thick description, and a more holistic understanding of the concept of SCT (Hsu, 2006).

CHAPTER V

DESCRIPTION AND DISCUSSION OF THEMES

In this exploratory and descriptive study both manifest and latent content analysis were used to yield a meaningful description of SCT, the phenomenon under study (Sandelowski, 1993, 1995). Manifest content analysis described the surface and visible components of the text, and resulted in coding of the data and the development of subcategories. Latent content analysis involved the inductive generation of categories and a major theme that expressed the underlying meaning in the communication (Sandelowski, 1993, 1995; Chang, 2001). In Graneheim and Lundman's (2004) words, this revealed "what the text was talking about" (p. 111). Participants' nonverbal communication (e.g. silences, tears, laughter, and posture), as noted in a reflexive journal, was also incorporated into the latent content analysis.

Content analysis of the data occurred within a naturalistic paradigm (Hsieh & Shannon, 2005). The analysis was content-sensitive (Krippendorff, 1980) in that a condensed and broad description of SCT in the participants' own words was attained (Elo & Kyngas, 2007). Carefully worded, standardized research questions served as a bridge across interviews (Patton, 2002).

Since prior research about SCT is limited and further description of the SCT phenomenon is needed, a directed content analysis approach was used to guide the initial coding of the text (Hsieh & Shannon, 2005). Sensitizing concepts (Patton, 2002), derived from a definition of SCT from previous social science research (Orbach & Carroll, 2006), were used to initially separate the text into the research question areas, but not to, as Patton (2002) advises "strain or force" the data (p. 457). An inductive approach was then

used to code the data, formulate the subcategories and categories, and generate a theme (Sandelowski, 1995, 2010). The participants' verbatim responses to the semi-structured in-depth interview questions (see Appendix G) are presented in this chapter.

The unit of analysis for this study was interview text pertaining to eight nurse TT practitioners' descriptions of SCT when working with traumatized clients. The content was analyzed close to the text, with coding and naming of the subcategories and categories derived directly from it. Only content-characteristic words were used (Polit & Beck, 2004). All data were taken into account in the analysis process (Sandelowski, 1994). The main research question and prompt questions were formulated to address the study aim which was an illumination of SCT phenomenon through nurse TT practitioners' description of it. The categories inductively described the SCT phenomenon, with the goal of generating a theme and to increase understanding and knowledge about its occurrence in nurse TT practitioners.

One major theme, three categories, and ten subcategories were identified in the analysis. In total, seventy-six codes emerged that led to the researcher's interpretation (Graneheim & Lundman, 2004). For an overview of the coding framework developed, see Appendix, Figure 1. SCT: A Language for Healing Trauma.

Major Theme

The major theme that inductively emanated from the latent content of the text is that SCT can be viewed as "A Language for Healing Trauma." Created by linking underlying meanings together in categories and subcategories, A Language for Healing Trauma was found to be a regularity developed through condensed meaning units. The theme is consistent with communication research in the social sciences (Krippendorff, 1989) in that the SCT phenomenon was found to be a factor in the healing of trauma

resulting from the nonverbal and verbal communication among members of one group of nurse TT practitioners in interaction with their traumatized clients. This allowed for meanings attributed to SCT during the healing process of trauma to be described directly by the participants themselves (Krippendorff, 1989).

Related Categories

Analysis of the interview transcripts identified three main categories that led to the emergent theme. The researcher's interpretation resulted in an overall conceptualization of SCT that emanated from the study participants' descriptions. The main categories related to SCT experiences described by nurse TT practitioners during their work with traumatized clients were: Nurse TT Practitioner, Communication, and Healing. The Nurse TT Practitioner category was subcategorized as: Experiences, Visualization, and Qualities. The Communication category was subcategorized as: Awareness, Boundaries, Information, and Mode. The Healing category was subcategorized as: Trauma, Spirituality, and Release (see Appendix, Figure 1).

Demographics of Study Participants

For this study, eight nurse TT practitioners from across the United States were interviewed. Individual participants were from Arizona, Utah, California, Oregon, Indiana, and New Jersey. All were female and ranged in age from 61 to 78 years. Seven of the participants had engaged in TT practice for more than 16 years; the other between eleven and fifteen years. Five of the eight participants held TT qualification. Six of eight participants held an additional type of certification, including Nurse Practitioner (NP), Reiki Master, Qualified TT Teacher (QTTT), Guided Imagery, Aromatherapy, Advanced Holistic Nurse Practitioner (AHNP), Clinical Nurse Specialist (CNS) Adult, Creative

Healing, National Board for Certified Counselors (NBCC), and Registered Nurse Certified (RNC).

Seven of eight participants engage in holistic practices other than TT: Meditation, Esoteric Studies, Voice and Sound Practices, Vibrational Energy, Aromatherapy, Acupressure, Guided Imagery, Reflexology, Medical Qigong, Massage Therapy, Emotional Counseling, Biofeedback, Herbal Therapy, Homeopathy, Nutrition, Polarity Therapy, Emotional Freedom Technique (EFT), Wholistic Healing Research (WHEE Portal), and Visualization. For a summary of the demographic data gathered during the face-to-face interviews with the nurse TT practitioners, see Appendix, Table 2.

All eight participants provided descriptions that were then subsumed within the categories of Nurse TT Practitioner, Communication, and Healing. Exemplar quotes for each category and subcategory are presented for the reader to understand the nature and context of the content analyzed. A complete list of all remaining data sources is provided in the Appendix, Table 3.

Findings

Nurse TT Practitioner

The nurse TT Practitioner provides the structure for the SCT phenomenon. Three subcategories comprised this category: experiences, visualization, and qualities. Study participants described their experiences in response to the main research question addressing SCT (i.e., question #1), and prompt question #2 regarding their body experiences. Visualization experiences were described in response to prompt question #4. What the study participants perceived was addressed in prompt question # 3, the descriptions of which are subsumed within the subcategory, “Qualities” (see Appendix G). A summary is provided at the end of each heading.

SCT Experiences

SCT experiences were described in answer to the main research question, “Please tell me, what is your experience of SCT when you have cared for traumatized patients within the previous six to twelve months?”

Participant 8 provided a summary of her SCT experiences when she said, “Some experience that I’ve had with the somatic countertransference is when I work with the individual, and of course I’m centered, and I’m in their field, and our fields are interacting with each other... I have thoughts. I sometimes have images, and sometimes sounds. I experience feelings, I can pick up a mood, general mood, whenever I do TT, especially with traumatized people.”

Three nurse TT practitioners also described somatic experiences. Participant 1 said, “I would pick up things with people on my body...sensations...feel upset...not be able to breathe...abdominal pain...distress...taking on whatever was going on with that person.” She added, “Initially, with less experience, you tend to take it in.” Also describing her work with clients, Participant 6 stated, “My hands, especially my right hand, are usually drawn to the area of the body where there’s a problem. That has happened repeatedly over the last number of years. And I’ll check with the client, asking is there a problem here. My hand is drawn there, and then they will verbalize.”

Participant 7 shared, “I’ve had headaches suddenly start in a particular pattern when I start to work on somebody. When I identify it as their headache then I can step back from it, but it does give me a key to what pressure points, trigger points I might need to be working on.” As a specific example, she also said, “With physical things, I was walking by one of the women that I work with and I looked at her. She was pale, I stopped, I put my hand on her, and I said, ‘what’s going on in your belly?’ because I

could just feel... that there was a sense of a drawing in her belly that were incredibly intense menstrual cramps, and I haven't had those in a few years. That was a physical sensation that I felt in my body."

Regarding SCT experiences two of the nurse TT practitioners mentioned emotions. As noticed by the researcher, Participant 2 pointed to her chest area saying, "With fear, you can definitely identify it in this area because your breath is caught up and you might even have a sudden change in your physical, like that." (Participant demonstrated by inhaling). Participant 4 discussed anxiety. She said, "I tend to feel the level of tenseness or anxiety, but if somebody is really clamped down, then I will find myself sometimes doing the same thing. It reminds me of nursing where...you will start to mimic some of the things that are coming at you as you're assessing them...and having these sensations. My usual first thought is let's get rid of these quickly so we're not going to keep sharing these in our field, the hot sensation of anger, and pain."

Work with traumatized patients also provides the structure for the SCT phenomenon. Participant 8 described emotional experiences during work with specific types of traumas, saying, "Sometimes I will feel a sense of chaos. My body doesn't take it on. I will sense it in my body." Providing two clinical examples, she recalled "a lady whose son committed suicide, I can feel in my body what she feels, but I don't take it on. I just take note of it. The same is true with the gentleman with the trauma with the leg. I can sense the pain in my own leg, where he's having the pain, but I don't take it on. I just know I'm guided, 'this is where to go.' This is what I'm feeling. So, in my own body sometimes I will feel what they are feeling. Other times I don't feel the pain, but I feel where to go."

A compelling description of SCT experienced while engaging in distant TT during a specific traumatic event was provided by Participant 4. She recalled, “I think that the best example for this study... involved a shooting at a university. I had my television on... I was instantly alert. I was riveted to the scene of the description...there’s something amiss...and...all of a sudden it was like something hitting me in the chest. I just sat back in the chair and I had this moment of just knowing immediately that I had to do something. I just knew that (this patient) needed help right at that moment, and it couldn’t wait. It had to be done right then...And I could just feel the shock, the fear. The whole chaos of the entire situation was just bombarding me with all of these feelings.”

The SCT phenomenon is also structured within the nurse-client encounter. Elaborating further on her SCT experiences, Participant 8 noted the therapeutic impact of SCT on patients. Providing one example, she said, “I said to him, ‘you know, the opposite of anger is love and peace. So let’s send love and peace to this pain and this area, and let’s see if that might reduce it a little bit more. And so, as he was breathing love and peace to the area, his whole body relaxed and his respirations became calm, and he went into a deep sleep...that’s another sense of how I get these somatic countertransferences. I sense the feeling, the depth of it, and then work the opposite with the person in order to help reduce it.”

In contrast to other study participants, Participant 4 summed her overall SCT experiences: “It’s just that I probably carry more trauma baggage than the patients that I work with. And, so consequently I don’t ... pick ... wouldn’t often have those experiences. And I’m more into the feelings and sight most of the time...or just thinking about it.”

Summary of SCT Experiences

To summarize SCT experiences, the nurse TT practitioner in the nurse-client encounter during work with traumatized clients provide the structure for the SCT phenomenon. As exemplified in the participants' own words, somatic experiences, thoughts, images, sounds, emotions, and general moods comprised the SCT experiences of nurse TT practitioners. Centeredness in the TT practitioner facilitated mutual field interactions.

Body Experiences

The SCT phenomenon is structured within the body of the nurse TT practitioner. In answer to, "What sort of experiences do you experience in your body during TT sessions, from everything you can think of?" Participant 1 shared, "I don't pick up things so much in my body anymore, I think because I tend to get more images now...more light." Four of the participants described experiences involving their heart. Participant 1 said, "around the central sternum, lower probably, mid-chest, and something about her." Participant 2 indicated, "Most of my experience of what I perceive to be is this kinesthetic feeling inside my body, and it's usually around my heart." Using an idiom, Participant 8 said "You know the expression, 'my heart goes out to you?'...well, that's basically the sense, or feeling, that I get in, 'my heart is going out to you'; my heart to your heart, my being to your being."

The nurse TT practitioners mentioned other areas of their body. "My hands get really hot" said Participant 3. Participant 8 reflected, "And, if a person is very depleted in their adrenals, or if they're really depleted, then my body is drawn around to start to facilitate the sending of the energy, or whatever is needed to that person." As stated by Participant 6, "Sometimes, I'll get like a knot in my stomach, in the solar plexus area."

Participant 7 provided a specific example from her clinical work: “There have been times when I have felt the sensation that, like an ovary that was very swollen. I remember feeling that sensation in my body, almost like a golf ball or orange-like sensation in my body. I asked my client if she were having any sensations around that area, and that was exactly the words she used for it: ‘between a golf ball and an orange, and it feels like it’s swelling and getting bigger every time. Every time it decreases, it gets bigger afterwards.’”

In her treatment of migraine headaches with TT, Participant 3 related, “Well, it’s like they are in this bubble, their aura bubble. And, as they come to me, I’m allowed to step into that bubble and then I can feel those spikes. And as I make those spikes go away the bubble becomes more pliable. It’s not stiff and rigid. It’s more pliable and then it’s easy for me to step out of that and for them to move freely in their protective, flexible bubble now.”

Describing her experience with a patient with drug addiction, Participant 2 shared, “She was sixteen when I first started working with her, and she had been a heroin addict, and had used heroin in her shoulders. So she had deep muscular ulcerations. She was in the hospital and had been grafted.” Reflecting further, she said, “I don’t have any in-the-body experiences with her. Mostly just the feeling around the wounds as they healed, and in the beginning, the field would be very full and like ‘oww’, like it’s saying ‘ouch’ because it hurt. So the field was uncomfortable. So as it worked and as she healed, that all got less and less.”

Participant 6 also reflected on her body experiences. She said, “I don’t get many feelings in my body because I make sure I’m well-centered. I can’t afford to go around picking up everybody’s pain...I don’t have changes within my own body...because I’m

very careful to maintain centering. I've recognized if I lose center I will have some sort of body reaction, or I'll start to feel anxious...if I start to feel anxious, I know that I'm picking up the patient's anxiety."

An example of a beneficial body experience was provided by Participant 3. She emphasized, "I always feel energized after giving a treatment. It does my body as much good as it does the client. I've never felt drained or exhausted. I've felt rejuvenated, relaxed, and just a sense of well-being that this is what I'm supposed to be doing."

Summary of Body Experiences

To summarize the nurse TT practitioners' description of their body experiences, the SCT phenomenon is structured within the body of the nurse TT practitioner, as well as within the nurse-client encounter. Body experiences in the nurse TT practitioners' heart predominated although other areas of the body, such as the hands and solar plexus, were mentioned. Clinical examples with patients with migraine headaches and drug addiction were described. Acquiring a body sense of a patient's fear was mentioned. With more experience comes less body experience for nurse TT practitioners, and more images, sight, light, feelings, and thoughts. SCT was described as a beneficial body experience for one nurse TT practitioner in that she felt energized, rejuvenated, and relaxed. A therapeutic impact is produced for patients through SCT when the depth of feeling is reduced by sending the opposite of painful emotions.

Visualization

The nurse TT practitioners were next asked: "What do you see, if anything, during TT sessions?" They described a number of visual experiences. When asked to recall hers during the Distant Healing session with the victim of the university shooting, Participant 4 suddenly experienced a bright white light during the interview. She said,

“When you’re working with trauma patients, it’s the noise and the brightness, and the everything that surrounds the person. And so it wouldn’t be unusual for me to pick up on that. It’s just kind of funny though because I normally don’t ever pay it ... I more just sense things. I don’t usually see things. Or if I do, I don’t pay any attention to them.”

Participant 5 noted, “Sometimes I have like just an object that comes up, like an animal or something, someone playing. I’ll sometimes share that with the person, like a turtle, which I recently, and I’ll share that with the person and say how, what would that mean, or a star, or I would try to just figure out what that could mean for that person.”

In contrast, two nurse TT practitioners indicated they don’t visualize during their work. When asked what she sees, Participant 3 said, “I don’t. I haven’t visualized a lot of stuff doing this work.” Participant 4, a 61 year-old female, responded similarly, “But on the other hand, I don’t visualize things; like one of the things is I don’t see colors.”

Summary of Visualization Experiences

To summarize the nurse TT practitioner’s visualization experiences, the research question brought to awareness one participant’s experience of seeing a bright white light describing distant healing soon after a university shooting. Another explored personal significance for clients when objects, animals, or someone playing was visualized. Some participants stated they do not visualize or see colors. One said she can hear someone else send a color across a room.

Images

The nurse TT practitioners described their images during work with traumatized clients. One described her specific experiences with veterans. Participant 5 said, “I just feel like their fields are just so, what can I say, totally jumbled up, mixed up, and that’s what I see in their fields.” She elaborated further: “Well, I can’t sense exactly how they

see, but someone who is blind, when I close my eyes, I can see much more than with my eyes open, the unseen world that they see.”

Several also described their experiences with specific diseases. Regarding heart disease, Participant 1 recalled, “People who have heart problems ... you can see where the problems are, where the coronary arteries are and where the blockage is, or what the state of the heart is, so I can see that, not all the time, sometimes.” Participant 7 stated, “I also see the blockages in the energy flows in the meridians or the nervous system or circulation...which will kind of light up for me in different ways.”

Participant 8 spoke similarly about circulation, saying, “So, what I did is I started to assess his field, and as I’m assessing, I’m sending calm and peacefulness. And as I get down to the field where the leg used to be, I’m sensing where the reason for the amputation was. And, I can see it like a sore there in my mind...and I can feel how that it was like stasis of the circulation had opened this huge wound that wouldn’t heal. And I said to him, ‘this is where you had your sore. This is where it’s hurting.’ And he just looked at me like, ‘there’s nothing there. How do you know this?’”

In discussing her clinical work, Participant 7 recounted, “I’ve seen toxins under the skin. I’ll see microbacteria, like I’m looking under a microscope. Sometimes there’s an inflammation in something. I will visualize organisms and can often get it whether it’s a round one or a spirochete. The images are sometimes extraordinarily clear and the name of the organism will come to me.” She elaborated further, “There have been times when I’ve been exploring something that felt wrong in the energy field. I’ve seen an image of like a kernel in the gall bladder or where somebody got hit when they were playing football. I can see the ball that they took and the bat their head took. I wish the visual stuff were more, not just clear, but continuous.”

Participant 8 also shared some of her clinical experiences. She said, “There are times when I do see images like the time when I saw the adrenals...just right out in front of me...I don’t usually get this vivid of a visualization.’ I asked the client, ‘is there something going on with your adrenals?’ And her whole body just stiffened up. She was young and, apparently, she had been diagnosed with adrenal cancer.”

During her work with an elder’s stressed caregiver, Participant 6 recalled an experience of resonant imagery. She said, “She was constantly thinking of her mother. And though I never saw her mother, I had a picture of her in my mind. And so, I described that to her and she said yes, that’s how her mother looked.” Finally, Participant 8 recollected, “I might see an image of a person who’s been so traumatized within. I may see an image of them crying inside.”

Participant 2 initially expressed that she did not get images. She said, “So I’m a person who rarely, if ever, gets images, or I don’t think I’ve ever heard a sound.” Upon further reflection, she was then able to speak of imagery related to positive emotions. She said, “one thing I do see when I’m working on people is sometimes I will have an image of them that is joyful and pain-free, and really, really, being happy in whatever situation they’re in. So, it will probably come to me...that image is like you conjure it yourself. It’s not like it necessarily comes from some place.”

Features of Images

The nurse TT practitioners mentioned different features of their various images. For Participant 2, “I’d say it’s like a holographic image of them. I’m seeing their, especially their face.” Elaborating further, she said, “But it’s three-dimensional and it’s alive. It’s not stagnant. It’s not a snapshot. It’s them smiling or laughing...or like if somebody is infirmed, say somebody is para (plegic), or a quad (riplegic), or had a

stroke, I might actually picture them like swinging, or skiing, or something that they loved to do. To get in touch with that place within them that is whole and timeless, and that joy that is within them still but may not be right now in this moment, they've lost touch with that."

Several nurse TT practitioners spoke of either the photographic- or movie-like quality of their imagery. Participant 1 said, "Sometimes (the images) are like you're developing a photograph and then it gets sort of a little bit fuzzy, and then it gets really clear." Similarly, Participant 2 said, "I might see part of their body. I might not see all of their body, but kind of like a nice photo."

Participant 7 also described her imagery as having a movie-like quality. She said, "There are times when I will get a memory of theirs as a complete little movie." She stated further, "Sometimes there is a sense of a movie of an incident that happened, or the image of a car accident that someone was in, the positions that they were flopped around into. I have seen incidents of sexual abuse or physical abuse to people when they were children or young adults. When I was working with them I had heard narratives of their family situation. I've seen like a little clip of family interaction from when the person was a child and intuited how the child interpreted that in terms of self-esteem."

Two of the study participants spoke about the cartoon-like quality of their imagery. Participant 1 recalled, "But when I let go of that idea of what would be helpful to her, it was the strangest thing. There was this sensation of a chimpanzee or an ape moving through the forest freely, and it was a visual image that was totally unexpected. And it gave me a sensation that what was happening to her in terms of potentially a link to her headaches was very old...was being sustained. It was frightening for me because it was not anticipated. I centered myself again, and was grounded, and recognized it would

be safe to go there again.”

Summary of Imagery Experiences

To summarize the nurse TT practitioners' imagery experiences, one described her work with veterans: “With my eyes closed, I see the unseen world they see.” Images occurred within the context of clinical work and involved specific diseases: heart disease; blockages in the nervous system or circulation; gall bladder disease; adrenal cancer; and, amputation following a non-healing wound from impaired circulation. Toxins, inflammation, and organisms were visualized. “Extraordinarily clear” images occurred. Trauma-related incidents such as the site of sports injuries were seen. An experience of resonant imagery was described in that a picture of a patient's mother was seen in the mind without ever having met her.

Both negative and positive emotions were discerned. One participant referred to patients being so traumatized, she could “see them crying inside.” In contrast, another described imagery related to positive emotions such as visualizing the patient as joyful, pain-free, and happy. The participant interpreted that these latter images were self-conjured and did not come from somewhere else.

Features of images were described as holographic, three-dimensional, alive, photographic, and movie-like. Parts of the body were described as photo-like. Incidents, accidents, sexual abuse, and physical abuse were seen as little movies. Images were also described as cartoon-like in quality. One participant saw an ape running through a forest, and interpreted the image as a clue that the patient's migraine headaches were linked to something very old, involving a sense of safety. One nurse TT practitioner discussed work with paraplegic or stroke patients, seeing them swinging or skiing, engaged in

something they formerly loved to do. She interpreted this as helping them to get in touch with a place of wholeness, timelessness, and joy.

Colors

Four of the nurse TT practitioners described their experiences with seeing colors. Participant 5 said, “Yes, lots of colors, but the colors are usually when my eyes are closed or half-closed, they’re colors that are not of this world. They’re beyond, colors that are way beyond this world. Colors, objects, circles sometimes ... and beautiful colors, sometimes rainbows, beautiful rainbows, but more beautiful than the rainbows that you would see just with your eyes.”

A rich description of her experience with color was provided by Participant 8. She shared, “When I work with people with fibromyalgia, another trauma, and they’ve been multiple traumatized through the medical system...I see their field as dark, and I see darkness in their body, so to speak, and I can sense it. And, I’ll say to them, ‘if you were thinking of a color, what color would it be?’ More often than not, they will say it’s black or gray. And, I will see, as I’m doing the Therapeutic Touch and filling them with blue, or filling them with a violet, I will see that dark dissipate. As it dissipates, they will validate it by saying, ‘well, it’s not as dark. Well, I’m getting a little hint of blue, or I’m getting a hint of violet.’ Then, when their whole being is filled, I can see that it is filled. And, I just wait for them to realize and say, ‘my body is now, I feel violet all through me, and all around me.’ And, that gives me the message that this session is complete...So, that’s what I see. I see multiple things.”

Summary of Visualization of Colors

To summarize the participants’ experience of colors, one nurse TT practitioner described seeing colors “not of this world” and “rainbows more beautiful than those seen

with just your eyes.” Another participant described her use of color with patients with fibromyalgia, a condition she considered to be a trauma. Initially, the patient’s field was visualized as dark, confirmed by the patient as black or gray. The nurse TT practitioner used blue and violet to replace the darkness and fill the field. When the patient confirmed seeing blue or violet, the participant knew the session was finished.

Anatomical (Body) Parts

Two of the study participants described seeing specific anatomical parts of the body. Participant 1 said, “I sometimes will get images of the particular body part, what’s going on, very clearly...It’s more seeing, like seeing lights or colors of lights...I can see sorts of anatomical things.” Elaborating on a clinical experience, she related, “One woman I treated a number of years ago was having some problems with her eyes...And I got a very clear picture of an artery and a vein crossing in her brain...In talking with the physician afterwards, he had said to me that she had had a couple of CT-scans, and what they finally found was an AV malformation, which is what I was seeing that she had.”

Participant 1 continued. “For me, most of it has been really images, anatomical images. With a colleague years ago, I was treating her, and I was picking up something on her hip, which she was not aware of. She wasn’t having any pain, but I was picking up some changes and some pain...she ended up having a hip replacement about six months later. So she phoned me and she said you picked that up...she wasn’t experiencing, from her perspective, anything at that moment in time...It was one of those situations where I could have drawn the change, so it was very clear. So those are the kinds of things that I get more than other sorts of sensations.”

Summary of Visualized Anatomical Body Parts

Two of the participants described seeing clear images of anatomical body parts and associated diseases that were later diagnosed and treated surgically. One clinical situation involved a patient's eye problems that were subsequently related to an arteriovenous malformation (AVM). The other pertained to a necessary hip replacement.

Guided Imagery Experiences

Three of the nurse TT practitioners mentioned the use of Guided Imagery in their work. To exemplify, Participant 7 said, "There have been times when I've cried because people couldn't. There certainly have been times when I've felt how closed into an emotional box some people have been in, and helped them to discover that the box is not a closed thing. And, use the visual image of the box and how to climb out of it, to assist them in using Guided Imagery to help them move out of the stuck places that they feel."

In treating a torn Achilles tendon, Participant 3 recalled her experience. She said, "While I was doing Therapeutic Touch, her (the patient's) job was to visualize the ends of that torn Achilles tendon intermingling just like her fingers intertwining and then twisting like a steel cable."

Summary of Guided Imagery Experiences

To summarize, three participants described their use of Guided Imagery. One used it to help people climb out of an emotional box, and move out of the stuck places they feel. Another used visualization to facilitate healing of the ends of a torn Achilles tendon.

Summary of Subcategory, Visualization

To summarize the subcategory, Visualization, some participants described their experiences during TT with Distant Healing. Objects, animals, or someone playing were

visualized. When this occurred, the client was asked what significance, if any, this held for them. Two participants indicated they do not visualize. For those who do, work with veterans involved, “seeing the unseen world they see.” Specific diseases such as heart disease, gall bladder disease, adrenal cancer, and problems with circulation were visualized, as were toxins, inflammation, and organisms. Sports injury-related conditions were identified. Participants described an incident of resonant imagery.

Emotion-laden experiences, both positive and negative, were also visualized. One participant described seeing activities formerly enjoyed by paraplegics or quadriplegics. In terms of quality, images were described as holographic, three-dimensional, photo-like, movie-like, and cartoon-like. The nurse TT practitioners described seeing colors and anatomical body parts that involved the need for surgery (e.g., arteriovenous malformation, hip replacement). Several nurse TT practitioners mentioned their use of Guided Imagery to help people out of an emotional box they were stuck in, or engage in self-healing of a torn Achilles tendon.

Qualities of the Nurse TT Practitioner

Inherent qualities in the nurse TT practitioner emerged from the latent, inductive content analysis of the interview text. These qualities were: perspective, guided to the work, innate and inherited gifts, centered, grounded, attunement, intention, compassion, perception, expertise, evolution, and use of holistic support.

Participant 1 described her perspective as, “I treat people sometimes as naïve, so I don’t look at their history...didn’t want to have preconceived ideas.” Two of the study participants felt they were “guided to the work.” Participant 3 shared, “It’s amazing how these people are brought to you, or you’re brought to them. And for me, I’m being guided

to do this work. I'm taken where I'm needed. And so, I feel like I have opened myself up a lot to that."

Three of the nurse TT practitioners spoke of their natural giftedness. Participant 4 noted "It's an innate gift. From the first time I received it I knew I could do it." Two spoke of having an inherited gift. Participant 8 stated, "I feel blessed that I have been able to learn a therapy, that I'm able to do it to this extent as a nurse and as a child, with my mother's healing hands, and my having inherited that and her sense of being intuitive and so open."

The importance of being, and staying, centered during their TT practice was a point of emphasis for six of the TT practitioners. Participant 7 said, "And that's why it becomes so important for me to really get into my center before I go into my extra-perceiving of another person." Referring in general to the experience of SCT, Participant 8 mentioned centering. She said, "Some experiences that I've had with the somatic countertransference is when I work with the individual, and of course I'm centered..."

In relation to work with traumatized patients, Participant 1 noted, "I really do feel that the teaching that I have in terms of being centered and grounded, and being an instrument...so the energy moves and flows." Regarding work with clients abused as children, she recalled, "but I centered myself again, and was grounded, and actually did, and recognized that it would be safe (to go there)."

In terms of detaching from clients' traumatic experiences, Participant 1 added, "So it is the centering and grounding in Therapeutic Touch, so you don't attach." Participant 6 contributed, "Well sometimes thoughts about their children, or thoughts about sadness ...I attribute this to either something that's going on within them, or that I have lost center. So I re-center myself. And if it continues, then I check in with them

what's going on." She continued, "So that's one thing that happens with me. If I start feeling sad, or anxious, I take that to mean that I've lost my center and I'll stop and re-center."

Expanding upon her SCT experience with the victim of the university shooting incident, Participant 4 recalled "And so I just immediately centered...And so I just felt all of the chaos and what was going on. And so I just centered myself...and I just started sending the healing energy."

Describing her work with veterans, Participant 5 said "I have a great deal of compassion for veterans that are coming back...and thinking of them as a whole, and opening up their bond...Well, just because so many of them are forgotten, and it's very sad, and I'm able to just develop a really caring compassion bond between them. They feel safe in sharing their stories with me."

Summary of Qualities of the Nurse TT Practitioners

To summarize the qualities of the nurse TT practitioners, one of the participants spoke of working with clients "as a naïve", without any preconceived ideas. Several spoke of being guided to the work. The possession of innate and inherited gifts was considered a contributor to TT. The importance of being, and staying, centered, especially in trauma work, was emphasized by six nurse TT practitioners. Other qualities addressed were being grounded and attuned, and experiencing intention and compassion.

Perception

In response to the question, "What do you perceive, if anything, during TT sessions?" the study participants provided rich, thick description. Participant 1 shared, "It's not always the same. It varies. I sometimes, mostly for me it is seeing, so it's more seeing, like seeing lights or colors of lights, light, a particular color of light, or no color.

Sometimes, when I'm working, I will be starting to send a particular color of light and it will change, because that means to me that the person doesn't want or doesn't need that particular color, it's something else. And so, just allowing that to happen and move with that."

Participant 2 spoke at length about what she perceives during her work with traumatized patients. She recounted, "Well, so as I'm doing TT, there's a lot of different things that have been what we call cues in the field that either vibrate or touch my hands differently. So from something that feels like little tiny lightning bolts, to things that feel like, putting your hands in radio static, crinkly all over, to big rocks falling out like down the person's body, to something where they absolutely don't feel anything, or certainly heat and cold. And, there are other times where my hand will go through the field and it will feel like there is something in the matrix of the energy rather than something actually touching my hand. It's like my hand touches the web and there is something in the web. So it's not moving on my hand, it's something that I feel when I go by it, like a bump or a wrinkle, or a rip."

When asked what Participant 4 experienced during the TT distance healing with the victim of the university shooting, she remembered, "Well now that you mention it, mainly blinding white light. And I don't normally pay any attention to that, so if you hadn't asked me I wouldn't have even thought about it."

Describing her experiences with dying veterans, Participant 5 shared: "Sometimes I see colors, like in a room with a dying veteran, I've had that experience. If I close my eyes sometimes I can see a whole lot more. And usually when I do Therapeutic Touch, most often my eyes are almost shut or totally shut, because I see more when my eyes are shut, and especially if the veteran is blind. Then I can close my eyes and see how they

see. So I guess that explains how I sense, feel my senses. Yes, because we have a program nobody dies alone, so we do in that in their final times, we do that.”

Participant 6 also spoke at length about her perceptual experiences. She said, “Well, I pick up patterns of asymmetry in the field, like pins and needles, and pain...And it’s usually tightness in the shoulders. I pick up their pain. And there’s a certain perception I pick up in my hands that now over a period of years these perceptions are ... Pain, I pick up as like paresthesias, it’s like pins and needles in the field. If there’s edema, it’s like the field is being pushed away from me. I don’t feel cold in the field...the field becomes absent. So those are the perceptions...based on the number of years that I’ve been practicing, and I validate this with the client, that I’m feeling something different in their field, and I’ll touch them in this area, does this mean anything to them. I’ll say ‘are you having pain here?’ and they’ll say ‘yes, that’s the spot.’”

Rich description of her perception was also provided by Participant 7. She stated, “I realize there is an extraordinary perception that goes on, but that the first perception of a client is always a visual assessment of their posture, their expression, how they’re holding or guarding their bodies. Then there’s a deepening in where I go into my silence and I begin to perceive more about their emotions, their physical expanse, what’s going on in their life, and it may come in just a simple sense of knowing. I don’t know how to describe knowing except it is concrete. It’s just there. I know it’s true.” Continuing, “There are also times when I am with someone and I hear. I hear a statement about what they need or what’s bothering them, and then I can ask an appropriate question that might trigger them to answer it.”

She expanded with “There’s also a sensation that I get that tells me I’m right on. When I locate...when my hands feel a blip in the energy field...whether it’s cold or heat

or prickles or a dip or an absent or a flare in an area of inflammation, around an area.

When I feel that, then as I begin to channel energy to it there's almost a shudder that moves through my body when a great deal of energy is being channeled through me. It's like it blows out my blocked vertex in my own physical body in order to bring through a much larger volume of energy than my body contains on its own. There is a shuddering sensation, and when I am balancing I'll stand at the foot of the bed and feel the energy coming off a person's feet and from that position channel energy into their body. Often I have like the sense of pulling taffy as I move my hands away from and closer to the feet. If there's an imbalance from the right, the left sides, I can feel when the energy flow balances out. My hands will come to a rest at equal distances from the feet. When the body has received enough energy, or at least that's my interpretation of it, it's like there's a letdown in my body. So, feeling the blip in the energy is my guideline for where I need to direct the energy to."

Participant 7 went on, "Another very important sensation I've learned to listen to is the sensation of prickling or pain in my hands when I'm checking a person's energy field. The more intense the prickling sensation, the stronger I know that disease is in there. And, in general, I have found that prickling sensations have come only from cancers."

Summary of Perception

To summarize, the nurse TT practitioners described their perception of lights and colors. They described cues in the field such as lightning bolts, radio static, heat and cold, something in the matrix of the energy, and touching a web. In the field they also perceived a bump, a wrinkle, a rip, patterns of asymmetry in the field like pins and needles, and pain. They described edema as the field being pushed away. They also

perceived a blip in the energy field, and an absent field. They described perceptions of cold or heat or prickles. Also mentioned were a dip or an absent or a flare in an area of inflammation, around an area, a shuddering sensation, a feeling of pulling taffy, and a letdown in their body. Importantly, several described the perception of prickling or pain in the hands as emanating only from cancer.

The nurse TT practitioners also mentioned validation with the client, extraordinary perception, initial use of visual assessment, deepening into silence, emotions, and a sense of knowing. Sometimes they heard, and one saw a blinding white light when questioned about her perception during distant healing with a university shooting victim.

Evolution

One of the nurse TT practitioners spoke about the impact of professional experience on SCT. Participant 1 said, “And I’ve been doing that for a lot of years now, so it’s ... yes. So you get more practice and more practiced...Initially, with less experience, you tend to take it in.” “You don’t feel it in the same way...you’re also not as fatigued. In fact you can be energized afterwards.” She concluded with, “That’s the evolution, I guess, in some ways.”

Holistic Support

Seven of the eight study participants indicated their utilization of holistic practices other than TT. Two spoke of the advantage to patients of receiving treatment with additional holistic modalities. As an example of the benefit of prior holistic treatment, Participant 5 said, “I mean if somebody else has treated them, a different practitioner, because then it makes it a little easier for them to understand that they’ll be fine if I ask them...”

Summary of Nurse TT Practitioner Category

To summarize the category of “Nurse TT Practitioner,” SCT experiences and related body experiences were depicted in participants’ own words. Visualization during work with traumatized clients was described, along with images seen. Qualities of the nurse TT practitioner that emerged from the interview text were a perspective that embraced working with the client without preconceived ideas. The participants described how they were guided to their work. They possessed natural giftedness, and qualities such as compassion. The importance of being and staying centered and grounded when working with patients with trauma histories was emphasized. They utilized attunement and intention during TT sessions. Thick, rich description was provided about what they perceived. Lights and colors were mentioned, and illuminative examples of cues in the field given. An important finding was the prickling or pain in the hands that was correlated with cancer.

Communication

The second category developed from the data was Communication. It is comprised of four subcategories: Awareness, Boundaries, Information, and Mode.

Awareness

Study participants spoke about awareness, both in the patient and in themselves. Participant 6 shared, “Usually, when I have clients and there’s a longitudinal over a period of time, I become very aware of how they are patterning stress in their body. And after they’re treated and they come back, and the same pattern reappears, I bring this into their awareness.”

Regarding self-awareness, Participant 1 distinguished between what belongs to the client, and what belongs to her “that was mine; that was not hers.” Similarly,

Participant 7 said, “I want to really make sure that I can clarify what’s mine; what’s my sensation and what’s theirs. And the only way to really do that is to know myself, and to know what I’m feeling before I ever step into the room.”

Two study participants mentioned the client’s inner self. Providing an example, Participant 5 said, “every session is different and I get messages that, from the other, from my other person’s inner self.” She added, “So, as we worked with Therapeutic Touch, and as the focus on wholeness, the focus on connecting with that place of inner-self in the client.” Referring to the Eternal Self, Participant 2 said, “I think the information I got was that she was actually beginning to understand more about the eternal self, and that is something that I became aware of first within myself...and then eventually we talked about it.”

Intuition and Intuitive Process

Several nurse TT practitioners discussed intuition and the intuitive process. Participant 4 said, “So, I think the extraordinary moments are when you get this intuition that you need to do it right away, and that being able to makes a difference that the energy travels.” Participant 8 also contributed. She said, “And so, I tried my best to listen and go with the intuitive; whether to say something or not say something.” “You know, it’s very hard to explain because a lot of it seems to be so intuitive, what I feel is a drawing, a drawing to go to a certain area...I’m having in my body this sense that I need to go to that leg, and I can feel that my leg is sympathizing with where the pain could have been.”

Observer

Two study participants described their experiences as an observer. Participant 1 said, “I am, as a watcher...in many ways I am the instrument or the channel, and there’s a

part of me that's a watcher, that's watching, that's observing. And that part is awe-struck every time when you're watching this process happening as it's happening. It's a kind of standing outside and inside at the same time. It's an interesting experience. It's not easily described... So it is a sense of you watching the participation or you being the instrument, and being the instrument at the same time, and being part of the process, and watching the process, which is a kind of a thing filled with awe."

Inner Self to Inner Self (ISSE to ISSE)

The Awareness of Inner Self to Inner Self (ISSE to ISSE; Krieger, 2013) during SCT was highlighted by several of the nurse TT practitioners. Participant 8 explained, "So, as we kind of disarm them, help them feel safe, go about this trust within their being, our Inner Self to their Inner Self, we connect heart-to-heart and we say, 'It's ok. I'm not going to do anything to betray you the way you've been betrayed' because I can feel with these people that have been traumatized." Participant 6 also commented, "So if any thoughts, especially thoughts that I wouldn't be thinking, then I imagine it as being that my ISSE and their ISSE are speaking to each other." As one example, "I just calmed her and grounded her, and stopped the treatment. And she said to me after that 'I felt like you reached down to my soul' and so of course now I realize that was my ISSE speaking to her ISSE."

Summary of Subcategory, Awareness

To summarize the subcategory, Awareness, different types were mentioned. These included self-awareness, and awareness of the patient's inner self. One participant spoke about the patterning of stress in the body, and raising patients' awareness of it. The participants provided exemplar statements about the importance of distinguishing between their own personal material and the patient's material; that is, what issues

besides their own were assessed in patients. They also spoke about information received in the form of messages. One brief description of a patient's awareness of the eternal self was also provided.

Intuition was described as the knowing to act immediately. The intuitive process was related to being guided to an area of the body in need of healing. The role of observer was described as being synonymous with being an instrument or channel; in particular, standing and watching on the outside and the inside at the same time. It was described as inspiring awe.

As related to TT for trauma, one participant spoke about the need to disarm patients who have felt betrayed by going heart-to-heart, Inner Self to Inner Self (ISSE-ISSE; Krieger, 2013). Another participant attributed thoughts without context to ISSE-to-ISSE speaking, enabling a client's felt sense of the TT practitioner "reaching down to one's soul."

Boundaries

Boundaries emerged as a subcategory of the category, Communication. Participant 1 spoke about allowing energy to flow, "So the energy moves and flows...so you don't protect yourself, you allow the energy to move." In contrast, Participant 6, a 73 year-old female, spoke of the need for boundaries. She said, "I can't afford to go around picking up everybody's pain."

The importance of creating a sense of safety in the client was discussed by three of the nurse TT practitioners. Participant 8 explained, "I can feel their fear of betrayal again, or their fear of somebody really understanding or knowing the pain that they have inside, that big wound that they are trying to keep band-aided, or closed. That wound is just so gaping. They're so protective of that wound because they don't want to relive

what caused that wound. And so, with sensing and feeling this real intense emotion that they have, and this protectiveness and this trauma that they had, I go along a little more gently with some, and with some more openly with others and talk about it...I do sense with people, of a person that's been so traumatized. Gentle, you're always gentle, but with more of the expression, more of bringing out and letting them talk or letting them be; allowing them to emote if they need to emote, and letting them feel safe to emote."

Participant 8 spoke at length about self-defensiveness, and the need to overcome it in traumatized clients. She said, "Whenever I do the Therapeutic Touch, especially with traumatized people, to break through the barrier, so to speak, of their armor, their protectiveness. You know, their trying to be OK when they're not...And going more inward."

Elaborating, she provided a rich description of the need to disarm traumatized clients. She said, "As I get more into doing the Therapeutic Touch, I can feel the barrier that they've put up, what their defenses are, and their fear. As I get more into the field, I can feel their fear...So, the emotion to access the depth of it, I find you can feel the surface emotion and you can feel some of what's going on, but to really access an inner emotion, we need to, what I call, disarm the individual, help get rid of some of their armor. That's disarming them."

To guard against negative SCT, three of the nurse TT practitioners emphasized the need to "recognize as other." To exemplify, Participant 2 revealed, "And I recognize it as not mine because I kind of know myself and know what I'm doing...But the sadness, if, when I've picked up sadness, it's also tended to be in that area. And it's like a feeling that I might be sad but I'm not sad right now. So I recognize it as not my sadness...And the sensation doesn't last very long. It's just a very fleeting thing."

Participant 1 similarly spoke of the importance of “recognition as other.” She emphasized, “Somatic experiences of sensations and separating out whether it’s mine or other...a very important and not necessarily easy thing to do for practitioners who are beginning...if you are sensitive and there’s somebody who’s had high trauma...Don’t take it in, recognize it as other...But that actually helps you to then identify whether it’s yours or others’. And then it helps you to help the person, or it helps you to let go, or decide what’s going on with the view, and what that’s about.”

Use of humor as a coping strategy during work with traumatized clients was described by two nurse TT practitioners. When allowing veterans to express their anger, Participant 5 said, “as long as they don’t hit me” and then added, “I’m just kidding. You have to keep it ... if someone’s angry, or sad, or having emotional problems, you need to bring some humor into it, too.” Participant 7 also contributed. She said, “I use a lot of humor in my work so that when I say things to them, it’s softer.” While laughing, she also said, “I used to work with primarily survivors of abuse. For twenty years that was my specialty, and it became too much to feel all of that pain all the time. And while I may have helped them move to better places in dealing with it, I still have a storehouse of their memories which I keep trying to move to the back of the filing system (Laughs).”

Summary of Subcategory, Boundaries

To summarize Boundaries, one participant spoke of the need to allow energy to flow while, in contrast, another spoke of the need for personal boundaries. Work with traumatized clients necessitated the creation of a sense of safety in the client to overcome their fear of betrayal, self-protectiveness, and self-defensiveness. One of the nurse TT practitioners, a Psychiatric Mental Health Clinical Nurse Specialist, shared her gentle approach that allowed traumatized clients to emote in order to help heal them.

In order to mitigate negative SCT, the nurse TT practitioners spoke of the skill of recognizing material as belonging to another. Additionally, two participants spoke of the use of humor as an important coping strategy in working with patients with trauma histories.

Information

Information was identified as the third subcategory subsumed within the category, “Communication.” It was comprised of messages, knowing, and embodied information.

Regarding information, two nurse TT practitioners described their experiences. Participant 4 said, “I don’t diagnose people. I simply just do what I do and allow them to process the information.” Participant 2 indicated, “and it comes in a sense of I guess you’d call it information.” Providing a clinical example, she recounted, “I think the piece of information that came to me over time...initially there was a reoccurrence of cancer, and this is something that she articulated, the fear of dying...And so, I don’t know that necessarily my work was what shifted her, but the information came to me during a TT treatment. That was for sure.” Expounding more fully, she said, “So it’s like in a moment, as you’re assessing, it’s like it takes your breath away. It’s like there’s this sudden feeling of ... and you know that it’s not happening to you so it must be information that you’re getting.”

Messages

Participant 8 stated, “With this somatic countertransference, what I have found is that it also gives me messages of when I would say something or when I would not say something...And so, I try my best to listen and go with the intuitive; whether to say something or not say something...But just the validation at that depth I find helpful, helpful for the person in their healing.”

Knowing

The study participants spoke of different types of Knowing: Informational Knowing, Inner Knowing, Knowingness, and Immediate Knowing. Participant 2 recalled, “And that was an informational knowing that was present in me before it was articulated.” Participant 8 spoke of Inner Knowing. She said, “But, to be able to understand it, and to learn to express what is going on and to be able to just know, the Inner Knowing, and the Inner Being being connected with that Inner Knowing of that other Being and how we assume Beings. Just so we need each other and we can be so helpful to each other, or we can be so harmful.”

Participant 2 discussed Knowingness in this way, “And that tends, it’s like this part of my body is, it’s like if my brain were in my heart, which is really what it is. I mean, your heart is more of a brain than your brain, this is just the thing that connects us to stuff out here. So the knowing almost feels like it’s here (pointing to her heart). And, I think when I practice, I feel like I’m a very heart-centered practitioner mostly.” Continuing, “Knowing...it’s just information coming from somewhere, and it’s in my body...I mean I got this impression, so it’s a feeling of, or a knowingness I guess is what you would say, an impression of a thought.”

Participant 7 referred to Knowing in several different ways. She said, “There are times when I will get ...a knowingness of something that has happened to them or a trauma that’s associated with their injury, or with their health issue.” Expounding, “So, it seems like my information comes in on a lot of different levels: kinesthetically, visually, auditorily, and then a sense of just Knowing.” Elaborating further, she said, “Yes, that’s where the perception begins generally, or in that sense of Knowing. And as I’ve developed, the sense of Knowing is getting stronger. I think because I’m trusting it more

and that the information doesn't have to be so dense in my own physical body in order for me to get it, like tug at me so hard, if that's the words to use for it." She concluded with, "I would like to have to not question so much of what I perceive and just have it go directly to Knowing more and more. And maybe that's happening over the years."

Summary of Types of Knowing

To summarize the exemplar quotes on Knowing, the nurse TT practitioners described several different types. Informational Knowing was described as being present in the practitioner before it was articulated. Inner Knowing was discussed as a connection to the Inner Being and Inner Knowing of the client. Knowing was also described as one's brain being in their heart, in the context of being a heart-centered TT practitioner.

One participant referred to a Knowingness of a client's traumatic event associated with their injury or health status. The same nurse TT practitioner described information coming in on different levels, Knowing being one of them. She reflected that her perception begins with Knowing, and that with experience, it has gotten stronger.

Summary of Subcategory, Information

To summarize the subcategory, Information, participants spoke of their not diagnosing people, and allowing the information to be processed instead. A clinical example pertained to the reoccurrence of cancer and the related fear of dying that "takes the (TT practitioner's) breath away." Other nurse TT practitioners spoke of messages received as related to somatic countertransference. These were described as intuitive, validating, and helpful for healing.

Thick, rich description about the different types of Knowing (e.g., Informational, Inner, Knowingness, Immediate) was provided. Considered a type of information,

Knowing was included among different levels of information: kinesthetic, visual, and auditory.

Mode

The category of communication comprised the subcategory, Mode, of which several types were described. These included: channel, instrument, connection, deepening, shared experience, validation, distance healing, and political messages.

Channel

Participants 1 and 7 both spoke of being a “Channel.” Participant 1 said, “I am the instrument or the channel...that’s watching...that’s observing...” Participant 7 described her experience in this way, “It’s like that excess energy just grounds and is shut off. It’s not like mine to command. It’s that I’ve offered myself as a channel. It uses me and then it stops when it’s done.”

Instrument

The nurse TT practitioners also spoke about being an “Instrument.” In particular, Participant 1 summarized, “You have the energy run through you and around, sort of more a circular thing, so it goes through you and the person, and through you again, and so you really are the instrument. And that way, you don’t get tired. In fact, you can be energized afterwards...The teaching I have in terms of... being an instrument...so the energy moves and flows...I revisit centering and grounding...move through...be an instrument of healing.”

Connection

Three participants made direct reference to “Connection.” Participant 6 recounted, “It depends on how frequently I see the patient. If I see someone and only give them one treatment, and I never give them another, there isn’t the same connection.”

Participant 5 also spoke about connection, saying, “Well actually, when I do distance healing, I go into a very meditative state, and become totally centered, and develop a connection, a bridge, whether from one state to another. I’ve been doing that and I will send a bridge of healing energy to the other person, and know just from my experiences that I’ve made the connection... Well, just thinking today with a patient that was in coma for three years, and when I started doing Therapeutic Touch with her maybe for about a year, just my connection, my centeredness in connecting to her center, her heart center, and her inner self, we communicated. We communicated.”

Deepening

Participant 8 spoke of a “deepening.” She explained, “The depth of the emotions, how things can affect us so deeply. So, again, back to the beginning, the process of Therapeutic Touch and deepening, and deepening, and deepening. And I just think it’s so extraordinary I’m still glowing. I’ve been doing this for twenty-six years.”

Shared Experiences and Validation

Examples of “Shared Experiences” were also provided. Participant 6 recalled, “And then sometimes, just a thought will come in my mind, and I will find some way of asking the healee if this has any meaning to them... And based on the number of years that I’ve been practicing, and I validate this with the client, that I’m feeling something different in their field, and I’ll touch them in this area, does this mean anything to them. I’ll say ‘Are you having pain here?’, and they’ll say, ‘Yes, that’s the spot.’”

In discussing her validating experience during distance healing with the university shooting victim, Participant 4 recounted, “The most interesting part of this story is what happened on the news the next morning... another patient was interviewed on television... he was being evaluated for a heart attack in the bed next to hers. He ripped

off his electrodes and tore out his IV and ran over to her at the exact minute that I finished doing the TT treatment...Therefore, I certainly associate the fact that I had finished and she was totally calm at the moment that this friend took her hand in the emergency room.”

Providing an example of validation during her clinical work, Participant 2 recalled, “So, after the assessment, that’s when I checked in with him to say ‘How are you doing? My sense is that there’s a lot of fear here,’ and that’s when he revealed his history of two other car accidents and one that had been quite severe. So we worked again to clear that feeling.”

A rich description of a validating experience was also recounted by Participant 4: “The tech one is an extraordinary incident because I had the validation. At a point when you know the exact time frame and you have documentation on national television that what you did actually happened, it’s sort of like one plus two equals three and you’re sort of watching these people and you know that that’s exactly what happened at exactly that time, and you were looking at your clock, you know, when these events happened. That’s great.”

Several of the nurse TT practitioners discussed communication during distance healing. Participant 1 said, “I’ve done distance work, too, and it can be like instantaneous, it’s very surprising.” Participant 5 also elaborated on distance healing by saying, “Well, I work a lot with mental patients, we would call it dementia, and a lot of times I do distance healing with them...And it was so amazing, there’s really not any difference between being in the room right next to the person, or across the room, or being like fifty miles away, and that’s very extraordinary to me, and the effect that I get feedback on.”

Finally, three of the study participants had a societal message they wanted to convey. Participant 3 emphasized, “I always feel energized after giving a treatment. It does my body as much good as it does the client. I’ve never felt drained or exhausted. I’ve felt rejuvenated, relaxed, and just a sense of well-being that this is what I’m supposed to be doing. So, be sure to include that in your study.”

Participant 8 also had an important message for society. She emphasized “I just think it would be the answer to a lot of our problems in our society if people could just be able to have that heart-to-heart feeling, and to be able to re-balance themselves and also re-balance others, it would be a better world. That’s all I really have to say. So, let’s spread Therapeutic Touch throughout the world.”

Summary of Societal Messages

To summarize two of the societal messages conveyed by the nurse TT practitioners, emphasis was placed on the beneficial effects of TT on the practitioner: energized after a session, feelings of rejuvenation, relaxation, and well-being; does the body good; and, never leaves the practitioner feeling drained or exhausted. Another participant suggested that the heart-to-heart feeling experienced during TT, and the ability to re-balance the self and others may be a solution to a lot of society’s problems, leading, in turn, to a better world.

Summary of Subcategory, Mode

The subcategory, Mode, can be summarized as describing a process of communication accomplished by the nurse TT practitioner being an instrument or channel. Connection serves as a bridge that deepens the process of TT. Shared experiences are related to validating experiences such as the one described about the university shooting, and accumulated fear related to multiple car accidents. Distant TT, a

form of distance healing, facilitated instantaneous communication without constraint of geographical distance.

Summary of Communication Category

To summarize the category, “Communication,” descriptions of awareness, the intuitive process, and the role of observer were included. Communication between the Inner Self of the nurse TT practitioner and the Inner Self of the client (ISSE-to-ISSE; Krieger, 2013) helped to disarm betrayed and traumatized clients.

In treating clients with trauma histories, boundaries were found to be paradoxical. Some nurse TT practitioners felt a need to allow energy to flow, while others felt a need to establish boundaries. A nurse TT practitioner trained also in Counseling discussed at length the need to gently disarm traumatized clients and allow them to emote. In order to mitigate negative SCT, participants spoke of the need to distinguish emergent material as belonging to self or other, and to use humor as a coping strategy.

Information comprised messages accessed through SCT and Knowing, as related to it. Modes of communication included channeling, being an instrument, connection, deepening, validation, and distance healing. On a global level, the receipt of information lent credence to the message of TT as significant for the healing of society.

Healing

The third and final category, Healing, was interpreted by the researcher as the result of SCT’s role in the communication process; namely, “A Language for Healing Trauma.” It is comprised of the following three sub-categories: Trauma, Spirituality, and Release.

Trauma

Incidents in childhood were subsumed within the sub-category of trauma.

Participant 7 said, “I have seen incidents of sexual abuse or physical abuse to people when they were children or young adults.” Similarly, Participant 1 mentioned “When the participant talks about ‘some of these situations that had happened to her when she was very young’.” Describing a clinical experience with a different client, Participant 1 further recalled, “She had also been abused as a young child (history known). She had severe migraines....It (TT) did relieve her headaches.” As related to trauma, Participant 1 spoke of dissociation. She mentioned “a client leaving her body,” and “finding a very small ball of light” to stay connected to her, and to keep her from “leaving her body.” She also referred to “psychic trauma” within the context of healing from childhood trauma.

The nurse TT practitioners in this study described working with people who experienced many different types of trauma. Four provided very specific examples. Participant 1 recalled, “My son would come and get me at soccer games when somebody had hurt themselves.” Sharing another experience, she said, “In a class with someone, I was treating someone and she had a bad accident to her shoulder...she wasn’t actually showing any symptoms...I spent so much time on this shoulder, and yet I picked up that there was so much blockage in that area from the scar tissue.”

Speaking further about her treatment of a client with drug addiction, Participant 2 tearfully said, “Just recently we reconnected...she just recently sent me an email when I retired and let me know that it had meant something to her...So even when you don’t know what’s happening, a lot can be happening. And she didn’t really articulate that at the time...she just committed to not going back to where she’d been. But talk about

working with somebody who'd been traumatized, we do - even when we're not in emergency rooms."

Participant 5 described her experiences with veterans who have had amputations. She said, "Just being aware that their absent limb, phantom limb pain, can be reduced very greatly with Therapeutic Touch...the veteran who's had an amputation is very comforted by the fact that the energy is still there and that can be, he can be helped in that way." Experiences with clients with amputations was also mentioned by Participant 8 who said, "Now in people with amputations, there's definitely post-trauma...they have this phantom pain...all it does is feed into the post-trauma because they've had the pain and then all of a sudden they're losing a limb...a part of what they think makes them whole. When we know that it really doesn't, but that's their perception."

Participant 5 added, "And something else that's really extraordinary, I sit with Eleventh Hour patients...I do the hand-heart connection. And I will sit for four hours, and maybe occasionally take a break for a minute or two, but I can sit for four hours and not be present in the physical sense, but I totally know that person, which is really amazing to me, that we've communicated on a totally different plane than the physical sense, that I can sit, which I can't sit that long, but when I'm doing Therapeutic Touch in a sustained centered state, I can sit there for four hours and I'm in a different place."

Other types of trauma were mentioned by Participant 8. She said, "For example, at our program we work with very sick people. They're very traumatized people. They're going through radiation. They're going through chemo. The cancer has come back, or it's not responding. They are in such states, and I will see in their field where the student needs to go. I can see the emotion. I can see where the pain is. I can see where the

imbalance is. And, generally, I can see the sluggishness of a field that it's just not moving."

Continuing, Participant 8 explained, "When I work with people with fibromyalgia, another trauma, and they've been multiple traumatized through the medical system...I see their field as dark, and I see darkness in their body, so to speak, and I can sense it." She also said, "I do counseling as a therapist, I'm also a licensed counselor in addition to the nurse... people with chronic fatigue, working with that and seeing them all of a sudden be able to do things they weren't able to do....People with phantom pain, being able to reduce or get rid of the phantom pain and the trauma from their amputation."

Subsumed within the sub-category of Trauma, many types of physical conditions encountered were described by the participants. Speaking of disease in general Participant 1 described, "If it's a chronic disease, it takes several treatments." Additionally, "Treating a colleague...picking up something on her hip, which she was not aware of...wasn't having any pain...picking up changes...she ended up having a hip replacement about six months later."

Describing her clinical work, Participant 2 provided examples of patients facing kidney dialysis, some experiencing panic attacks, and patients who had had surgery such as an appendectomy. She said, "For another person who was having panic attacks, feeling tremulousness in the field...when I have worked with people who are anxious, anxiousness is like all over." Elaborating further, she said, "You might be able to feel something right over where a patient had surgery, maybe over their throat from their intubation, or something around their head because they're having anesthesia; but, it's not everywhere in their field."

Participant 3 provided her own clinical examples: “A runner came...on crutches...had completely torn her Achilles tendon. A year later, the client came back on crutches; and, I said I thought that was fixed. She said the wound dehiscd, and had an abnormal amount of scar tissue that had to be removed. ‘They’re talking about a third surgery. I don’t want a third surgery. I’m going backwards, not forwards’... She never had to have that third surgery.” She also recalled, “I had a patient complaining of a migraine headache. Talk about somatic experiences. When assessing their energy field and you can feel these spikes five feet from their head that can be unruffled. They leave your office ten or fifteen minutes later with no headache at all...it’s very satisfying.”

The therapeutic effect of TT on the condition of Grave’s disease was mentioned by Participant 6 who said, “One client had...hyperactive thyroid. She was responsible for her mother; but, her mother did not want any help, or wear a 24 hour alert. This woman was in denial, because her thyroid problem was a result of the stress she was under. She was very thin. One could see that she was under a lot of stress. But she denied it. When I gave her TT, she would relax.”

Sharing more, Participant 6 said, “I see many cancer patients, especially breast cancer, undergoing chemotherapy. I see them on the day they receive chemotherapy.” She also said, “everybody has some kind of emotional issue, but most of my clients are in chronic pain, or cancer patients, patients with arthritis, patients with high blood pressure...Of course they have anxiety and they have some depression. TT seems to help them. I make it a point not to get attached to the outcome. That’s very important.”

Participant 7 described her experiences: “With broken limbs, I can often pinpoint the exact break, the type it is. As I run my hand over the area. I can feel the spiral or crack of it, or a very distinct impression of where the energy is jagged rather than smooth.

I don't necessarily feel their bone pain. Feeling the blip in the energy is my guideline for where I need to direct the energy to." She added, "There are other sensations I feel...from a blocked gall bladder, it's not about prickling, it's a squeezing heaviness...at other times, the acupuncture points pull me in, a sensation of being drawn to a point...I put my fingers an inch away and it will automatically slide...A connect goes on in my body, and then, 'ok, that's it'."

Describing her work with a client having a heroin addiction, Participant 2 said: "...her intention was to never use heroin again...she got into a methadone program. I worked with her for several months...TT has the potential to connect a person to a deeper place within themselves...giving them strength and support. She is now the mother of two children and a certified medical office assistant."

Cancer and Chemotherapy

Cancer and chemotherapy in relation to trauma were encountered. Participant 2 said, "I worked with the woman through first her chemotherapy, then a double mastectomy, and then radiation. I did two to three sessions a week for over a year...was one of my most in-depth experiences." Participant 7 elaborated on her work with cancer patients: "I don't jump in with 'go to the doctor' about everything, but when I hear the message 'you must get to the doctor', I know it's really important. There have been probably around ten times over the years where I perceived cancer before clients experienced symptoms, or had been medically diagnosed. I had people go in and have it taken care of."

Embellishing her prior description of treatment of a patient with breast cancer, Participant 7 also shared, "The tumorous growth had a sensation of thick, gooey sludge that I was pulling out of her breast...a small kernel of energy was left in the breast tissue

– not squeezing, but the blip I kept trying to pull out...it wasn't going any further so we started working on the emotional issue about dying and the guilt about family members who had already died. She called me on the afternoon of her surgery and said, "I didn't have surgery. They did an MRI because they couldn't feel anything, and it's all gone."

Two other participants also spoke about chemotherapy in relation to cancer. Participant 2 said, "The only other time I felt something everywhere in the field was when a patient has been on a fairly potent drug, like oral chemotherapy...with intravenous chemotherapy I don't really experience it that way. In the three patients I felt something in the field were all on Tamoxifen. I thought 'Maybe this is the pattern that happens with Tamoxifen.' A patient I recently treated was on IV chemotherapy, but I certainly didn't feel it everywhere in her field." Also talking about TT and chemotherapy, Participant 6 described, "I performed TT on her every three weeks, immediately after her chemotherapy. She was able to continue to work because she had very few side effects."

Regarding the use of TT as a potential diagnostic aid to assess physical conditions before medical diagnosis, Participant 1 said: "I got a very clear picture of an artery and a vein crossing in her brain. Afterward the client had a couple of CT scans...her physician finally found an arteriovenous malformation (AVM)...said jokingly too bad I hadn't seen her first...it took three CT scans to find it. I could draw it for him, so he could tell where it was." She added, "People who have heart problems you can see where the problems are, where the coronary arteries are blocked, or the state of the heart."

Summary of Subcategory, Trauma

Various types of traumas in adults and children were encountered. Mentioned were child physical or sexual abuse, severe migraines, dissociation, and psychic trauma.

Clinical conditions related to trauma included: sports injuries, drug addiction, veterans with leg amputations, phantom limb pain, dying veterans in an Eleventh Hour program, fibromyalgia, chronic fatigue, and hip replacement. Invasive interventions such as surgery, intubation, and anesthesia were also assessed in clients' energy fields.

Other types of trauma-related physical conditions described were a torn Achilles tendon with several episodes of wound dehiscence, migraine headaches, Grave's disease due to stress, broken limbs, and patients with cholelithiasis, arthritis, hypertension, or cancer. Therapeutic Touch was mentioned as a potential diagnostic aid in assessing physical conditions such as arterio-venous malformations and coronary artery disease before medical diagnosis.

The beneficial effects of TT in cancer treatment were described as mitigating the unpleasant side effects of post-mastectomy chemotherapy and radiation that allowed people to continue working. One nurse TT practitioner mentioned having approximately ten experiences during her career wherein she perceived the presence of cancer before symptoms presented, or cancer diagnosis was medically confirmed.

Two unexpected findings emerged from this study. The first was the description of breast cancer as being very hard, hot, strong, and prickly. The second was the identification of Tamoxifen, a oral chemotherapeutic agent, and generalized anxiety being assessed throughout the entire energy field of the client. Additionally, emotional issues encountered in the context of physical conditions included panic attacks, anxiety, depression, heroin addiction, guilt, shame, and fear of dying.

Emotional Issues

Emotional issues identified in clients also fit into the subcategory, Trauma. In response to the prompt question, "What emotional issues, if any, do you perceive in

clients?” the nurse TT practitioners described encountering a multitude. Participant 7 exemplified by saying, “Probably, I’ve perceived every emotion that people experience at one time or another.”

Several of the participants spoke about grief. Referring to unexpressed grief, Participant 1 said: “Another woman who had a problem with an intraocular lens...it turned out she was grieving for her husband...there was a problem for her of not seeing something, or people not seeing and appreciating something...it was her grief and being able to express her grief.” Participant 8 also contributed: “If there’s a loss, I can almost see that person and what’s in their field, and try to help comfort them in their trauma, in their sudden loss. Usually...you’re traumatized when you have a death and you’re grieving, but when you have a sudden death, the grief, I can see that grief in their field.”

In addition to grief, fear and anxiety were emotions also perceived by several of the nurse TT practitioners. Participant 7 said, “Grief is a very easy one for me to pick up on, as is fear...anxiety.” Providing a specific clinical example of PTSD, Participant 2 recalled, “I was working with a gentleman who had been in multiple car accidents, and that was definitely a time that the fear, it was definitely something that I knew it wasn’t mine. And the intensity of the fear, the accident that he had been in and that I thought I was working with was not that bad of an accident. But it turned out that the two accidents before were very severe, and so the level of fear that I felt in my body didn’t correspond in my mind. So I checked in with him. So what he was doing was he was reliving the fear of the initial big accident, but it had been retriggered or re-stimulated by the current accident. “

Participant 4 also described her perception of fear. She said, “And I could just feel the shock, the fear, just the whole chaos of the entire situation was just bombarding me

with all of these feelings...And so I just immediately could sense the terror...I could feel that she was just so frightened by the whole situation and just that she was so shocky...She felt so alone...and my psyche resonates with that because I often feel that way...no one should be alone then.”

Anger was another emotion described. Elaborating on her experiences, Participant 8 said, “I feel in my body also the sensation of whether they are angry, or not angry. I feel the depth of that emotion.” Recalling a particular experience with a patient with a leg amputation, she said, “And I asked him, because I sensed anger...around this pain, and around the amputation, and I said, ‘how do you feel? What emotion are you feeling with this leg?’ And he just said, ‘I’m mad. I’m angry. I’m, you know...’ He didn’t use any bad language, but you could just sense that he wanted to.”

A feeling of resentment was perceived by one of the nurse TT practitioners. Recalling an experience with a Vietnam veteran, Participant 7 said, “He had his jolly face on, but my emotion...I could feel them being pulled down into resentment. I was prompted to just kind of confront him directly on that. ‘Well, you’re looking happy but it doesn’t feel like you’re feeling happy. Do you want to tell me about the resentment that I’m sensing?’ And then he was able to go ahead and talk about what was going on in his marriage.”

Sadness and depression were mentioned by two of the participants. Participant 7 commented about sadness, saying “I pick up things like sadness and profound sadness, pain...Those, I pick up more often than things like joy or glee, but you can pick those up, too.” Participant 6 spoke about depression. She said, “How I pick up depression is that their field becomes contracted. Also, after working on them, they may release some of this by becoming teary-eyed. And they may release some of the grief and depression. I

just pick up when patients are anxious or sad.” Explaining, she said, “You see, I sit and talk to the patient. So it’s not only the Therapeutic Touch but I also sit and talk to them and see what’s going on with them.” She concluded with, “Happy go-lucky people usually don’t come to me. They don’t need Therapeutic Touch.” And, “It’s like I’m always doing Therapeutic Touch because there are people who have pain, they hurt themselves. I really don’t get involved too much with people who have emotional, extraordinary emotional issues.”

Referencing exhaustion, Participant 3 described her work with nurse colleagues. She said, “The main interpretation as I’ve worked on them...is a lot of exhaustion, a lot of feelings of being overwhelmed, overburdened. Nurses are intensely overburdened, and it’s never enough. We put weight limits on equipment, but we don’t put any on human beings.”

Positive emotions were also perceived in clients. Participant 7 described, “Sometimes the playfulness, or the joyful person that’s there even though that may not be what’s happening in emotion to them right then. So you can kind of see both...But the joy and glee are frequently related to the age and stage, which is not the person at that moment in time. It’s contextual.”

Summarizing her experiences of emotional issues encountered in patients, Participant 3 said, “Gratitude, intense gratitude... intimacy. With my mother, indifference, low energy. With the torn Achilles tendon, a lot of heat, a lot of anger, frustration, and some fear in there. I don’t think fear is too far away from anger. With our cancer patient, just uncontainable gratitude.”

Participant 8 concluded with, “And so, the emotional field is really the easiest field to access on an outward level...With different people I feel different things, but

we're talking about post-traumas. I've already connected, but then, how deep do I go with it? How deep do I let them open up? But, I sense it. I sense the depth of their despair and darkness, the dark, dark space they are in and their fears, and their need to keep them in. Or, their need to let some of that out a little bit."

Summary of Emotional Issues

To summarize the exemplars of emotional issues in clients provided, many different types of emotions were mentioned. These included unexpressed grief, sudden loss, anger, heat-related anger, fear, fear related to anger, anxiety, profound sadness, pain, indifference, low energy, frustration, emotional chaos, shock, terror, aloneness, depression, and resentment.

To exemplify the overall perception of emotional issues, Participant 8 stated, "The emotional field is really the easiest field to access on an outward level." She generally described how she is able to connect with the patient's emotion. Referring to post-traumas, she indicated she sensed the depth of a patient's despair and darkness, and "the dark, dark space that they are in...and their fears." She then described how she makes therapeutic decisions when working with clients as to "how deep to go with it...let them open up."

Two clinical examples described a client who developed PTSD after a car accident in one instance, and a patient with a leg amputation in another. Regarding the first, the degree of intense fear perceived in a client was felt by one nurse TT practitioner not to be commensurate with the severity of a recent car accident the patient was describing. She stated, "The level of fear that I felt in my body didn't correspond in my mind." This discrepancy offered her the clue that the client's fear "was not hers." Checking in with him brought the realization that the original accumulated fear from

several prior car accidents had been retriggered by the current minor one. Regarding the second clinical example, anger, sudden loss, and grief was associated with a leg amputation.

What could be interpreted as “Therapeutic Use of Self” was represented by several exemplar quotes. A few of the nurse TT practitioners contributed to the emotional well-being of their patients, as well as nursing colleagues. One described how she brought “comfort” to the post-trauma of leg amputation. Using herself therapeutically, Participant 4 identified, through distance healing, with the perceived aloneness in a client receiving treatment in an Emergency Room after involvement in a university shooting. She stated, “My psyche resonates with that.” Speaking about post-trauma, Participant 8 similarly said, “I feel the depth of that emotion.” Participant 6 noted, “I sit and talk to them and see what’s going on with them.” She emphasized that “I don’t get involved too much with people who have emotional, extraordinary emotional issues.”

Describing her administration of TT to nurse colleagues, Participant 3 said she perceived in them, “A lot of exhaustion, a lot of feelings of being overwhelmed, intensely overburdened.” She then advocated for nurses in general.

A significant finding in this study was the description of the assessment and manifestation of depression in the energy field during TT. Describing her perception in clients, Participant 6 exemplified by stating, “The field becomes contracted.”

Positive emotions were also perceived. One described picking up “intense gratitude” and “uncontainable gratitude” in a cancer survivor. Several of the participants mentioned picking up on clients’ playfulness, joy or glee, and their pleasure from previous participation in enjoyable activities. While describing these positive emotions, the participant expressed the gleaning of insight. Engaged in reflection during her

research interview, she noted that positive emotions perceived by her were contextual. In other words, the bodily-stored and residual joy, glee, or playfulness perceived in a patient was from their prior life experience and “related to the age or stage of occurrence” and “not the person at that moment in time.”

Engagement in the research interview brought further insight into awareness for another nurse TT practitioner. When asked what she experienced during her visualization of the traumatized patient involved in the university shooting, she gasped and said, “blinding white light.” She stated that she had not had prior awareness of this, but the research question prompted the recall.

Referral

Participant 6 noted the need to make referral to a specialist when necessary. As an example, she said, “If there is a very deep depression, then I discuss referring them to someone who has a specialty in psych nursing, a psych clinical nurse specialist, because in my main practice I’m an adult medical-surgical clinical nurse specialist. Psychiatry is not my field.”

Spirituality

Spirituality is the second subcategory of the category, Healing. Participant 3 related one of her experiences. She said, “I’m going to share with you an experience that I don’t share with a lot of people because it was a very sacred experience. It was the most sacred experience.” She then went on to describe two memorable clinical experiences. The first involved her use of Reflexology to successfully stop a patient’s esophageal spasms. The second involved accelerated healing in an elderly woman after a serious fall. Regarding the latter, Participant 3 said “What medication can you give somebody for a

bruise? ... In two weeks she's already at the yellow staging with bruising that severe."

She shared photographs of this case with the researcher.

Spiritual Intimacy

Sharing another clinical experience about a cancer survivor who received TT, Participant 3 described her interpretation of "profound spiritual intimacy...that spiritual connection...Yes, it can be physical, but it can be mental, emotional, and spiritual, and that's what I experienced with this lady...Five of her six children participated in giving their mother a (TT) treatment with me. How many people are blessed to experience that kind of interaction between a mother and a child, a parent and a child? And she's cancer-free now. And I believe that's why. She is breaking the mold."

Angels

Within the subcategory, Spirituality, the nurse TT practitioners spoke of Angels and Beings serving as Guides and Supportive Presences. Regarding angels, Participant 7 revealed this: "There was only one time that I was fully aware of an Angel stepping into my space and moving through my body. And, that was an ecstatic experience. I was feeling that and soaking up the energy and wrapping my client in a cocoon of protection. She had cancer and was a very spiritual woman. We had done some praying together that she asked for before her session, and called on the Angels to come and help. At the end of the session when I had my arms spread out, one over her head and one over her feet, and was just running the energy to clear it, I felt this presence step into my space and wings spread out along my arms. It was thrilling. Transporting. I don't know how long I stood with my arms out like that. I had no sense of time. When it released me and I stepped back I said a prayer of thanks, and bent over to release any excess energy that I might be carrying on and went out of the room...When I came back in she said, 'I felt wings over

my body while you were working.’ And, I said, ‘Honey, so did I’ and she got a clean bill of health within a month. That was undoubtedly the most dramatic.”

Beings

Participant 7 described Beings in this way, “But there is a sense of tugging towards another Energy Being or body that’s in trouble for me...I have also seen other entities around people. They’re usually like glows or a presence that is body-size. I can sometimes see the expressions of the person or get a physical description of the Being...I have also perceived angelic presences and other helpful Beings at other times. That’s something to explore more.”

Supportive Presences

The nurse TT practitioners spoke about people as supportive presences. Participant 1 said, “Sometimes you can have people, if you think that there’s going to be potentially a problem, you can have people who are actually a support with you, can be energetic and present so it can help you...Have real people help the situation. But you can also call on others who are not real...their presence is not physically present.”

Participant 2 also mentioned supportive presences, sharing “the most extraordinary for me is when I actually feel the presence of somebody working with me, whether it is the experience of a presence almost like overlaying me like from behind and just supporting me or just feeling the presence of somebody that supports the person that I’m working with. I suppose that’s extraordinary, but it doesn’t surprise me.”

An experience was described by Participant 3. She recalled, “There was this one time specifically as I was working on her, it was just as clear as if you would say something to me right now, that said ‘Stop, you’re done, don’t touch her anymore.’ I

assumed that was her mother...And the next time I came back to give her a treatment, I asked her, I said 'Did you feel your mother here?', and she said, 'No, I felt my dad here.'”

Participant 7 also described her experiences. She said, “I’m not the only one who is experiencing the help that is around me when people are working. And people bring their own guides in. And if they are very present, then I will talk with their guide about, get information about what’s needed and how I can help. I have seen little elves and little people around some clients. I’ve seen spirit animals around a lot of clients.”

Cherubs

Participant 5 described her experiences with supportive presence, naming them as cherubs. She said, “And I can feel presences in the room...I don’t think I ever had with veterans but I see for me, well I guess for me there are different beings. I call them beings, but usually they’re cherubs. There are cherubs that help. They just show up to be part of... Well, it’s just sort of like say a veteran is dying, I sense presences. I don’t see them.”

Summary of Subcategory, Spirituality

To summarize the exemplars of the subcategory, Spirituality, the nurse TT practitioners provided clinical experiences and described the presence of different types of entities offering support during TT. Considered a sacred experience by Participant 3, she described her use of Reflexology to stop a patient’s esophageal spasms. She also described the accelerated healing of bruising in an elderly woman after a serious fall. Describing a clinical case with a cancer survivor, Participant 3 also used the terms “profound spiritual intimacy” and “spiritual connection.”

The nurse TT practitioners provided quotes that also exemplified their spiritual experiences with Angels, Cherubs, Beings, and Guides that were considered to be

supportive presences during TT. A significant finding in this study was the resonant experience of angel's wings described by Participant 7. Other study participants described people, such as mothers or fathers, as supportive presences.

Regarding work with traumatized clients, Participant 8 spoke about the presence of Beings, or an Energy Being, that served as both a Guide and supportive presence via communication in her mind. She summarized, "Have real people help the situation...or call on others who are not real...their presence is not physically present." As further exemplification, Participant 2 said, "I feel the presence of somebody working with me, like overlaying me like from behind and just supporting me - or just feeling the presence of somebody that supports the person that I'm working with."

Exemplar quotes which supported the researcher's interpretation of spirituality as a communication pathway in healing trauma were, "People bring their own guides in," and "I get information about what's needed and how I can help." Of cultural interest, two of the nurse TT practitioners who described themselves as part Native American Indian, shared, "I've seen little elves and little people around some clients"; another, "I've seen spirit animals around a lot of clients." Previous literature supports these types of experiences as occurring more frequently in Caucasians and Native Americans.

Release

Subsumed within the category, Healing, is the subcategory, Release. It is comprised of: posttraumatic growth, shift, opening the field, patterning, quantum physics, cellular level, energetic, extraordinary, power of TT, and miracles.

Talking about growth following trauma, Participant 2 said, "I'm absolutely certain that I have also picked up the experience at times of, and it's funny to say this, but it's a

joyfulness, somebody that is relieved and glad that they're still here, that they've been traumatized but they're kind of getting on to the other side."

Participant 1 spoke of shift. She said, "Open the field, and then some shift can happen...then you can open it more and some more shift can happen in this way." She also mentioned quantum physics in relation to distance healing with TT: "I can begin and be completed probably within one or two minutes sometimes. It's very fast...the process is very fast compared to working with somebody one-to-one. Theoretically I suppose it could be quantum physics. It's a release in space and time."

The cellular and energetic levels were described by Participant 2. She stated, "And I have found that when people can identify the feeling and almost bring it to their awareness, and then you clear, it supports their ability to actually clear, because they've got that on a cellular level. It's in their body, energetically. I mean you look at it energetically, and so you clear, and then it can begin to actually release...at least that's my current belief."

Summary of Subcategory, Release

To summarize exemplar quotes for the subcategory, Release, the nurse TT practitioners described healing from trauma as involving: posttraumatic growth; shift, and an opening of the field to promote it; the role of quantum physics in TT distance healing that leads to a release in space and time; and, increased awareness in the client at the cellular and energetic levels of their bodies that also leads to release.

Extraordinary Experiences

When asked the final prompt question, "What experiences do you consider extraordinary, if any?" the nurse TT practitioners replied with the following. Participant 3 said, "I consider all of these experiences I've told you about extraordinary." Providing an

overview of them, she exemplified: “There are no words to describe the feeling in that room when that lady finally went to sleep, the feeling when her husband told me she never had another esophageal spasm the remaining days of her life. The excitement when I see the improvement I could make in my mother within just two weeks, the satisfaction with the torn Achilles tendon not having to have a third surgery, and the fact that that mother of six children and twenty grandchildren is still alive and just running herself crazy...So, the work is extraordinary, without a question.” As a summary, she added, “So you can see we had medications there, we had surgery, we had no medications, nothing else we could do there for my mother, the Therapeutic Touch, there’s no doubt in my mind, benefitted all three of those patients.”

Participant 5 replied in this way, “I think every time I do Therapeutic Touch it’s extraordinary. Every time.” Providing a specific clinical example, she said, “a veteran, had a lot of unresolved issues, he was very combative, wouldn’t let anyone touch him, go near him ... he would walk, walk, walk until he could fall down on any bed there was. And actually the very first time I did Therapeutic Touch on him, the rest of my peers that referred me, and they had tried everything, every medicine, every psychiatrist, everything. And when I went back and checked, they said, because he never slept more than five minutes around the clock and just was not with them, and she said he slept for two hours after and then slept all night just in one treatment. So that was just really extraordinary. And now he’s a model patient and no longer needing our service, which is what nursing is about.”

Participant 5 presented another clinical vignette: “Another extraordinary experience was when I worked with a woman who developed behavioral problems and three different personalities after a fall. I intuited she needed a separate TT practitioner

for each personality. Each practitioner lived in a different state and did distance healing with her. After a year her behavior became normal again. When she died, two of the three TT practitioners knew the exact moment, even though they lived in different states.”

Summary of Extraordinary Experiences

To summarize exemplars of the nurse TT practitioners’ extraordinary experiences, several described the whole process of TT, in general, and the specific clinical experiences they provided to be extraordinary. Clinically, they described the permanent relief of esophageal spasms in an elderly woman; accelerated healing in an elderly woman after her serious fall; the lack of need for a third surgery on a woman with a torn Achilles tendon; the cancer-free status of an elderly woman, now enjoying her twenty grandchildren; the resolution of insomnia in a formerly combative veteran; the resolution of behavioral problems and integration of three emergent personalities subsequent to an elderly woman’s fall; the treating of a woman diagnosed with breast cancer and the coincidence of sitting at her former desk; hearing a patient say, “you reached down to my soul”; connecting the nurse TT practitioner’s sense of heart and love with a patient’s sense of anguish, and then helping it change; and finally, being able to teach the process of TT to students who learn to facilitate balance in another human being.

Power of TT and Miracles

One nurse TT practitioner referred to the “Power of TT” while describing the case of a woman with eye problems. Participant 1 recalled, “They removed the lens and her eye was fine, and there was no problem, and she actually did recover very well...She recovered from her grief and depression...it was a one-time treatment. So, it can be very powerful.”

In conclusion, and to exemplify a precaution Participant 1 emphasized, “We have to be careful we’re not seduced by the almost miracles that happen in acute situations, because they do look like miracles.”

Summary of Healing Category

To summarize the third category, Healing, it was comprised of three subcategories: Trauma, Spirituality, and Release. The subcategory, Trauma, was comprised of nurse TT practitioners’ descriptions of traumas encountered in their clinical work: abuse in childhood and related migraine headaches, dissociation, and psychic trauma; many clinical conditions such as sports injuries, drug addiction, leg amputations and associated phantom limb pain, fibromyalgia, chronic disease such as cardiac, hypertension and arthritis, Grave’s disease, gall bladder disease, kidney dialysis, cancer, especially breast cancer, and conditions requiring surgery such as a torn Achilles tendon, and broken limbs. Trauma-related emotional conditions described in the context of medical diseases and surgery included panic attacks, anxiety, depression, heroin addiction, guilt, shame, and the fear of dying.

Beneficial aspects of TT included: using it as a potential diagnostic aid to assess arterio-venous malformations, coronary artery disease, and cancer before medical diagnosis; and, mitigation of unpleasant side effects of chemotherapy and radiation post-mastectomy. Regarding the latter, significant study findings were the energetic description of breast cancer, the effect of Tamoxifen on the human energy field, and the pervasiveness of anxiety in the overall field.

The second subcategory, Spirituality, comprised descriptions of nurse TT practitioners’ experiences with different types of entities, including people, offering supportive presence during TT sessions. A significant finding in this study was the

resonant experience between one nurse TT practitioner and a client of angel's wings, as described by Participation 7. In sum, these presences, also called Beings, served as Guides and facilitators of information and communication. Cultural heritage, such as Native American Indian, may have influenced the experience of spirituality.

The third subcategory, Release, manifested in posttraumatic growth; shift; an opening of the field to promote it; patterning; implications for quantum physics; healing at the cellular and energy levels; extraordinary experiences; and, regard of TT as a powerful healing modality wherein miracles may sometimes appear to occur.

Meanings Inherent in the Theme

Subcategories and categories that emerged from the interview text were used to develop a theme and build a conceptualization of SCT (Elo & Kyngas, 2007). The overall theme that emerged from the content analysis of the nurse TT practitioners' descriptions of their SCT experiences was that somatic countertransference can be conceptualized as "A Language for Healing Trauma." Through thick, rich description, the nurse TT practitioners themselves provided justification for the emergent theme. For a depiction of the researcher's conceptualization of the dynamic and quantum nature of the SCT descriptions, see Appendix, Figure 2.

To expand, the theme emerged to bring meaning and identity to the recurring experience of SCT and its different manifestations in nurse TT practitioners. As such, it was interpreted to capture and unify the nature of the SCT experience into a meaningful whole (DeSantis & Ugarriza, 2000). Moreover, development of the theme through content analysis was consistent with communication research in the social sciences (Krippendorff, 1989) in that the SCT phenomenon was found to be a factor in the healing

of trauma emanating from the verbal and nonverbal communication among members of one group of nurse TT practitioners in interaction with their traumatized clients.

As conceptualized, the theme captured the categories of Nurse TT Practitioner, Communication, and Healing. The description of the common theme embraces a language to describe the context of the Nurse TT Practitioner during work with traumatized clients, Communication occurring during the interaction, and the Healing of trauma. SCT was interpreted as a factor in facilitating communication that promoted the healing of trauma.

The nurse TT practitioner's body was conceptualized as providing the structure for the experience of the SCT phenomenon. The nurse-client interaction was interpreted as fostering a process of communication contributing to the release and healing of trauma. Viewed from a quantum perspective, mutual somatic awareness at both the nurse TT practitioner's and client's cellular and energetic levels (Pert, 1997) can be conceptualized as involving a transfer of healing energy in space and time (Rogers, 1970) that promotes the release of trauma.

CHAPTER VI

DISCUSSION OF FINDINGS

The Research Question

As with all empirical research, the study design started and flowed from the research question (Forman & Damschroder, 2008). With the goal of producing a high quality study, the purposive sampling strategy, data sources, collection methods, and analysis techniques were thoughtfully and deliberately matched to it (Forman & Damschroder, 2008). Sensitizing concepts from previous research (Orbach & Carroll, 2006) were used to initially separate the text into the research question areas. The manifest content of the interview text was identified through codes and subcategories. Categories and one emergent theme represented the latent content.

Main Research Question 1

The main research question was formulated to address the study aim: an illumination of the phenomenon of SCT through nurse TT practitioners' descriptions of it. The participants were first asked, "Please tell me, what is your experience of SCT when you have cared for traumatized patients within the previous six to twelve months?"

Orbach and Carroll's (2006) definition of SCT was supported in this study as evidenced in the participants' own words. When asked about their SCT experiences when working with traumatized clients, the nurse TT practitioners provided thick, rich descriptions. An awareness of their own bodies, sensations, images and feelings were described that did offer a link to the client's healing processes (Orbach & Carroll, 2006).

To summarize the SCT experiences described by the study participants, the exemplar quotes incorporated descriptions of somatic experiences, thoughts, images, sounds, emotions, and general moods when working with traumatized clients. In the

mutual field interaction with them, centeredness was noted to be an important facilitator.

The following statement made by Participant 8 best exemplifies the SCT experience:

“Some experience that I’ve had with the somatic countertransference is when I work with the individual, and of course I’m centered, and I’m in their field, and our fields are interacting with each other... I have thoughts. I sometimes have images, and sometimes sounds. I experience feelings, I can pick up a mood, general mood, whenever I do Therapeutic Touch, especially with traumatized people.”

Sub-Research Question 2

When asked the next research question about their body experiences during work with traumatized clients, the nurse TT practitioners’ responses indicated that the SCT phenomenon is structured within their body, the client’s body, and within the nurse-client encounter. Areas of the body described included, for example, the practitioner's hands, their solar plexus, and theirs and participants’ hearts. Clinical examples involving body experiences were given. Emotions in the client felt by the nurse TT practitioners were also described. Emphasized was the fact that body experiences, in general, diminish with increased experience and are replaced with more images, sight, light, feelings, and thoughts. Somatic countertransference was described as a beneficial body experience for nurse TT practitioners in that feelings of being energized, rejuvenated, and relaxed were produced. Somatic countertransference was credited with decreasing the depth and intensity of painful emotions in clients.

Sub-Research Question 3

When asked what they perceived during TT sessions with traumatized clients, the study participants again provided thick, rich description. Subsumed within the category, Nurse TT Practitioner, their perceptions were subcategorized as a quality (i.e., perceptive

ability). They described perceiving lights, and colors, and gave vivid descriptions of cues in the field. Words used to describe the latter were “lightning bolts, radio static, a bump, a wrinkle, and a rip.” Phrases used were: “touching a web; patterns in the field like pins and needles, and pain; a shuddering sensation; and, a feeling of pulling taffy.”

An important finding was the nurse TT practitioners’ perceptions associated with specific physical conditions in clients such as edema (e.g., “the field being pushed away). Quite significantly, several of the nurse TT practitioners described “prickling or pain in the hands as emanating only from cancer.” One participant in particular noted that throughout her career she had identified cancer in a client’s field before medical diagnosis in about ten cases.

Regarding perception, the nurse TT practitioners also mentioned validation with the client, using “extraordinary perception,” initial use of visual assessment, deepening into silence, emotions, and a sense of knowing. Sometimes they heard, and one saw a blinding white light when questioned about her perception during a distance healing TT session in real time with the victim of a university shooting.

Sub-Research Question 4

When asked what they saw during their work with traumatized clients, the nurse TT practitioners provided vivid descriptions of visual experiences, sometimes during TT with Distant Healing. One nurse TT practitioner who does most of her TT through distance described “being able to hear someone else send a color across a room” in contrast to seeing colors. Two participants indicated they do not visualize.

For those who do visualize, one described seeing objects, animals, or someone playing, and asked the client what, if any, significance this held for them. Visual experiences with veterans were described as “with the eyes closed, seeing the unseen

world that veterans see.” Specific diseases such as heart disease, gall bladder disease, adrenal cancer, and problems with circulation were visualized. Toxins, inflammation, and organisms were seen.

Within the context of what they saw, the nurse TT practitioners also described emotion-laden experiences that were both positive and negative in nature. One participant referred to patients being so traumatized she could “see them crying inside.” In contrast, another nurse TT practitioner described her imagery being related to positive emotions such as visualizing the patient as joyful, pain-free, and happy. It was interpreted by this same participant that these latter images were self-conjured and did not come from somewhere else. Another participant described seeing formerly enjoyed activities of patients with paraplegia or quadriplegia.

In terms of their quality, images were described as holographic, three-dimensional, photo-like, movie-like, and cartoon-like. The nurse TT practitioners described seeing colors and anatomical body parts that involved the need for surgery (e.g., arterio-venous malformation, hip replacement). Several nurse TT practitioners mentioned their use of guided imagery to help people out of an “emotional box they were stuck in,” and engage in self-healing of a torn Achilles tendon.

Additional descriptions of images that occurred within the context of clinical work and involving specific diseases were given. These included heart disease; blockages in the nervous system or circulation; gall bladder disease; adrenal cancer; and, amputation following a non-healing wound from impaired circulation. “Extraordinarily clear” images occurred. Trauma-related incidents such as the site of sports injuries were seen. An experience of resonant imagery was described in that a picture of a patient’s mother was seen in the mind without the practitioner ever having met her.

Incidents, accidents, sexual abuse, and physical abuse were seen as “snippets of little movies.” An example of an image with a cartoon-like quality was given by one participant. She described seeing an ape running through a forest, and interpreted the image as a clue to the patient’s migraine headaches being linked to something very old from her childhood that involved her sense of safety.

Sub-Research Question 5

When asked what emotional issues they perceived in traumatized clients, the study participants provided in-depth descriptions. Participant 8 exemplified with, “the emotional field is really the easiest field to access on an outward level.” The nurse TT practitioners described perceiving many different types of emotions, both negative and positive.

Emotions in need of healing included unexpressed grief, sudden loss, anger, heat-related anger, fear, fear related to anger, anxiety, profound sadness, pain, indifference, low energy, frustration, emotional chaos, shock, terror, aloneness, depression, and resentment.

Positive emotions perceived by the nurse TT practitioners included picking up “intense gratitude” and “uncontainable gratitude” in a cancer survivor. Several of the participants mentioned picking up on clients’ playfulness, joy or glee, and their pleasure from previous participation in enjoyable activities.

Exemplifying the perception of emotions related to past trauma, Participant 8, a clinical nurse specialist, indicated she sensed the depth of a patient’s despair and darkness, and “the dark, dark space that they are in...and their fears.” She described how she makes therapeutic decisions when working with clients as to “how deep to go with it...let them open up.” One nurse TT practitioner discussed her experience with

paraplegic or stroke patients, seeing them swinging or skiing, engaged in something they formerly enjoyed doing. She interpreted this as helping them to get in touch with a place of “wholeness, timelessness, and joy.”

Two clinical examples described a client who developed PTSD after a car accident and a patient with a leg amputation. Regarding the first, the degree of intense fear perceived in a client was felt by one nurse TT practitioner not to be commensurate with the severity of a recent car accident the patient was describing. She stated, “The level of fear that I felt in my body didn’t correspond in my mind.” This discrepancy offered her the clue that the client’s fear “was not hers.” Checking in with him brought the realization that the original accumulated fear from several prior car accidents had been retriggered by the current minor one. Regarding the second clinical example, anger, sudden loss, and grief was associated with a leg amputation.

What the researcher interpreted as “therapeutic use of self” was demonstrated by several of the nurse TT practitioners’ exemplar quotes. Several described their contribution to the emotional well-being of their patients and nursing colleagues. For example, describing her administration of TT to nurse colleagues, Participant 3 said she perceived in them, “A lot of exhaustion, a lot of feelings of being overwhelmed, intensely overburdened.” She then advocated for nurses in general.

Regarding the perception of emotions, several significant findings emerged. The first was the description, by Participant 6, of the assessment and manifestation of depression in the contraction of the energy field. The second involved a gleaning of insight during a description of positive emotions. Specifically, while engaging in reflection during her research interview, one nurse TT practitioner noted that positive emotions perceived by her were contextual. In other words, the bodily-stored and residual

joy, glee, or playfulness perceived in a patient was from their prior life experience and “related to the age or stage of occurrence” and “not the person at that moment in time.” She concluded with, “sometimes the playfulness or the joyful person that’s there, even though that may not be what’s happening in emotion to them right then.”

Further insight was also brought into self-awareness by another study participant during the research interview. When asked what she experienced during her visualization of the traumatized patient involved in the university shooting, she gasped and said, “blinding white light.” She stated that she had not had prior awareness of this, but the research question prompted the recall.

Sub-Research Question 6

When asked what experiences they considered extraordinary during their work with traumatized clients, rich, thick descriptions were given. Several nurse TT practitioners described the whole process of TT, in general, and the specific clinical experiences they provided to be extraordinary. Additionally, they regarded being able to teach the process of TT to students who learn to facilitate balance in another human being as extraordinary.

Describing two experiences she regarded as extraordinary, Participant 5 shared some of her work with veterans. She recalled the resolution of insomnia in a formerly combative veteran. She also described the resolution of behavioral problems and integration of three emergent personalities subsequent to an elderly woman’s fall. Besides herself, two nurse TT practitioners in two other states were recruited to treat the woman through Distant Healing. When the woman died, two of three of the TT practitioners knew the exact moment.

Relationship Among Categories

In this study, the codes were clustered together to create tentative subcategories. Three main categories then emerged from the data that were based on the patterns and relationship discerned among the subcategories. The categories identified were the Nurse TT Practitioner, Communication, and Healing. These categories were used to describe the different meanings the phenomenon of SCT had for the nurse TT practitioners sampled and to provide a framework for data analysis. These categories were therefore generated inductively (Forman & Damschroder, 2008). The description of the common theme, “A Language for Healing Trauma,” includes the relationship among the Nurse TT Practitioners interviewed during their work with traumatized clients, communication occurring during that interaction, and the healing of trauma.

The data revealed that the Nurse TT Practitioner provides the structural input for the environment of the therapeutic relationship and the resulting healing process. In this study, the nurse TT practitioners’ descriptions revealed their contribution toward change in the relationship over time (Hughes, Meise-Grochowski, & Duncan Harris, 1996). Therefore, this content analysis identified patterns of SCT experience described by the study participants, what situations characterized their participation, and what healing patterns of change they reported and observed (Patton, 2002).

When viewed within systems theory, the relationship between the nurse TT practitioner and the client defined an intersubjective field, or a contained space (Macecevic, 2008). Descriptions provided by the study participants revealed that their body is a therapeutic tool (Hart, 1997) that actively participates in their client interactions (Orbach, 2004, 2006; Shaw, 2003).

In this study, the Communication category was conceptualized as relating to a therapeutic process occurring during the interpersonal relationship between the nurse TT practitioner and their client. Applying Ogden's (1994) term, this "unconscious intersubjectivity" (p. 11) fostered the nurse TT practitioners' descriptions of their subjective experiences at an intrapsychic level (O'Shaughnessy, 1983). Mutual dialogue between the nurse TT practitioners and their clients therefore allowed their bodies to communicate. Increased awareness of their experience of SCT phenomenon enabled the nurse TT practitioners' descriptions of the emergence of subtle material during work with traumatized clients (Macecevic, 2008).

Based on the study participants' descriptions, SCT can be viewed as a valuable clinical tool (Miller, 2000). Nurse TT practitioners' heightened awareness of body sensation and body knowledge enabled the receipt of valuable communication from the client's body manifestations and unconscious messages (Jakubowski, 2012). Corroborating Lude's (2003) findings, SCT, when used effectively, can be viewed as a two-way process between energetic connection and non-verbal communication.

The Healing category identified in this study related to the results of the verbal and nonverbal communication occurring between the nurse TT practitioners and their traumatized clients. In this study, healing in the context of TT comprised subcategorized descriptions of trauma, spirituality, and release. This is consistent with DuBrey's (1996) perspective on TT as a means to restore one's wholeness, balance, harmony, and sense of well-being at the physical, emotional, and spiritual levels. The SCT experience described by the nurse TT practitioners in this study incorporated somatic, emotional, and spiritual themes.

Relationship of Findings to the Extant Literature

A relationship was found to exist between the rich descriptions provided by the nurse TT practitioners in this study and findings from previous theoretical and empirical literature.

Somatic Countertransference

The study findings further support findings from prior nursing and psychology investigations reported in the literature. Similar to previous findings, the results of this study showed that there is still a need for more systematic study of nurses' understanding and use of countertransference as either a therapeutic or nontherapeutic factor in nurse-patient relationships (Geach & White, 1974). The findings of this study supported Puckey's (2001) position that countertransference is now viewed as a natural part of the therapeutic relationship that yields deeper empathetic understanding of the patient.

Schroder's (1985) discussion of countertransference was supported in this study in that the client's past was found to enter into the here-and-now aspects of the nurse-client relationship. This conclusion was aligned with Yontef's (1979) earlier view that "the client's and therapist's wisdom is revealed through sensory awareness in the Gestalt here-and-now" (p. 30). The findings of this study similarly support Hirose's phenomenological (1999) findings that embodiment in the nurse psychotherapist helps the patient to live more in the here and now.

The findings from this study also support those found in Ens' (1999) phenomenological study in which a structural description of five nurses' countertransference evolved. The lived experience was found to be a process of the continuous growth of self-awareness. Nurses' emotions were able to be used therapeutically in interactions with patients when they abandoned the principles of

objectivity, emotional neutrality, and therapeutic omnipotence. Consistent with the findings of this study, the hallmark of the lived experience was nurses' growing self-awareness to provide an appropriate level of care to the patient (Ens, 1999).

This study supports Irvine's (1988) findings that countertransference, in the context of a relationship, has therapeutic intent since the patient's reactions and material are taken into account. Regarding somatic experience, this study also supports Dosamantes-Beaudry's (1997) conclusion that attendance to it in both the patient and therapist during psychoanalysis has clinical relevance. The nurse TT practitioners' descriptions lend further support to the clinical relevance for patients who use their internal experience to communicate primarily through various forms of bodily expression; that is, for those patients who have been traumatized (Dosamantes-Beaudry, 1997).

The study findings support Puckey's (2001) position that intentional countertransference is a valid therapeutic strategy. Pert's (1997) and Reed's (2007) premise that somatically attuned and aware clinicians such as TT practitioners are better able to identify and work with bodily aspects of experienced trauma was validated in this study.

Lude's (2003) posit that effective use of SCT is a two-way process between energetic connection and non-verbal communication was further supported. Shaw's (2004) suggestion that "the therapist's body experience (may provide) invaluable information about the intersubjective space between therapist and client" (p. 273) was also found to be true in this study.

Findings in this study were also consistent with Ens' (1998) finding that inherent self-knowledge, attunement, reflection, and analysis are essential tools used by the

therapist in the healing process (Ens, 1998). Study findings were also consistent with Jakubowski's (2012) exploratory descriptive study findings emerging from a qualitative content analysis of eight therapists' interview texts; that is, therapists use their physiological responses in work with trauma survivors. Consistent with her study, participants' use of clinical functions such as the ability to attune, assess, maintain boundaries, and prevent vicarious trauma, the nurse TT practitioners in this study described similar proclivities.

Overall, in comparing the findings to the past literature on SCT, participants' responses were congruent with Vulcan's (2009) research in which the therapist was described as an active participant whose somatic responses are part of the therapeutic interaction. A comparison can also be made to Raingruber and Kent's (2003) finding that, according to participants, "physical sensations served as a Geiger counter of meaning that helped clinicians reflect on and understand the traumatic event in the patient" (p.454). In this study, participants viewed SCT within the framework of TT, illustrating a view of nurse TT practitioners' experiences and use of SCT during therapy with trauma survivors as experiences of what the literature calls somatic countertransference.

Like Schroder's (1985) conclusion, countertransference, if left unrecognized or ignored, can facilitate or interfere with the nurse's therapeutic work with the patient. Unlike Schroder's (1985) position, however, countertransference was not found to be a strictly unconscious response of the therapist, involving only his/her own attitudes and feelings originating in the past.

A comparison to the findings in past literature on SCT demonstrated participants' responses contrasted to Field's (1989) work. Namely, they described their SCT

experiences as related to the client's material rather than as unrelated to or in contradiction to the client's manifest material. The majority of the findings indicated agreement with Orbach and Carroll's (2006) more contemporary view of SCT that defines it as the "therapist's awareness of their own body, of sensation, images, impulses, and feelings that offer a link to the client's process and to the intersubjective field" (p. 64).

Body Experiences

The findings from this study support previous research on somatic, or body, experiences, and embodiment. Early on, Casement(1985) stated that the clues to recognizing countertransference reactions are sometimes experienced as feelings, moods, or thoughts; sometimes as unbidden, or spontaneous, images, fantasies, or sounds. Similar to Orbach and Carroll's (2006) more current definition, the experiences of SCT described in this study corroborated Casement's (1985) as appearing to embody something that "belongs" to the patient.

The findings from this study support previous research on embodiment. Wilde's (1999) concern with the phenomenology of perception (Merleau-Ponty, 1962, 1968) wherein embodiment was described as "how we experience the world – perception, emotion, language and movement through our bodies" (p. 27) was supported. Gale's (2011) reference to embodiment as the phenomenological lived body/self, and use of the term "body-talk" was similarly interpreted as the body's ability to communicate its distress and need (Gale, 2011).

In addition to somatic countertransference, synonymous terms describing the physiological aspects of countertransference (e.g., body-centered countertransference and embodied countertransference) (Jakubowski, 2012), could also be applied in this study.

Phenomenological approaches used previously by anthropologists to understand social issues of the body, and to focus on lived experiences including pain, emotion, violence, and trauma are also relevant. Nurses have therefore used embodiment, now termed "mind-body connection," as a central paradigm (Wilde, 1999). The findings in this study further support the nurse TT practitioners' descriptions of their body experiences during work with traumatized clients as being embodied.

Raingruber and Kent (2003) also supported an embodied stance used by nurses and social workers in trauma work, especially with regard to self-care and prevention of burnout. Their phenomenological investigation explored embodied responses to traumatic clinical events experienced by nurses, social work students, and faculty. The nurse TT practitioners' descriptions of their body experiences during work with their own traumatized clients further supports the benefit of TT in self-care and diminished vicarious traumatization.

Shaw's (2004) grounded theory study was the first to explore SCT; that is, psychotherapists' somatic experiences during the therapeutic encounter (Macecevic, 2008). Based on the lived-body paradigm of phenomenology (Merleau-Ponty, 1962), a grounded theory of embodiment was generated, indicative of the relationship among first-order themes (e.g., physical reactions, communication, and styles and techniques); second-order themes (e.g., body empathy, body as receiver, body management); and permeative themes (e.g., psychotherapeutic discourse and researcher embodiment) (Shaw, 2004). By interpreting SCT as a form of communication in this study, further contribution, like Shaw's (2003, 2004a, 2004b) can be made to theory and clinical practice - in both the fields of psychology and nursing.

Imagery

Prior research on imagery experienced during work with traumatized clients is supported in this study. Like van der Kolk (1994) who found that imagery experienced during energy healing may be revelatory for verbally inaccessible content, the imagery experiences described by the nurse TT practitioners in this study may be clinically significant in treating PTSD (van der Kolk, 1994). Heinschel's (2002) recommendation that consideration should be given to the TT practitioners' experience of imagery, the role of the nonordinary state of consciousness in healing, and the nurse's presence (Heinschel, 2002) was also supported.

Findings on imagery reported in previous studies were similarly corroborated. Csordas (1994) had described TT practitioners' experience of imagery as revealing links to clients' healing processes, with prior minimal investigation in nursing or other fields predominating. Casement (1985) also conjectured that experiences of SCT-related imagery may appear to embody something that "belongs" to the patient. In describing SCT as the effect on the therapist's body of the patient's material, Forester (2007) also noted that SCT can sometimes be recognized by feelings, moods or thoughts and sometimes by spontaneous images. The findings in this study are therefore supported by previous research.

Shaw (2004) posited that SCT phenomenon described by the therapists in his study arose from experiences within their own bodies, and not from their clients' bodies. Using an example given by one therapist (e.g., "I think what I was doing was picking up the unconscious body memory of the client."), he emphasized verification with the client. This practice of validation was described by several nurse TT practitioners in this study. The findings of this study therefore support the possibility that the phenomenon of SCT

can be attributed to the client's unconscious, bodily-stored material. Much further evidence is needed.

The findings in this study also lend support to Macecevic's (2008) observation that inherent spontaneity manifests SCT phenomenon and imagery in a supportive environment where there is a willingness to let go of preconceived ideas or plans (Macecevic, 2008). Statements made by participants in this study indicated that they, too, worked "without preconceived ideas or plans."

Heidt's (1990) provision of examples of two nurses' experience of imagery during TT was consistent with experiences of resonant imagery described by participants in this study. One of Heidt's (1990) study participants described that while treating a patient with deep muscle tears after childbirth, "I got the feeling that the problem is not in the pelvis. It is higher. It is here (points to the heart). I then asked her if she was afraid that she wouldn't heal." (p. 183). Another nurse attributed the source of the many thoughts coming to her as she was treating one patient: "I began to connect the tension of her shoulders with her life choices and life-style right now" (p. 183). In this study nurse TT practitioners similarly described resonant experiences and imagery.

Features of Imagery

The different types of imagery experienced by participants in this study also support previous findings. Leuner (1966/1969) and Horowitz (1970) had called images which occur while the person is in the receptive mode (i.e., relaxed but conscious) hypnagogic. These were noted to be preconscious, preverbal, and visual symbols that have a motion picture quality (Shorr, 1974; Singer, 1974), and which can be watched with the mind's eye. In this study, images were similarly described by participants as "movie-like." In the state of relaxation during TT, imagery that spontaneously emerges in

the practitioner may promote emotional healing in the client. It is therefore reasonable to speculate that the nurse TT practitioners' images described in this study served to bypass, and compensate for, blocked images and affect in the client. More evidence is needed.

In this study, Participant 5 described her experience of "sensing without seeing" when working with veterans. This described experience also corroborates past research on imagery. Described as both an intrapsychic and an intersubjective event, the occurrence of SCT-related imagery can be conceptualized as "catathymic imagery" wherein inner vision occurs in accordance with and is related to affect and emotions (Leuner, 1966/1969). Dosamantes-Alperson (1979) described an experiential receptive mode as most effective when dealing with the world of sensation, emotion, and imagery which are nonverbal, intrapsychic events. Morgan and Bakan (1965) had found that movement occurring in this mode is associated with more vivid imagery and a greater number of memories (Berdach & Bakan, 1967). Participant 5's visual experience is therefore consistent with the findings of previous researchers.

Resonant Imagery

Experiences of resonant imagery described by the nurse TT practitioners in this study also support Csordas' (1994) previous research. Referencing Jung's (1921) perspective on the role of imagery as tapping unconscious processes, he, too, had described the phenomenon of separate, but complementary images, experienced simultaneously by both the healer and client. Like Csordas (1994), imagery described in this study can be conceptualized as emerging from the intersubjective milieu which, in turn, contributes to the evolution of human growth, integration, and individuation (Csordas, 1994).

The findings of this study also corroborate Samuels' (1985) prior research. Investigating the countertransference experiences of twenty-six psychotherapists, covering fifty-seven cases, Samuels (1985) found that responses involved embodied and reflective countertransference reactions, the latter stimulated by communications from the patient. He regarded all these instances as images, true even of the bodily or feeling responses. This was because they were active in the psyche in the absence of a direct stimulus which could have caused them. Consistent with Samuels' (1985) observation, the same was true for the nurse TT practitioners in this study.

Similarly, Csordas (1994) surmised that spontaneous imagery in the healer likely reflected important unconscious content in the client, typically evoked during moments in a healing session devoted to "openness," but not during periods of discussion and "counseling" (p. 75). The nurse TT practitioners in this study also described "opening the field." Csordas (1994) also indicated that revelatory imagery in the healer was invariably spontaneous, was experienced as a nonverbal sensory image, and signified that healing is occurring. Substantiating Csordas' (1994) findings, the participants in this study used the same phrases to describe their imagery experiences: visual (e.g., mental pictures); intuitive (e.g., "sense" about person/situation); auditory (e.g., inner words); and, affective (e.g. specific emotions).

As specific examples, one nurse TT practitioner described seeing in her mind a picture of a patient's mother without ever having met her. Another related her shared experience with a client of the sense of an angel stepping into her body while the patient described simultaneously feeling an angel's wings over her body. Another nurse TT practitioner described her shared experience during a distant healing session that was later corroborated on television.

Study findings also corroborate Smyth's (1995, 1996) previous hermeneutic phenomenological (van Manen, 1990) investigation that was framed by quantum physics. Exploring the experience of imagery and the healing phenomenon during TT, the participants reported sometimes having insights (e.g., visual images and feelings) that evolved as the sessions progressed. Imagery seemed to be of a supportive nature, directly related to the patient's situation. Smyth (1996) concluded, "the mobilization of healing seemed to take the form of imagery, warmth and vibration-like sensations, and a generalized presence of energy" (p. 21).

The findings of this study also lend support to Pert's (1997) prior endorsement of TT, within the context of her work on cellular intelligence. She initially conceptualized trauma as being stored in somatic memory at the receptor level of cells. She also noted that cellular intelligence is connected to the conscious and unconscious processes of mind and emotions, concluding that the body can reveal the forgotten areas of experience embedded within it (Pert, 1997). Using Pert's (1997) term, bodymind, Hartley (2004) later noted that "wisdom is sometimes revealed by surrendering and listening to that which is sometimes beyond rational" (p. 186).

In this study, TT was described as allowing access to bodily-stored memory and cellular intelligence. To exemplify, Participant 2 stated, "And I have found that when people can identify the feeling and almost bring it to their awareness, and then you clear, it supports their ability to actually clear, because they've got that on a cellular level. It's in their body, energetically. I mean you look at it energetically, and so you clear, and then it can begin to actually release."

These findings also corroborate Hughes, Meize-Grochowski, and Duncan Harris' (1996) conclusion that as a nursing intervention in Psychiatric Mental Health nursing, TT

continues to offer a holistic approach to care. In their exploratory study, the term body/mind connection emerged as one of two themes to describe seven hospitalized, adolescent psychiatric patients' experience of receiving TT. Specifically, the subcategory of somatic concerns was subsumed within the category of body awareness; in turn, to the emergent theme, Body/Mind Connection. The other theme was the therapeutic relationship that could inform interpersonal communication with the patient (Hughes, Meize-Grochowski, & Duncan Harris, 1996).

In summary, there is a relationship between the findings of this study and the extant literature. Prior research on SCT, somatic experiences, embodiment, imagery, including its features, and resonant imagery is supported. Literature on imagery and its relation to quantum physics and the concepts of cellular intelligence and bodymind communication (Pert, 1997) was also validated.

Contribution of Findings to Current Knowledge

First, the findings of this study address gaps in the literature regarding SCT. Dissertations by Long (1999), Forester (2001), and Wilson (2004) comprise the contemporary empirical research on body-centered countertransference (CT). Their data is unsubstantiated (Jakubowski, 2012). Also, a large amount of the literature on body-centered CT has a focus on it as a protective factor against the symptoms of vicarious traumatization (VT), and less on how the CT interacts with therapists' meaning-making (Jakubowski, 2012). Descriptions in this study provide further evidence.

Hayes and Gelso (2001) previously defined CT as the therapist's reactions to clients that are based on the therapist's unresolved conflicts - a perspective aligned with the traditional negative view of CT. Current research is now focused on how therapists can use the concept of the self as a therapeutic tool to enhance their work with clients.

The view of use of CT in therapy as potentially positive was endorsed by Surrey (1997), who speculated that a lack of mutuality and authenticity on the part of the therapist is more likely to create a negative experience within the therapeutic context. In contrast, focus is now on the role of a therapist's self-experience in therapy, and how their self-awareness functions within an understanding of CT (Jakubowski, 2012). Ens' (1999) conclusion that "situations involving patients' validation of the nurturing, care-giving role of the nurse decreased the occurrence of CT (p. 325) validates the findings of this study. Corroborating these more contemporary views, this study contributes further to current knowledge.

Currently, there is speculation about therapists' use and management of their somatic experiences in therapy. A moderate amount of literature explores the clinical use of managing countertransference (CT) during work with patients who have Post Traumatic Stress Disorder (PTSD) (Vulcan, 2009). The results of this study demonstrate that nurse TT practitioners' also experience SCT with somatic, visual, emotional, and spiritual components when working with their own traumatized clients. Many subcategories in this study therefore corroborate findings from previous research (Beitz & Goldberg, 2005) and add to current knowledge.

Second, the study findings provide more evidence on energy healing approaches in PTSD, and their impact from the practitioner's point of view (Potter, 2003). Quinn and Strelkauskas (1993) found that outcome studies focused on the effects of TT treatments on recipients rather than practitioners. Only four studies explored the subjective experiences of TT on the part of nurse healers and adult recipients (Green, 1998; Heidt, 1990; Lionberger, 1985; Samarel, 1992). Coppa (2008) again noted the paucity of

literature on the experience of the nurse who performs TT. This qualitative research therefore contributes to this literature.

Third, the study findings contribute to the discussion about alternatives to traditional exposure-based therapies in treating trauma (IOM, 2007; Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). Psychological exposure is a component of established PTSD treatments, including Cognitive Behavior Therapy (CBT), Virtual Reality Exposure (VRE), and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001). Feinstein (2010) notes that although CBT combined with psychological exposure is still considered the treatment of choice for PTSD, half of the patients do not respond, few therapists are trained in it, and few patients receive it.

According to Ogden and Minton (2000), for traumatized individuals, fully re-experiencing symptoms may be disconcerting or even frightening. In exposure protocols, anxiety- or fear-producing memories are provoked as a form of information processing (Feinstein, 2010). In a recent finding of 49,425 veterans of the Iraq and Afghan wars with newly diagnosed PTSD, less than one in ten completed recommended treatment at the Department of Veterans Affairs (Feinstein, 2010).

To mitigate retraumatization, some alternative therapies use brief psychological exposure. Collectively referred to as “energy psychology” (Gallo, 2002), these approaches include Thought Field Therapy (TFT), Tapas Acupressure Technique (TAT), and the Emotional Freedom Technique (EFT) (Feinstein, 2010). TT may come to be viewed as an additional method to treat trauma.

Fourth, the findings of this study address the conceptualization of “trauma.” The diverse responses gathered from the sampled nurse TT practitioners’ demonstrate their individual understanding of it. While each participant met the inclusion criteria of

practicing TT with traumatized clients, they also employ other holistic modalities.

Operationally, the data illustrate that each nurse TT practitioner offered their own unique take on the definition of trauma.

Though single incident traumas account for those diagnosed with post-traumatic stress disorder (PTSD), most adults who seek psychotherapy have had numerous traumatic events (van der Kolk, 1994; Wheeler, 2007). Hence, the effects of trauma are thought to be much broader than the diagnosis of PTSD and overlap with many other diagnostic categories. This is true for both adults and children (Wheeler, 2007).

As exemplified by the nurse TT practitioners' descriptions in this study, corroborated were these and Slater's (2004) findings that the same energetic, physical, emotional, mental, and spiritual disruption occur in people whether directly exposed to a natural disaster or not, and that the damage does not disappear spontaneously over time. In this study, the nurse TT practitioners provided examples of work with clients traumatized by myriad events, not necessarily requiring emergency department treatment.

Fifth, despite the fact that many symptoms of traumatized clients are somatically-based, traditional psychotherapy lacks techniques that work with these physiological elements (Ogden & Minton, 2000). Integrating somatic body memory treatment with cognitive-based narrative therapy is recommended in PTSD (van der Kolk, 1994). As noted earlier by Janet (1925/1973), the residual effects of trauma are removed, in part, by the practitioner's experience and the phenomenon of SCT. The augmented use of TT may therefore be highly beneficial to both clinicians and patients.

Sixth, the findings of this study contribute knowledge on ways to decrease the occurrence of vicarious traumatization (VT) in mental health practitioners. Researchers have credited SCT, also called embodied empathy, with containing self-regulatory

processes that help diminish VT in the healthcare provider (Raingruber & Robinson, 2007). In this study, nurse TT practitioners' ability, described in their own words, to attune, assess, and choose interventions based on their SCT experiences help them to maintain boundaries and prevent vicarious trauma. TT that does not require a patient's re-traumatization and reduces VT has important implications for trauma therapy.

In summary, the results of this study corroborate Jakubowski's (2012) exploratory-descriptive study findings that therapists' physiological responses have an impact on their work with trauma survivors. Participants in this study described their SCT experiences as positive; thereby, adding to the literature that calls for focus on non-exposure based therapy. The findings from this study also offer further conceptualization of SCT to include both the nurse TT practitioner's and client's material. The qualitative data produced in this study adds to the foundation of literature that has begun to elucidate how therapists construct meaning about their clients and the role of somatic and implicit communications within the therapeutic interaction (Jakubowski, 2012).

In conclusion, this qualitative study adds to the few that have been conducted on TT, in general, and on the subjective experiences of nurse TT healers and adult recipients, in particular. The study findings also further support Slater's (2004) suggestion that energy healing techniques and TT hold promise for victims of PTSD and trauma. This research therefore contributes to the literature base, and to current knowledge in the field of trauma therapy.

CHAPTER VII

CONCLUSION

Summary

This qualitative study examined the research question, “What is your experience of somatic countertransference (SCT) when you have cared for traumatized patients within the previous six to twelve months?” It builds on past research by exploring and describing eight nurse Therapeutic Touch (TT) practitioners’ experiences of SCT when working with trauma survivors.

The findings illustrate that nurse TT practitioners are aware of their somatic responses within the nurse-client relationship, and that SCT can be used as a valuable clinical tool (Miller, 2000). The findings of this study corroborate the extant literature in that SCT was found to be a two-way process between energetic connection and non-verbal communication (Lude, 2003). By articulating their heightened awareness of SCT, body experiences, perception, imagery, and emotional issues identified while working with traumatized clients, a language for the communication of clients' body knowledge was revealed.

A newly articulated phenomenon (Shaw, 2003, 2004), a paucity of empirical study on SCT has prevailed (Vulcan, 2009). Shaw (2004) conjectured that an impediment to investigation has been the perceived inadequacy of language to articulate SCT. Knoblauch (2005) discussed the limitations of language in providing accurate symbolization for a client’s experience, and proposed incorporating nonverbal embodied communication in addition to language as a gateway into the unconscious meaning in therapeutic interactions. The findings of this study address these issues.

The major theme that emanated from the latent content of the text is that SCT can be viewed as a “Language for Healing Trauma.” The theme is consistent with communication research in the social sciences (Krippendorff, 1989) in that the SCT phenomenon was found to be a factor in the healing of trauma resulting from the nonverbal and verbal communication among members of one group of nurse TT practitioners in interaction with their traumatized clients. This allowed for meanings attributed to SCT during the healing process of trauma to be described directly by the participants themselves (Krippendorff, 1989).

As described in this study, the mutual dialogue between the nurse TT practitioners and their clients allowed the body to communicate (Grotstein, 2005). Multiple responses from different participants evoked Eagle’s (1993) conceptualization of a corrective emotional experience for clients resulting from implicit communications and interpretations between the participants and their clients. This validated previous discourse that communication need not be explicit in order for it to function therapeutically. In this study, nurse TT practitioners’ descriptions of their SCT experiences involved implicit, or non-conscious, communication.

In this study, Participant 2’s description of knowing exemplified one example of implicit communication. She said, “It’s like if my brain were in my heart, which is really what it is. I mean, your heart is more of a brain than your brain...So the knowing almost feels like it’s here (pointing to her heart)...it’s just information coming from somewhere, and it’s in my body...I mean I got this impression, so it’s a feeling of, or a knowingness I guess is what you would say, an impression of a thought.”

The literature currently indicates the relationship between the emotional and physical is not yet fully understood. Findings from this study offer further elucidation.

Conclusions

The major theme that emerged from this study is that SCT can be conceptualized as “A Language for Healing Trauma.” A way of articulating and researching the language of the body was previously posed as a means to more effective trauma treatment (Vulcan, 2009). Immersion in non-verbal relating, as described in this study, bypasses ordinary language and leads to new and deeper dimensions that allow the client’s body to tell its own story (Lude, 2003). As the findings of this study imply, when SCT awareness in nurses is cultivated, reactions stimulated by the client increases mutual understanding (Macecevic, 2008). In other words, a recall of the nurse TT practitioners' SCT experiences illustrated a means for clients’ bodily-stored memories to be articulated.

As emerged in this qualitative study, articulation of the body’s language through a conceptualization of SCT as “A Language for Healing Trauma” may be particularly productive in clinical work with clients who have experienced trauma. Since, according to Macrae (2010), TT is “a mode of communication in its own right” (p. 5), there is an opening to a new dimension or mode of perceiving. Mindfulness of the nurse TT practitioner is a state of consciousness that directs awareness toward the here-and-now experience (Ogden & Minton, 2000). Aligned with Benor's (2002) position, non-local consciousness (Dossey, 1993), connecting the awareness of the nurse TT practitioner and client, demonstrated an exchange of information that facilitated healing.

In her exploration of somatic experience in psychoanalysis, Dosamantes-Beaudry (1997) had concluded that attending to it in both the patient and therapist was especially relevant to traumatized patients who use their internal experience to communicate primarily through various forms of bodily expression. Miller (2000) had described SCT as a relevant clinical tool whereby body sensation and body knowledge could be used by

the therapist as valuable communication from the client's body manifestations and unconscious messages (Jakubowski, 2012). Intending to contribute to the dialogue between body-oriented and psychoanalytic approaches to the psychotherapy of trauma, Forester (2007) found that SCT plays a central, facilitating role in body and movement psychotherapy. SCT experiences provide a critical window into patients' material and dynamics, and lessen vicarious traumatization of the therapist (Forester, 2007).

The conceptualization of SCT as "A Language for Healing Trauma" corroborates previous research. Quinn (1989) had stated that human beings are capable of perceiving incredibly subtle inputs from the environment at both conscious and unconscious levels; thereby, creating a theoretical foundation for the role of non-verbal communication. Easter (1997), in her integrative review of the literature on TT from 1981 to 1996, described TT as a form of nonverbal communication, an integral part of the nurse-patient interaction.

In her qualitative descriptive study Heidt (1991) combined TT with psychotherapy techniques to help in patients' healing processes. She described a period of unblocking, a letting go of the impediments to a free flow of energy within the system between nurse and patient. Heidt (1991) noted that "in many situations, the experience of the patient paralleled those of the nurse, with a seeming 'transfer of energy' between the physical and psychological level in each of the phases of the healing interaction" (p. 66).

Heidt (1991) concluded that the TT treatment is a reciprocal communication process. Openness emerged as a key variable and was identified as opening intent, opening sensitivity, and opening communication (Heidt, 1990). The findings of this study, like Heidt's (1990), are consistent with the postulates of Rogers' Science of Unitary

Human Beings (SUHB; 1970; 1989; 1990) which are energy fields, openness, pattern, and pandimensionality (Malinski, 1993; Hagemaster, 2000).

In contrast to Heidt's (1991) research, Samarel's (1992) qualitative study findings were not entirely consistent with Rogers' (1987, 1988) conceptual system. One of the underpinnings of the SUHB is the concept of pandimensionality, or the non-linear nature of the universe. The participants in Samarel's (1992) study, without exception, described the lived experience of TT as a linear experience. In searching for an explanation for this inconsistency, Samarel (1992) conjectured that the nature of human experience and the memory of that experience are difficult to express in a non-linear fashion. Although the experience may be non-linear, the expression of it, limited by language, reduces it to a linear description (p. 656). The dynamic and non-linear nature of the SCT experiences described in this study may address this limitation.

Rogers' (1990) SUHB does not include the concept of nurse-client interaction. Furthermore, Rogers did not view TT as a body of knowledge in its own right. Meehan (1988) contended that a more appropriate perspective of TT was that it is a nursing health patterning modality (Malinski, 1993). The emergent theme in this study was developed from the relationship between the nurse TT practitioner and the client. The description of the SCT phenomenon occurring during TT in this study may therefore contribute to TT's unique body of knowledge, and to its place among nursing modalities to treat trauma.

The IOM (2007) has recommended development of alternatives to traditional exposure-based therapies for PTSD. Psychotherapists are incorporating energy healing into their practices. Some psychologists already use TT at the beginning or end of counseling sessions (Wager, 1996). They have found that clients treated with TT at the beginning of a session report feeling more connected to the therapist and talk about their

difficulties more openly (Wager, 1996). Sometimes during TT, as described in this study, a practitioner becomes aware of the patient's problems in an intuitive way, without the need for conversation (Wager, 1996).

Contemporary research by Panhofer (2011) demonstrates the importance of non-language ways of knowing to express the lived, embodied experience. Wager's (1996) and Panhofer's (2011) views are aligned with Schulz's (1999) discussion of the brain as the chief interpreter and processor of intuition. Panhofer (2011) recently concluded that crossing over brain hemispheres allows access to valuable, and even unconscious, material during clinical work.

It is possible that during TT, as in EMDR (Shapiro, 2001), both brain hemispheres are stimulated bilaterally. According to Schulz (1999), the right hemisphere, which controls the nonverbal, image-bound processes, provides the Gestalt, the general overall sense that is the initial spark of intuition. The left hemisphere is where verbal and communications skills reside. Corroborating this and Corbin's (1969) discourse, in this study the nurse TT practitioners' descriptions of their images could be viewed as representing a non-language way of knowing (Panhofer, 2011) that expresses the nonverbal.

Recently, study participants in Jakubowski's (2012) exploratory-descriptive study described countertransference (CT) as "communication from both the client and therapist" (p. 26). Exemplar quotes by study participants were, "unconscious and nonverbal," "both verbal and nonverbal communication," and "a psychic phenomenon" (p. 25). Jakubowski's (2012) study participants also referred to their physiological responses as "body as communicator," and "our minds and bodies can be communicators" (p. 29). Agreeing that emotional and physiological CT are linked, and

describing the difficulty in articulating experiences, one of Jakubowski's (2012) study participants also said, "CT is largely unconscious, until you have to write about it or talk about it" (p. 36). This study produced similar findings.

Regarded as a clinical tool by participants in Jakubowski's (2012) study, CT, including physiological responses, was described in this way: "For me it is non-verbal, when I can pay attention to that and keep it separate from my own anxiety about, or my own stuff, it is really helpful. It gets you right to it. It goes right to the heart of it really...I think of it as just pure amygdale to amygdale communication, and part of what we are doing is somehow having the connection where we are sharing the experience to some degree...and it informs me about what my client's experience is, and what I'm going do with that. So, I guess every minute is assessment; every minute is an intervention" (pp. 40-41). Participants in this study described a similar perspective.

The findings from this study suggest that TT can access the knowledge of the body beyond the use of words. This has wide applicability to research in counseling and psychotherapy. The state of relaxation induced by centering in TT facilitates the spontaneous emergence of imagery that corresponds with preconscious, preverbal memory of the client, the emergence of which facilitates their emotional healing. Nurse TT practitioners' images described in this study may have bypassed, and compensated for, blocked images and affect in the client (Krieger, 1979; 1993) without re-exposing the client to traumatic memories. This possibility is highly significant for trauma therapy.

In conclusion, the language of the SCT phenomenon that emerged from this study demonstrates that SCT during TT is a source of intuitive information that guides the therapeutic process (Shaw, 2003, 2004; Vulcan, 2009). As an adjunct to talk therapy, TT may allow patients to bring unconscious feelings and perceptions to conscious awareness

through the nurse TT practitioners' SCT experiences, followed by a release, and then healing.

Since, as the participants described, feelings are stored in the body, TT may provide the nurse with an opportunity to assist the patient in releasing emotional energy blocks. This supports Schulz's (1999) view that when trauma is not dealt with properly, disease in the body can ensue. This also supports Leddy's (2004) conclusion that actual physical touch and exchange of energy are not needed for energetic healing. Given the multitude of trauma experiences in the clinical population, findings of this study will contribute to knowledge about the phenomenon of SCT and the role TT plays in trauma treatment.

Strengths and Limitations

The research design and methodology of this study incorporating the rigor of qualitative inquiry contributed to its strength. In this study where the straight description of SCT phenomenon was desired, a qualitative descriptive approach was an appropriate method of choice (Sandelowski, 2000). Since existing theory or empirical literature on the SCT phenomenon is limited, this qualitative research method was theoretically aligned with the study aim. The researcher allowed the subcategories, categories, and a theme to flow exclusively from the text (Kondracki & Wellman, 2002). Direct information was therefore gleaned from the study participants' unique experiences in their own words. Knowledge generated from the content analysis was grounded in the total and actual data.

An additional strength of this study was the method of data analysis. Qualitative data from verbatim transcription of in-depth, face-to-face interviews was analyzed using the method of content analysis described by Sandelowski (2000, 2010), preferred for

qualitative inquiry (Sandelowski, 1995). Inductive content analysis produced subcategories and categories that described the manifest content of what the text said; one main theme expressed its latent content (Sandelowski, 1993, 1995).

The theme that emerged from the text, “A Language for Healing Trauma,” was consistent with communication research in the social sciences (Krippendorff, 1989). A phenomenon in need of further articulation, SCT was found in this study to be a factor in the healing and release of bodily-stored trauma that emanated from the verbal and nonverbal and communication of one group of nurse TT practitioners in interaction with their traumatized clients.

The content analysis was further strengthened by the sample’s composition of a homogeneous group of expert nurse TT practitioners who self-identified as having had SCT experiences during work with traumatized clients, and who were willing to talk about them. The demographic characteristics of the sample were similar. A wide range of ages did not comprise the sample. The participants were all members of the nursing profession and had similar levels of education. Geographical diversity was evident in that the nurse TT practitioners live in different regions of the United States: East Coast, Midwest, and Pacific Coast.

The researcher constructed an interview guide based on a literature review of SCT. The open-ended interview questions incorporated elements from Orbach and Carroll's (2006) definition of SCT. Responses were requested and provided accordingly. These sensitizing concepts from the definition (Patton, 2002) initially guided the content analysis of the manifest content of the interview text. This methodological rigor lends support to the future development of a survey instrument with a clear definition, or

description, of SCT to be measured (Budin, Brewer, Chao, & Kovner (2013). The method of data collection and analysis therefore added strength to the study.

Prior to the gathering of qualitative data, four pilot interviews were conducted in Spring, 2013 in order to evaluate the interview guide, the researcher's interviewing skills, and to reduce the potential for the introduction of researcher bias. Ongoing review by the researcher's doctoral dissertation committee, and consensus on coding and results of data analysis fostered a credible research report.

This study intended to have no a priori commitment toward a definite view of the targeted SCT phenomenon. Patton's (2002) guideline was upheld in that the nurse TT practitioners' own thick description provided "the skeletal frame for analysis that led to the researcher's interpretation" (p. 503). Patton's (2002) endorsement of "the structure/process/outcome framework as an appropriate application to fit and cluster the data" (p. 375) justified the development of the categories, Nurse Practitioner, Communication, and Healing.

Although the qualitative findings provided thick, rich description of the minimally understood phenomenon of SCT, several limitations were identified in this study. First, although the nurse TT practitioners were expert practitioners, they necessarily self-selected as participants because they had experienced the SCT phenomenon. They may have also perceived their SCT experiences to be a factor in therapeutic interactions.

The use of purposive sampling could also be viewed as a possible limitation because the sample was potentially biased by the selection process. In other words, a certain type of informant with a certain type of knowledge was chosen (Morse, 1991; Soderberg, Strand, Haapala, & Lundman, 2003). However, as per Creswell's (2007)

recommendation, this type of criterion sampling was acceptable in that it facilitated the research, and produced thick, rich, and vivid descriptions of the SCT experiences.

Although this research study contributes to existing literature regarding SCT; namely, the description of it during trauma work, findings cannot be generalized. The nature of the study and the small sample size of eight limit generalizability of the findings to the larger population. The nurse TT practitioners in this study may also not be representative of all TT practitioners in the United States.

There were also study limitations in terms of participant recruitment due to time and financial constraints. In general, small sample sizes can jeopardize the achievement of data saturation. Although data saturation was reached in this study, the small sample size limits transferability of the findings. A larger sample could have provided even greater depth and broader scope regarding the SCT phenomenon.

The data analysis was also limited to the nurse TT practitioners' descriptions and did not address clients' perceptions. Future studies that include the experiences of both practitioner and client would provide better validation of TT as a beneficial non-exposure-based treatment modality. Additionally, the sample did not include practitioners of other energy healing methods such as Reiki or Healing Touch. It is also acknowledged that because the majority of the participants were affiliated with TT-related professional organizations (e.g., TTIA and AHNA) the sample represents the particular perspective of the TT practitioner affiliated with them.

It is also important to note that the study participants were all well-educated, older, experienced, and Caucasian females. A more racially and ethnically diverse sample of participants that also included males would have the potential to produce more

representative data in terms of the articulation of subjective opinions and themes, which could then be generalized to a diverse larger population (Jakubowski, 2012).

Implications for Knowledge Generation

First, the study findings generated knowledge that contributes to holistic nursing theory. The development of the emergent theme, “A Language for Healing Trauma,” was critical to the interpretation of the qualitative data (DeSantis & Ugarriza, 2000; Sandelowski, 2010). The richness of the thick descriptions provided by the culture of the nurse TT practitioners in this study reflected their emic perspective; that is, the conscious and unconscious meaning of SCT attributed by them. Relevance therefore exists for the further development of TT as a culturally appropriate holistic nursing intervention in the care of the diverse and potentially vulnerable population of traumatized patients (DeSantis & Ugarriza, 2000).

In this study nurse TT practitioners’ description of their use of intuition validates TT as an intuitive process. This is aligned with the definition of TT (Woods, Beck, and Sinha, 2009) as “a contemporary interpretation of ancient healing practices, founded on the premise that the human body, mind, emotions, and intuition form a complex, dynamic energy field” (p. 182). The findings of this study also lend further support to Maret’s (2009) definition of energy medicine as the “diagnostic and therapeutic application of energetic and information interactions resulting from self-regulation, brought about by interactions between mind and body” (p. 4).

In parallel, the findings of this study validate Macecevic’s (2008) posit that “the ability to perceive our clients in a way that encompasses their mind, body, and spirit, using our own mind, body, and spirit is the most comprehensive means to asses for

holistic well-being” (p. 184). Holistic nursing theory may therefore be further advanced based on these premises and the findings of this study.

Second, the study findings contribute knowledge to theory development in the field of psychology. Regarding the phenomenon of SCT, further articulation of the body’s language will be productive in clinical work with traumatized clients (Vulcan, 2009). The descriptions of SCT experiences provided in this study further elucidate the SCT phenomenon, and articulation of the body's language. These will enable future theory development.

There is also current discourse in the field of psychology about therapists’ claims that their experience of unsolicited and spontaneous imagery is a manifestation of unconscious material in the client. Shaw (2004) emphasized that such imagery experiences be verified with the client. A considerable contribution to this discourse by nursing can be made; that is, by providing the input of the participants in this study.

The nurse TT practitioners described shared experiences with clients, and also seeking validation with them. As interpreted by one participant, and to exemplify, bodily-stored positive emotions perceived in clients were noted to be contextual and related to a patient’s prior life experience. When validated with the client, emotions were found to be “related to the age or stage of occurrence,” and attributed “not to the person at that moment in time.” This finding has significance for the further refinement of Gestalt theory, its integration with nursing theory, and psychology, in general.

Of particular importance, the findings of this study also have the potential to contribute to Information Processing (IP) theories in PTSD. Research has found that non-“major trauma” events are more strongly associated with PTSD than exposure to a disaster (Solomon & Canino, 1990; Mol, Arntz, Metsemakers, Dinant, Vilters-Van

Montfort, & Kottnerus, 2005). Complex PTSD patients with Disorders of Extreme Stress Not Otherwise Specified (DESNOS; American Psychiatric Association, 2000) have a history of interpersonal trauma, especially in childhood (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). Psychological abuse has also been found to be more significant, as is the category of relational problems (Street & Arias, 2001). Frequently refractory to conventional PTSD therapies (Ford, 1999), they often require long-term treatment (Wheeler, 2007).

Psychological interventions have increasingly focused on exposure-based therapies for cognitive restructuring of past events (Marks, Lovell, Noshirvani, & Livanou, 1998). A therapeutic method currently used in PTSD treatment is Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001). EMDR is included in the category of mind-body medicine, and is exposure-based. It is an accelerated information-processing method using alternating stimuli – either eye movements or sounds – to desensitize and reprocess emotional wounds and install a healthier belief system. EMDR has been found to be effective with posttraumatic stress syndrome, childhood trauma, depression, addictions, compulsions, unhealthy patterns, and future-oriented solutions (Elwell & Waud White, 2014).

In contrast to EMDR, energy healing approaches, such as TT, do not involve retraumatization of the patient. They are not exposure-based. According to the Adaptive Information Processing Model (AIP; Shapiro, 2002) in which EMDR is framed, memory is stored in neural networks that are linked together and organized around early events with associated emotions, thoughts, images, and sensations. The essential component of EMDR and other exposure-based therapies is the client's repeated exposure to memories

of the traumatic stressor. In the process of releasing negative emotions, painful memories, previously long-buried and forgotten, may re-surface (Benor, 2002).

However, the confrontation with traumatic memories through debriefing has not been proven sufficient to provide a therapeutic effect (Lewis, 2003). The restructuring and integration of memories is suggested as an alternative. Like EMDR, TT may have a very important role to play in this area. New treatments, both psychotherapeutic and psychopharmacologic, aimed at bolstering prefrontal emotion regulation systems may benefit PTSD or otherwise traumatized patients (Etkin & Wager, 2007).

Elwell and Waud White (2014) describe mind-body medicine as a category subsumed within types of integrative healing modalities. Counseling/psychotherapy that treats individuals, families, or groups as a whole also belongs to the category of integrative medicine. It has been argued that psychotherapeutic interventions involving altered states of consciousness during traumatic memory will make an important contribution to the treatment of PTSD. For this reason, mindfulness-based therapies from the Eastern traditions, such as TT, have shown to be efficacious. Support is, therefore, lent to the notion that treatment of traumatic stress may need to include becoming mindful; that is, learning to become a careful observer of internal experience, and noticing whatever thoughts, images, feelings, body sensations, and impulses emerge. In this study, participants described the role of observer and self-awareness in their work with traumatized clients.

The conceptualization of SCT as "A Language for Healing Trauma" can help promote the translation of physical sensations and emotions into communicable language (van der Kolk, 2006). Regarding IP theory, TT may access for the client past trauma that is verbally inaccessible - without retraumatizing the client. According to Dalgleish

(1999), knowledge of traumatic origin is represented as a type of situationally accessible memory (SAM). Additionally, PTSD treatment approaches should be inclusive of a wider range of emotional experiences. As described by nurse TT practitioners in this study, the SCT phenomenon facilitated the emergence of somatic knowledge and emotional issues about clients' past traumatic experiences.

Germane to the findings of this study, although IP theories generally assume only one level of processing, Elzinga and Bremner's (2002) dual representation model distinguishes between conscious and non-conscious processes (Brewin, Dalgleish, & Joseph, 1996). In this model, conscious, verbally accessible memories (VAMs) contain information about the sensory features of the traumatic situation, the emotional and physiological reactions experienced, and the perceived meaning of the event. According to this theory, VAM memories are integrated with other autobiographical memories within the greater autobiographical memory system and can be deliberately retrieved, appraised and verbalized when necessary (Kenny, 2006).

In contrast, SAMs can only be accessed involuntarily and are triggered by internal and external trauma reminders. Memory stored within this system has often been implicitly encoded and has not been the focus of conscious processing. When triggered, these memories contain strong emotional and physiological responses akin to those experienced during the trauma (Kenny, 2006). As related to the phenomenon of SCT, Brewin, Dalgleish, and Joseph (1996) argue that trauma recovery must involve the conscious processing of information stored in the SAM system. This processing facilitates the transformation of SAM memories into VAM memories that results in trauma memories being available for conscious retrieval (Kenny, 2006).

The SAM form of memory contains information that has been obtained from lower-level perceptual processing of traumatic events and from the person's bodily responses. In other words, visuo-spatial information has received little conscious processing. Since SAMs do not involve verbal representations these memories are difficult to communicate, and therefore may not interact with other autobiographical knowledge (Peres, McFarlane, Nasello, & Moores, 2008).

In view of the current theory of IP, and as articulated in this study, the phenomenon of SCT may be one way of accessing and integrating the verbally inaccessible, difficult-to-communicate SAM system. The study findings can therefore further refine Information Process theories of PTSD.

Finally, SCT has hypothesized links to "mirror neurons" (Gallese, 2001; Rand, 2002; Macecevic, 2008), is facilitated by empathy, and occurs in the middle stages of the therapeutic alliance. A hallmark of expertise, SCT experiences described in this study corroborate Benner's (1984) conceptualization of expert nursing practice. In particular, imagery, a manifestation of SCT, was attributed to experience. Increased imagery experiences were also related to decreased negative countertransference reactions. These findings have implications for the validation and application of the Mirror Neuron Theory of Empathy (Gallese, 2001) to the nursing care of traumatized clients.

Implications for Practice

The findings of this study contribute to evidence-based practice in psychiatric mental health nursing. According to Feltham (2007), many clinical settings believe that "cognitions and rationality are more reliable conduits to therapeutic improvement than affective ventilations and somatic experiences" (p. 135). This view may be partially incongruent with the core values of mental health nursing (Hurley, Barrett, & Reet,

2006). Furthermore, despite insufficient evidence and given untoward side effects, medication usage for PTSD continues (IOM, 2007; Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011).

Many experts have expressed strong interest in fostering the evidence base for energy healing approaches in PTSD (Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). Hill and Oliver's (1993) research revealed that teaching patients to use a combination of visualization and TT on themselves can be an effective strategy in mental health recovery (Hughes, Meize-Grochowski, & Duncan Harris, 1996). As described by the nurse TT practitioners in this study, a therapeutic effect was produced for patients during SCT experiences wherein the emotional impact of trauma was reduced. These study findings corroborate Woods Smith, Arnstein, Cowen Rosa, and Wells-Federman's (2002), and add to the body of knowledge that TT lowers emotional distress (Quinn & Strekauskas, 1993, Samarel, Fawcett, Davis, & Ryan, 1998). Concurring with Woods Smith and colleagues' (2002) suggestion, TT may be a useful adjunct to CBT for people with chronic pain, in general, and that associated with emotional distress, in particular.

As one empirical example, Gagne and Toye (1994) examined the effects of TT on experienced anxiety in thirty-one inpatients of a Veterans Administration psychiatric facility. Multivariate analysis of variance (MANOVA) showed a significant reduction in reported anxiety. The researchers concluded that since patients may lack the abilities needed to benefit from extensive visual imagery techniques, and anxiety is a key component of many disorders, especially those trauma-related, development of a passive anxiety reduction technique such as TT would be invaluable for clinical mental health.

Regarding the effect of TT on persons with dementia, Schwab and colleagues (1985) found a decrease in the use of psychotropic medication and noisy behavior but

they did not assess the efficacy of TT alone. Woods and Dimond (2002) investigated the effect of TT on agitated behavior and cortisol in persons with Alzheimer's Disease. An analysis of variance for repeated measures indicated a significant decrease in overall agitated behavior and in two specific behaviors, vocalization and pacing or walking, during treatment and post-treatment. In this study, Participant 5's description of her experiences with veterans corroborates Woods and Dimond's (2002) findings.

Regarding implications for substance abuse treatment, Hagemaster (2000) examined the efficacy of TT as a complementary therapy in prolonging periods of abstinence in people who abuse alcohol and other drugs. A trend ($p = .068$) toward decreased depression among participants treated with TT was reported. Similarly, with no prior studies located, Larden, Palmer, and Janssen's (2004) research findings suggested that TT, when compared to nursing presence alone or standard care, may promote lower levels of anxiety in pregnant inpatients with a chemical dependency. They concluded that TT is a simple and inexpensive way to deal with the complex, multifaceted issues of chemical dependence. It uses a holistic approach that may have the potential to improve compliance with chemical dependency treatment protocols (p. 330).

In this study beneficial aspects of TT to patients were described as using it as a potential diagnostic aid to assess arterio-venous malformations, coronary artery disease, and cancer before medical diagnosis. The unpleasant side effects of chemotherapy and radiation post-mastectomy were described as lessened. Significant study findings were also the energetic description of breast cancer, the effect of Tamoxifen on the human energy field, and the pervasiveness of anxiety in the overall human energy field. SCT experiences during TT therefore have relevance in the neurology, coronary, and oncology clinical settings.

Noting minimal research conducted “on the value of TT to expand nursing practice” (p. 40), MacNeil’s (2006) qualitative descriptive study indicated that TT is an effective nursing intervention to treat adult tension headache pain. She emphasized that students need to be introduced to complementary methods of pain control other than narcotics. The implications for nursing practice in the community setting is further strengthened by the findings of this study.

Regarding nurses' overall practice, the findings of this study have implications for the prevention of burnout and vicarious traumatization related to exposure to patients with trauma histories. As described in this study, TT is beneficial to nurses because SCT experienced during TT with colleagues facilitates the recognition of their “feelings of exhaustion, being overwhelmed, and intensely overburdened.” As described in this study, somatic complaints, such as migraine headaches, were relieved in nurse colleagues. TT is also beneficial to nurses in that it fosters feelings of rejuvenation, relaxation, and well-being.

In terms of fostering the ability to maintain boundaries and prevent, or decrease, the experience of vicarious traumatization, data in this study revealed the nurse TT practitioners’ ability to do so. Findings illustrated that when SCT experiences, especially imagery, occur during work with traumatized clients there are decreased negative effects on physical health. Beneficial effects of TT on the practitioner were described as “feelings of rejuvenation and relaxation”, and “never feeling drained or exhausted.” In contrast to Jakubowski’s (2012) findings that SCT increased negative effects on the therapist participants in her study, the nurse TT practitioners in this study described the meditative experience of centering, their own self-awareness, and recognition of experiences as belonging to clients as helping them to detach from their clients’ traumatic

experiences. In other words, their descriptions implied decreased negative countertransference reactions, and lessened vicarious traumatization. Further qualitative inquiry is needed.

In conclusion, the findings of this study illuminate multiple important themes for mental health professionals. Nurse TT practitioners' physiological responses play an important role in clinical practice. Clinically, bringing body awareness into the therapeutic interaction brings another level of attunement to the intersubjective space and the non-verbal, or implicit, communications that occur in the nurse-client encounter.

Implications for Doctor of Nursing Practice (DNP)

There is a need to demonstrate the utility of qualitative research for evidence-based practice in health care. As Sandelowski (2004) exhorts, "researchers, front-line practitioners, policy makers, and other stakeholders are calling for the findings of studies to improve the public health" (p. 1366). According to Elwell and Waud White (2014), the "DNP is unique in providing education in components of advanced nursing practice essential to the highest level of clinical practice" (p. 386).

The Clinical Nurse Specialist (CNS) role is now over fifty years old, tracing its origins to Rutgers University where Dr. Hildegard Peplau created the first master's degree program in psychiatric nursing. In 2004, the American Association of Colleges of Nursing (AACN) established a target date of 2015 for the replacement of master's preparation for advanced practice nursing education with doctoral level education. The AACN Doctor of Nursing Practice (DNP) Taskforce (AACN, 2006) noted that "nurses prepared at the doctoral level with a blend of clinical, organizational, economic, health care improvement, and leadership skills were most likely to be able to design and continuously improve systems of care delivery based on best evidence" (p. 11). However,

as of 2010, the Institute of Medicine (IOM) cited a current lack of evidence on DNP outcomes (Croenwett, Dracup, Grey, McCauley, Meleis, & Salmon, 2011).

Edwardson (2010) makes the argument that the doctor of nursing practice (DNP) and doctor of philosophy (Ph.D.) degrees support one another and together can help to advance the creation and translation of knowledge into the practice of the discipline of nursing. Edwardson (2010) also extols the DNP's preparation for careers in delivering services and translating scientific and theoretical knowledge into the solution of practice problems; in other words, "DNPs can contribute to solving health care problems" (p. 139).

A paucity of literature examining the nurse practitioner role in the psychiatric/mental health field also exists. The primary care setting is an appropriate venue for screening and identifying, for example, depression in children, adolescents, and adults. According to Hamrin, Antenucci, and Magorno (2012), NPs are "in a crucial position to ensure that appropriate and timely assessment, diagnosis, and treatment are given" (p. 22).

Nurse practitioners (NPs) can also provide initial management or referral to psychiatric mental health professionals for evidence-based treatments. A collaborative model, rather than an integrative one, is being tested in a number of conventional academic and CAM health care centers. Rather than full integration of services, conventional and CAM practitioners are referring patients to one another within a clinic or network. In models currently being pilot tested, they work side-by-side as equals, collaborating in both the diagnosis and treatment of patient conditions (Muscat, 2000). In physician-centered models, CAM practitioners provide services independently but under

the supervision of a primary or a specialty care physician (Starr, Benjamin, Berman, & Jacobs, 1999; WHCCAMP, 2012) (<http://www.whccamp.hhs.gov/fr2.html>).

These activities of the integrative DNP practitioner are in keeping with the AACN's (2006) Essential VI that addresses inter-professional collaboration, and Essential VII that describes clinical prevention and population health. DNPs can promote evidence-based treatments such as psychopharmacologic interventions, cognitive behavioral therapy, and interpersonal psychotherapy (IPT) (Hamrin, Antenucci, & Magorno, 2012).

Unlike most psychotherapies for PTSD, interpersonal psychotherapy is not exposure-based. It focuses instead on clients' current social and interpersonal functioning (Bleiberg & Markowitz, 2005). Transference-countertransference interactions are influenced by interpersonal understanding that occurs primarily outside conscious awareness (Pally, 2010). Brain mechanisms called shared circuits operate by re-creating the others' experience in the same regions used for Self experience (Jakubowski, 2012). Increasing clinician's awareness of SCT experiences heightens awareness of these processes. DNPs can recommend TT as a holistic modality that augments, as one example, interpersonal psychotherapy.

The role of the DNP as an integrative or holistic practitioner has been endorsed by Elwell and Waud White (2014), who "advocate for patient access to all relevant forms of intervention that promote wellness" (p. 387). They extol, for example, the University of Minnesota's DNP Integrative Health and Healing area of concentration. In this course of study "graduates are prepared with skills necessary for working with individuals, families, communities and health systems in developing holistic approaches to health promotion, disease prevention and chronic disease management with a special emphasis

on managing lifestyle changes and incorporating the use of complementary therapies” (p. 386).

With their professional expertise, Doctors of Nursing Practice (DNPs) are therefore in an excellent position to immediately translate the knowledge generated from the present, and future, study findings to evidence-based practice (Edwardson, 2010). This can both strengthen it, and effect desired change. They can contribute to finding a solution to the daunting task of treating traumatized clients, a clearly specified clinical population. A non-exposure based therapy, such as TT, can potentially offset the heavy reliance on psychopharmacology. DNP-prepared nurses can therefore help reduce already untenable health care expenditures (Edwardson, 2010).

Recommendation

Recommendation is made for future research on SCT experiences in nurses, in general, and in nurses who practice TT and other holistic modalities. The validity of TT as an evidence-based practice in trauma therapy will reside in its utility (Sandelowski, 2004). More in-depth interviewing of nurse TT practitioners who work with traumatized patients, especially those working exclusively with patients with PTSD should occur. A diverse and larger population of therapists who practice from a multitude of therapeutic frameworks is recommended.

Although additional future studies can well serve to document the prevalence and incidence of SCT in varying settings among nurses with diverse levels of experience and education, more rigorous qualitative research will help understand the roots of the SCT phenomenon and its impact on nurses. Patients should be included in these studies.

Instrumental utilization (Sandelowski, 2004) will occur through “the concrete application to practice of these research findings; for example, translation to clinical

guidelines, or intervention protocols” (p. 1371). Symbolic utilization (Sandelowski, 2004) will address the use of the research findings as “a persuasive or political tool to legitimate” (p. 1372) the practice of TT as a form of trauma therapy. Albeit less tangible, concept utilization (Sandelowski, 2004) will manifest in a change in the way users think about the benefit of SCT to trauma therapy, clients and mental health clinicians, and to traumatic events.

Regarding suggested future research, further development of the concept of SCT will benefit from phenomenological, grounded theory, and comparative studies. Quantitative content analyses will deductively analyze the frequency of the experience of SCT. Since there are currently no quantitative measures of SCT, studies need to be designed that will aid in instrument development. In addition, intervention studies will need to be designed and conducted to evaluate best practices and policies to incorporate TT therapy into trauma treatment. Research funding should be allocated to investigate the beneficial use of TT in trauma therapy, and the occurrence of SCT phenomenon in nurses caring for traumatized patients. Educational programs such as those already being implemented in the VA system should be expanded to all hospitals, and included in nursing curricula.

Findings from this study have implications for further education of mental health professionals, including nurses, on the topic of SCT and body awareness (Jakubowski, 2012). A greater awareness of implicit communication within the therapeutic context implies professional collaboration and education for the ethical and constructive use of SCT (Jakubowski, 2012). Clinical training should include TT to increase health care professionals' body awareness and body experience. Nurse TT practitioners will make an important contribution in this regard.

The results of this study demonstrate that the phenomenon of SCT is indeed real and that it occurs in nurse TT practitioners. Importantly, it can be articulated and conceptualized as a language to describe a process of nonverbal communication whereby useful clinical information is garnered from clients' somatic memory. The researcher proposes that the nurse TT practitioner's SCT experiences represent the invisible energy matrix in which the transmission of somatic information occurs.

In conclusion, nurses, advanced practice nurses, doctors of nursing practice, and nursing faculty can all contribute to the evolution of nursing knowledge and human consciousness. Participant 8's recommendation, "So, let's spread Therapeutic Touch throughout the world!" should be upheld.

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Appendix A

Test of E-Mail Subject Recruitment

To: TT Practitioner

From: cmjmonet@pegasus.rutgers.edu

Subject: From Catherine J. Monetti, PhD (c), RN, CNE (RWJF Scholar) re:
Invitation to Participate in a Qualitative Study

Dear Colleague:

Currently in the midst of my doctoral dissertation research, I would like to enlist your study participation as a Therapeutic Touch (TT) practitioner, or referral to an interested colleague. To increase understanding of the role of TT in trauma therapy, I seek to show its particular relevance, and the specific role TT will play in it.

In clinical practice SCT phenomena experienced during the administration of TT can be used therapeutically to inform conventional diagnosis and intervention; foster empathy; and, prevent or lessen the severity of vicarious traumatization in healthcare providers.

If you, or someone you know, experienced this phenomenon during the past six to twelve months when working with patients who have been traumatized, is willing to talk about it, and is interested in participating in this research study, please feel free to contact me. A sixty minute face-to-face interview, at maximum, will then be scheduled in a comfortable location of your choice. The interview will be audio taped, and the related verbatim transcription will then be sent to you by regular mail (certified return receipt) for verification and written feedback. An envelope with pre-paid postage will be provided for return of the transcript and comments to the researcher.

Your consideration and help is most appreciated.

Sincerely,

Catherine Jirak Monetti, PhD (c), RN, CNE
Robert Wood Johnson Foundation Scholar,
Doctoral Student
Rutgers University, College of Nursing
H: (973)586-8827
cmjmonet@pegasus.rutgers.edu

Appendix B

Therapeutic Touch Study**Recruitment Flier**

**“Somatic countertransference experiences
as described by nurse Therapeutic Touch practitioners:
A Content Analysis”**

A Qualitative Dissertation Research Study

- **Goal:** To increase understanding of the role of Therapeutic Touch (TT) in trauma therapy; to interview TT practitioners to explore how one's awareness of their own body, sensations, images, impulses, and feelings may offer a link to clients' healing journeys.
- **When:** August to December, 2013
- **Where:** A Private Setting of Your Choice
- **Time Involved:** 1 sixty minute, audio-taped face-to-face interview
- **Reimbursement:** None

Please contact:

Catherine Jirak Monetti, PhD (c), RN, CNE,
RWJF Scholar, Rutgers, College of Nursing
cmjmonet@pegasus.rutgers.edu
(973)586-8827

Participation in this study is completely voluntary, with your confidentiality protected.

Thank you for your interest !

Appendix C

Informed Consent Form to Participate in a Research Study

Title of Study: Somatic countertransference experiences as described by nurse
Therapeutic Touch practitioners: A content analysis

Principal Investigators: Catherine Jirak Monetti, PhD (c), RN and Deanna Gray-Miceli,
PhD, APRN

RESEARCH STUDY:

_____ has been asked to participate in a
research study under the direction of Catherine Jirak Monetti and Dr. Deanna Gray-
Miceli.

INTRODUCTION

You are invited to participate in a research study. Before you agree to participate in this study, you should know enough about it to make an informed decision. If you have any questions, ask the investigators. You should be satisfied with the answers before you agree to be in the study.

BACKGROUND/PURPOSE

The purpose of this study is to explore Therapeutic Touch practitioners' experiences of their own body and thoughts while working with patients. Further understanding of these experiences will help in the treatment of trauma.

PROCEDURE INFORMATION

You have been told that during the course of this study, you will:

- 1) Be asked to read and sign a general form of Informed Consent.
- 2) Be asked to read and sign a form of Informed Consent for Audio Taping.
- 3) Be asked to complete a demographic questionnaire.
- 4) Be asked to provide on a separate sheet your name, current postal address, and phone #.
- 5) Engage in one face-to-face interview, lasting up to sixty minutes, in a private setting of your choosing.
- 6) Be audio taped during the interview by the researcher.
- 7) Be sent by regular mail (certified return receipt) a printed, hard copy of the word-by-word transcript of the interview for accuracy.
- 8) Be provided with an envelope with pre-paid postage and asked to return the transcript with your written feedback to the Principal Investigator.

_____ Subject's Initials

ALTERNATIVES TO PARTICIPATION

Your participation in this study is voluntary. You may withdraw from this study or end an interview at any time without penalty. You may also refuse to be audio taped. Your decision whether or not to participate in this study will not affect your current or future care or relations with Rutgers University or any health care provider associated with these organizations.

RISKS

There are no anticipated physical risks due to the exploratory nature of this study and no invasive intervention. If you experience emotional distress or discomfort during the interview, you may choose to not answer a question, or immediately stop the interview. You can choose to continue at a later date, or withdraw from the study entirely. As determined by you, if emotional assistance is needed, you will be advised to see a counselor of your choice. If immediate assistance is needed, you will be referred to the free Safe Horizon Counseling Hotline at (800)621-4673 (HOPE). Payment for any services will be your responsibility, or that of your private or public health insurance carrier.

BENEFITS

Benefits of participating in the interviews may be emotional release, self-awareness, healing, and empowerment (Thomas & Pollio, 2002). Furthermore, knowledge gained from your study participation may promote Therapeutic Touch practice in nursing. It may also help achieve a better understanding of SCT phenomena that, in turn, can benefit future patients undergoing trauma-related treatment.

CONFIDENTIALITY

Your confidentiality will be maintained during and after this research study. Your individual audio tape and word-by-word transcription will be coded numerically (#1, #2, etc.). Any specific details that could potentially reveal your identity will be changed in the research report.

The word-by-word transcription of your interview will be kept in a locked file by the researcher for 7 years and then shredded. The audio tape will be destroyed following transcription, and the data sheet with your name, postal address, and phone # destroyed immediately after the transcription has been returned with your feedback to the researcher.

COMPENSATION

There will be no monetary compensation or gifts awarded for study participation.

_____ Subject's Initials

FINANCIAL COSTS TO THE SUBJECT:

You understand there will be no costs to you for participation in this study.

RIGHT TO REFUSE OR WITHDRAW:

You understand that your participation is **VOLUNTARY** and you may refuse to participate, refuse to be audio taped, or may discontinue your participation at any time, without loss of care to which you are entitled. You also understand that the investigator has the right to withdraw you from the study at any time. If you wish to participate in the study, but do not wish to be audio taped, then you will be withdrawn from the study by the Principal Investigator.

You will receive a copy of this consent form if you agree to participate in this research study.

INDIVIDUAL(S) TO CONTACT:

If you have any questions about your participation in this study, the research, or the procedures, you can contact the researchers: Catherine Jirak Monetti, PhD (c), RN, (973)586-8827 or Deanna Gray-Miceli, PhD, RN, (973)353-3848.

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848 932-4058
Email: humansubjects@orsp.rutgers.edu

PARTICIPATION

Your participation in this study is **VOLUNTARY**; you may refuse to participate or withdraw from the study at any time without penalty. If you withdraw from the study before data collection is completed, your data will be removed from the data set and destroyed.

_____ Subject's Initials

Signature of Subject

You have read this entire form, or it has been read to you and you understand it completely. All of your questions regarding this form or study have been answered to your complete satisfaction. You agree to participate in this research study. You have been given a copy of this form to keep.

Subject's signature _____ **Date**

Investigator's signature _____ **Date**

Legally authorized representative's signature _____ **Date**

(if applicable)

Appendix D

Informed Consent Form for Audio Taping

Title of Study: Somatic countertransference experiences as described by nurse
Therapeutic Touch practitioners: A content analysis.

Principal Investigators: Catherine Jirak Monetti, PhD (c), RN and Deanna Gray-Miceli,
PhD, APRN

RESEARCH STUDY

_____ has been asked to participate in a
research study under the direction of Catherine Jirak Monetti, PhD (c), RN, and Dr.
Deanna Gray-Miceli, PhD, RN.

INTRODUCTION

You are invited to participate in a research study. Before you agree to participate in this
study, you should know enough about it to make an informed decision. If you have any
questions, ask the investigators. You should be satisfied with the answers before you
agree to be in the study.

AUDIO TAPING

The research design and protocol involves your participation in a face-to-face interview
lasting up to 60 minutes that will be audio taped (tape-recorded). If you wish to
participate in the study, but do not wish to be audio taped, then you will be withdrawn
from the study by the Principal Investigator.

Signature of Subject

You have read this entire form, or it has been read to you and you understand it
completely. All of your questions regarding this form or study have been answered to
your complete satisfaction. You agree to be audio taped in this research study. You have
been given a copy of this form to keep.

Subject's signature _____ **Date**

Investigator's signature _____ **Date**

Legally authorized representative's signature _____ **Date**

(if applicable)

Appendix E

Individual Demographic Data Sheet

ID #: _____ Date: _____

Please take a minute to complete this information about yourself. Place a (check) in the appropriate box. Thank you.

1. What is your age? _____
2. What is your sex? _____ Female _____ Male
3. Marital status? _____ Married _____ Unmarried
4. What is your living arrangement? _____ Alone _____ With spouse/other
5. To which ethnic background do you belong?

_____ Black

_____ Hispanic

_____ White

_____ Asia/Pacific Islander

_____ Other

6. What is the highest educational level you have attained?

Diploma/Degree:

_____ Associate

_____ Baccalaureate

_____ Masters

_____ PhD or earned doctorate

7. How many years, on average, would you say you have completed in Nursing Practice?

_____ 0-5 years

_____ 6-10 years

_____ 11-15 years

_____ > 16 years

8. How many years would you say you have practiced Therapeutic Touch?

_____ 0-5 years

_____ 6-10 years

_____ 11-15 years

_____ > 16 years

9. Do you hold a national or state-issued Certification in Therapeutic Touch?

_____ Yes _____ No

10. Do you hold any certification other than Therapeutic Touch certification?:

_____ Yes _____ No.

If yes, please specify

11. Do you engage in any other Holistic Practice(s)?

_____ Yes _____ No.

If yes, please specify

Appendix F

Individual Contact Information

ID #: _____ Date: _____

The information on this form will remain confidential. It will be destroyed immediately subsequent to receipt by the researcher of the verbatim transcription of the audiotaped interview mailed to you.

Please take a minute to complete this information about yourself. Thank you.

NAME

ADDRESS

PHONE

EMAIL

Appendix G

Semi-Structured In-Depth Interview Questions*Main Research Questions #1:*

“I am interested in hearing about your experiences with patients while engaged in the practice of Therapeutic Touch (TT)” “Not yet fully understood in the literature, somatic countertransference (SCT) is currently defined as ‘the therapist’s awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the client’s process’ (Orbach & Carroll, 2006, p. 64, as cited in Vulcan, 2009). Sometimes the clues to recognizing countertransference reactions are feelings, moods, or thoughts; sometimes they are unbidden images, fantasies, or sounds. The experiences of SCT may appear to embody something that “belongs” to the patient (Casement, 1985). For instance, charismatic healers who practice TT experience revelatory imagery with links to clients’ healing processes (Csordas, 1994).

- 1) “Please tell me, what is your experience of SCT when you have cared for traumatized patients within the previous 6 to 12 months?”

Sub-Research Questions # 2 - # 6:

- 2) “What sort of experiences do you experience in your body during TT sessions, from everything you can think of?”
- 3) “What do you perceive, if anything, during TT sessions?”
- 4) “What do you see, if anything, during TT sessions?”
- 5) “What emotional issues, if any, do you perceive in clients?”
- 6) “What experiences do you consider extraordinary, if any?”

Appendix H

Agency Letter of Permission:
Therapeutic Touch International
Association



Therapeutic Touch International Association

Catherine Jirak Monetti, PhD (c), RN, CNE

April 28, 2013

Dear Ms. Monetti:

On behalf of the Board of Trustees of Therapeutic Touch International Associates, Inc., I am pleased to inform you that the Board has approved your research project titled *Lived experiences of somatic countertransference in Therapeutic Touch practitioners: A hermeneutic phenomenological inquiry*.

If you would like for Sue Conlin to include an invitation to the membership to participate in your project in the TTIA eNews, please send the wording for the invitation and your contact information to her at ttrainer@verizon.net

Changes or deviations from the original conditions and purpose of the project need to be submitted to the TTIA Board for approval. You must obtain approval from the Board to make any material changes to the research project, including but not limited to research objectives, implementation strategy, key personnel, timetable, or for activities or items not previously included in the approved project. Such approval must be requested from the in writing, and the Board's approval must be obtained before such changes are implemented.

We would appreciate acknowledgement of TTIA in any communication, publications, or presentations referring to or resulting from this research project.

We would like to share a summary of your proposed project with the membership in the Cooperative Connection. Please let me know if you agree. We will attribute the project to you.

We are pleased to support your research project and look forward to reports of your findings.

Sincerely,

Mary Anne Hanley, PhD, RN
Research Trustee

Appendix I

Agency Letter of Permission:
American Holistic Nurses Association

AMERICAN
Holistic
Nurses
ASSOCIATION

100 ST 9th St.
Suite 3A
Tucson, AZ 85722-8212

(602) 278-2442
(705) 234-1752
(705) 234-1713 fax

www.ahnna.org
info@ahnna.org

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Colleen Delaney
PhD, RN, AHN-BC
Research Coordinator

Carole Ann Drick
PhD, RN, DNP, TBCSP
Practice Coordinator

Louise Lorenz
BSN, PMRN, RN, AHN-BC, NEPA
Membership Coordinator

To: Catherine J. Monetti, PhD (c), RN, CNE
From: Colleen Delaney PhD, RN, AHN-BC, Research Coordinator
Terri Roberts JD, BSN Executive Director, AHNA
Date: March 11, 2013
Subject: AHNA Research Proposal Approval for Posting and Solicitation of Subjects

The Research Committee of the American Holistic Nursing Association has reviewed your proposal: *Lived experiences of somatic countertransference in Therapeutic Touch practitioners: A hermeneutic phenomenological inquiry*. Your study is consistent with the mission and goals of our association, and on behalf of AHNA we give you permission to recruit/solicit members of AHNA to participate in your study.

We will plan on posting your study invitation in our bi-monthly e-news and quarterly research e-news. Your research invitation will appear later this month in our AHNA e-newsletter and again in April in our Research e-news.

Best of luck with your research!

Colleen Delaney PhD, RN, AHN-BC

Terri Roberts JD, BSN

Table 1

Table 1: Selected Sociodemographic Characteristics of the Participants (Sample)

(n = 8)

<i>Characteristic</i> (%)	<i>Frequency (N)</i>	<i>Proportion</i>
Age distribution:		
Range: 61-78 (<i>M</i> 67.13, <i>Md</i> 66)	8	100
Sex		
Female	8	100
Male	0	0
Marital Status		
Married	5	62.5
Unmarried	3	37.5
Living Arrangement		
Alone	2	25.0
With spouse/other	6	75.0
Ethnic Background		
Black	0	0
Hispanic	0	0
White	6	75.0
Asia/Pacific Islander	0	0
Other	2	25.0
Highest Educational Level		
Associate	1	12.5
Baccalaureate	2	25.0
Masters	4	50.0
PhD or earned doctorate	1	12.5
Years in Nursing Practice		
0-5 years	0	0
6-10 years	0	0
11-15 years	1	12.5
>16 years	7	87.5
Years Practicing TT		
0-5 years	0	0
6-10 years	0	0
11-15 years	1	12.5
>16 years	7	87.5
Certification in TT		
Yes	5	62.5
No	3	37.5

Other Certification

Yes	6	75.0
No	2	25.0

Other Types of Certification:

Nurse Practitioner (NP), Reiki (Master), Qualified Therapeutic Touch Teacher (QTTT), Guided Imagery (GI), Aromatherapy, Advanced Holistic Nurse Practitioner (AHNP), Clinical Nurse Specialist (CNS), Adult Advanced Practice Nurse (APN), Creative Healing, National Board for Certified Counselor (NBCC) , Registered Nurse, Certified (RNC)

Other Holistic Practices

Yes	7	87.5
No	1	12.5

Other Types of Holistic Practice:

Meditation, Esoteric Studies, Voice & Sound Practices, Vibrational Energy, Aromatherapy, Acupressure, Guided Imagery, Reflexology, Medical Qigong, Massage Therapy (65 modalities), Emotional Counseling, Biofeedback, Herbs, Homeopathy, Nutrition, Visualization, Emotional Freedom Technique (EFT), Polarity Therapy

Table 2

Table 2. Demographic data gathered during face-to-face interviews: Nurse TT Practitioners ($n = 8$)

Participant #	Age ^a	Marital Status	TT Practice ^b	TT Qualification	Other Certification	Other Holistic Practice	Social History
1	67	Married	16+	No.	Yes.	Yes.	Lives with spouse/other
2	65	Married	16+	Yes.	Yes.	Yes.	Lives with spouse/other
3	61	Unmarried	11-15	Yes.	Yes.	Yes.	Lives alone
4	61	Unmarried	16+	No.	No.	No.	Lives with spouse/other
5	78	Unmarried	16+	Yes.	No.	Yes.	Lives alone
6	73	Married	16+	Yes.	Yes.	Yes.	Lives with spouse/other
7	63	Married	16+	No.	Yes.	Yes.	Lives with spouse/other
8	69	Married	16+	Yes.	Yes.	Yes.	Lives alone

^a years of age at the time of the interview^b years

SCT: A Language for Healing Trauma												
Theme (Latent Content)	Nurse TT Practitioner → Communication → Healing											
Category (Manifest Content)	Experiences		Visualization	Qualities	Awareness	Boundaries	Information	Mode	Trauma	Spirituality	Release	
Subcategory (Manifest)	Somatic Counter-transference (SCT)		Imagery	Perspective	Self	Sense of Safety	Messages	Channel	Childhood	Sacred Experience	Posttraumatic Growth	
Descriptive Codes (Manifest) ↑ (Condensed Meaning Units Close to the Text)	Body		Features	Guided to Work	Inner	Self-Defensiveness	Knowing	Instrument	Dissociation	Spiritual Intimacy	Shift	
			3D	Gift	Intuition		Embodied	Connection	Psychic	Angels	Opening the Field	
			Holographic	Centered	Intuitive Process	Disarming		Deeper Self	Type	Cherubs	Patterning	
			Photo	Grounded	Eternal Self	Recognition as Other		Deepening	Physical Conditions	Beings	Quantum Physics	
			Movie	Attunement	Observer	Coping		Shared Experience	Drug Addictions	Supportive Presence	Cellular Level	
			Cartoon-like	Intention	Inner-to-Inner (ISSE-ISSE)	Letting Go of Responsibility		Validation	Cancer	Native American Indian	Energetic	
			Colors	Perception				Distance Healing	Chemotherapy		Extraordinary	
			Anatomical Parts	Compassion				Societal Message	Emotional Issues		Power of TT	
			Guided Imagery	Evolution					Diagnostic Aid		Miracles	
				Holistic Support					Referral			

Figure 1. Coding Framework

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Catherine Jirak Monetti, MA, RN, CNE

(Graneheim & Lundman, 2004, p. 108)

SCT: A Language for Healing Trauma

A Depiction of the Dynamic & Quantum Nature of SCT

An Individual Participant's (P1-P8) Overall Descriptive Content Falls at any Point Within the Content Space

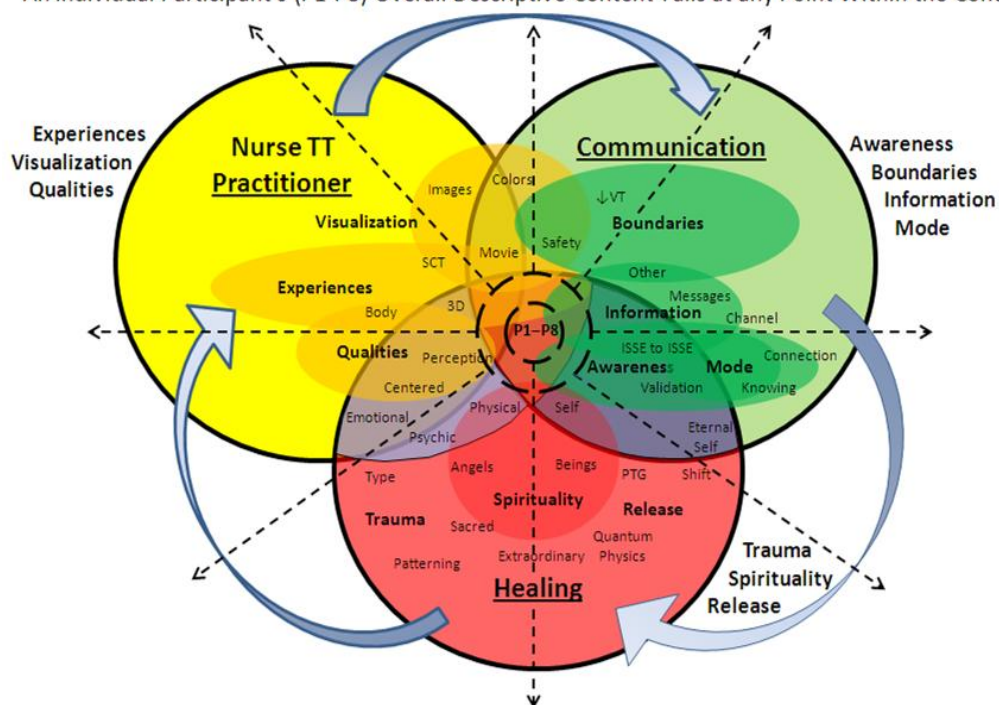


Figure 2: Conceptualization of Major Theme

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Catherine Jirak Monetti, PhD, RN, CNE

Table 3. Content analysis: Somatic countertransference (SCT) experiences of nurse Therapeutic Touch (TT) practitioners

Direct quotes from Interview Data (Meaning Unit)	Code	Sub-Category	Category	Theme
Participant 8, a 69 year-old female, explained, "With somatic countertransference, I found that it gives me messages of when I would say something or not say something. I get the message, 'bring this up', 'run this by the person.' Or I get the sense it would cause that person to shut back down. So, it's more intuitive...I tried my best to listen and go with the intuitive; whether to say something or not say something. But I get these types of messages."	SCT	Experiences	Nurse TT Practitioner	A Language for Healing Trauma
Generally describing her body experiences, Participant 7, a 63 year-old female, shared, "There is a sense [at] times when my body starts to ache, or have pain, in an area where they are. Or I will feel in myself, like an energy center has completely slowed down, or the chakra has just shut in on itself. Then as I release that or open the chakra in my client, that sense in my body eases, too."	Body	Experiences	Nurse TT Practitioner	A Language for Healing Trauma
According to Participant 5, a 78 year-old female, "I don't feel ... when I'm doing Therapeutic Touch, I don't think of my own body, just as being a connection, a bridge from myself to the other person, my heart to their heart, opening that up. That's what I feel in my body, just love, compassion, and caring."	Body	Experiences	Nurse TT Practitioner	A Language for Healing Trauma
Describing her own body sense of a patient's fear, Participant 2, a 65 year-old female, stated, "and so it isn't necessarily the feeling in my body, but the field itself, was like shaking everywhere, ... trembling everywhere in the field ... it was just an experience of tremulousness that I would experience by moving my hands through the field...the nice thing is being able to know as the field changes. As you work, you notice that it calms down."	Body	Experiences	Nurse TT Practitioner	A Language for Healing Trauma
Participant 3, a 61 year-old female, said, "I don't. I haven't visualized a lot of stuff doing this work. A colleague and I were at a conference, with a medicine man speaking; and, she leaned over and said, 'can you see his aura?' She coached me into looking off to the side of him; and, then I saw this brilliant turquoise aura. I saw it briefly, then lost it. As far as seeing a lot, no, I don't."	Visual	Visualization	Nurse TT Practitioner	A Language for Healing Trauma
Participant 4, a 61 year-old female, responded similarly, "... I don't visualize things; I don't see colors...Dora (Kunz) was always funny, I talked to her about that and she simply said, 'well then, just say it in your head', and so I do. But, I can hear someone else send a color from across the room."	Visual	Visualization	Nurse TT Practitioner	A Language for Healing Trauma
Regarding emotion-laden experiences, Participant 6, a 73 year-old female, described her imagery as,	Imagery	Visualization	Nurse TT Practitioner	A Language

“there have been times, one in particular, a woman who seemed very happy and jolly, no problems at all; when assessing and treating her, I got this image: I was over her heart chakra that she had a broken heart. It persisted. I said something to her, and she started to cry. She revealed that she was in the process of thinking about getting a divorce ... “			titioner	for Healing Trauma
Participant 8, a 69 year-old female, continued further: “Sometimes I see things; e.g. with the adrenals, or with seeing the wound. Other times I don’t. I just follow where I’m guided. I keep an eye on the person. It’s not something where you just close your eyes and go, ‘Ohm’, and think you’re going to do something. I observe what is going on with the field. I see, a lot of times, the field.”	Imagery	Visualization	Nurse TT Practitioner	A Language for Healing Trauma
Participant 7, a 63 year-old female, also mentioned a cartoon-like quality. “sometimes I get images about people’s feelings or the traumas they’ve been through. It almost has a cartoon quality ... which is a strange thing, but maybe it helps me to be feeling, a little lighter inside me.”	Features of Imagery	Visualization	Nurse TT Practitioner	A Language for Healing Trauma
Participant 7, a 63 year-old female, mentioned seeing colors: “I also sometimes see colors around the body. I wish they were stronger.” Colors were also sometimes seen by Participant 6, a 73 year-old female: “I, sometimes, see colors but very rarely.”	Colors	Visualization	Nurse TT Practitioner	A Language for Healing Trauma
Participant 6, a 73 year-old female, voiced the incorporation of the intentional use of imagery in her TT practice. She revealed, “And after they’re treated ... the same pattern reappears, I bring this into their awareness. I made a CD for them to do relaxation, to do imagery, to get rid of the stresses in their body ... ”	Guided Imagery	Visualization	Nurse TT Practitioner	A Language for Healing Trauma
Participant 4’s stance was, “I don’t diagnose people. I simply just do what I do and allow them to process the information.”	Perspective	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Participant 3 provided a specific example: “So I said to her tell me your mother’s name... We gasped. She goes how did you know that? I said I was her next-door neighbor for over nine years. She said you’re one of the girls next door. I said, yes, I was. The hair stood up on the back of my neck. That’s why I was brought to her doorstep. Her mother took me there... It was her mother that told her, guided her to call me.” She also related this experience to karma. She said, “talking about karma today. I know darn well her mother took me to her doorstep.”	Guided to the Work	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Participant 8, a 69 year-old female, similarly stated, “I feel I’m being guided. My body is being guided. My Being is Being guided in what I am doing, in where I am going to be working, or how I’m going to proceed.”	Guided to the Work	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Participant 7, a 63 year-old female, spoke of her	Inherited	Qualities	Nurse TT	A

inherited gift: “I have a relationship with a great, great uncle who was a miraculous healer in the early 1900’s. For many years, when I first started doing healing work in my 20’s, I would hear this brogue, now I know it was Welsh, telling me how to do things: what to look for in a person’s body, how to treat it. That was always very emphatic. ‘Do this. Now do that. OK, it’s done. Step away!’ Very pragmatic, and I didn’t know who he was. I had never met him until maybe 15 years into it...And he always called me great niece. So, he has been a very awesome guide.”	Gift		Prac-titioner	Language for Healing Trauma
According to Participant 5, a 78 year-old female, “I’m always totally centered. I find a bridge between myself and the other person’s self...I have to be centered, it is so important not to go off center and to restore them back to a healthy place mentally.”	Centered	Qualities	Nurse TT Prac-titioner	A Language for Healing Trauma
Finally, Participant 4, a 61 year-old female, summarized the importance of one’s centering ability by saying, “which freaks people out, I simply go and take a breath, let it out, and I’m centered. You can put in your notes that I demonstrated, and so I’m centered.” (The study participant did indeed demonstrate her centering technique, as was chronicled in the researcher’s field notes and Reflexive Journal). She extolled the benefit to her of centering by concluding with, “I think it’s extraordinary that I have a gift to center immediately because I am not a calm person...yet, with this modality I can be a really calm person. I can really make a difference in people’s lives.”	Centered	Qualities	Nurse TT Prac-titioner	A Language for Healing Trauma
Participant 1, a 67 year-old female, also stressed the importance of grounding by expressing, “Revisit centering and grounding...move through...be an instrument of healing.”	Ground-ed	Qualities	Nurse TT Prac-titioner	A Language for Healing Trauma
The importance of being grounded was also noted by several of the TT practitioners. Participant 6, a 73 year-old female, said, “What happens is thoughts come into my mind. And while I’m doing TT, especially deeply centered, there are no thoughts, because I’m completely grounded.”	Ground-ed	Qualities	Nurse TT Prac-titioner	A Language for Healing Trauma
Other qualities of the nurse TT practitioners extracted from the data were attunement and intention. Participant 4, a 61 year-old female, said, “I’m very attuned to the other person...generally, I don’t attune to me at all. That’s sort of a good thing.”	Attune-ment	Qualities	Nurse TT Prac-titioner	A Language for Healing Trauma
Participant 4, a 61 year-old female, also mentioned, “I work a lot with friends and family, as for specific things, most of them are very well-balanced ... wound healing is a big thing that I do for people. And the intentions that we get in the TT network, I do a lot of that.”	Intention	Qualities	Nurse TT Prac-titioner	A Language for Healing Trauma

Participant 5, a 78 year-old female, shared, “my intention is always to restore order to all of these levels of consciousness...My intention, my thought, my centered state, I have to be centered.”	Intention	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Regarding veterans, Participant 5, a 78 year-old female, commented, “my intention is always to restore order ... and just put them in a safe place, their mental, physical, to make them more whole and at peace.”	Intention	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Participant 1, a 67 year-old female, continued, “I can see sort of anatomical things. And, so those images sometimes come. I don’t hear things. I get a sensation...like a light, sort of a bubble, not really seeing it clearly. I don’t smell things in terms of senses. I once in a while feel something in my body, like a sensation, being short of breath, but not so much anymore. I don’t hear things, although sometimes there seems like there should be a song involved. Sometimes I ... but I don’t hear it. It’s more like it needs to be sung, where there needs to be some sound. But that is just once in a while. I don’t do, that’s not common for me.”	Perception	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Recalling her experience with a patient’s accelerated healing after a fall, Participant 3, a 61 year-old female, said, “I just felt, I recall feeling very low energy every time I would do the strokes over any part of her head, and that surprised me because I expected to feel a lot of heat coming off there, but there wasn’t. It was just very low energy.”	Perception	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Providing another clinical example, Participant 3, a 61 year-old female, described her perception during a TT session. She said, “I feel stuff...With the torn Achilles tendon, I felt a lot of heat, not only at the incision site but also as I’d go past her heart, and that’s because she was so angry...reading her heart chakra ... her emotions were anger, bitterness, frustration, discouragement. So, that was very easy to pick up on.”	Perception	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Participant 2, a 65 year-old female, continued, “Yes, if it’s jagged, or it might be a little sharp, or it might be smooth. It might be rounded and full. But my hand, there’s a difference between like my hand having something touch it and then feeling like I’m touching something.”	Perception	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Participant 7, a 63 year-old female went on with “There are other sensations I can feel. From a blocked gall bladder that is not about prickling; it’s about a squeezing heaviness. Where, with cancer, it’s a prickling and a painful sensation on my hand. The more developed the cancer the stronger the sense of prickling and pain and the sense of urgency that I must get them to a doctor.”	Perception	Qualities	Nurse TT Practitioner	A Language for Healing Trauma
Participant 7, a 63 year-old female, added, “The acupuncture points, when they’re in need, pull me	Perception	Qualities	Nurse TT Practitioner	A Language

in, it's like a sensation of being drawn directly to a point. I might put my finger down an inch away from that and it will automatically slide. It will be like a connect goes on in my body and then, 'ok, that's it'. But seeing the energy flows, where the blockages are, where the circulation isn't getting to - allows me to focus on bringing more life force into an area. I will wait until I see the meridian re-connect itself and flow freely. Nerve energy is more of a white fire kind of energy in the way that I perceive it. And, certainly I've felt when there's a blockage or a pressure on a nerve and there's a zing move through somebody's body. If I put my hand on that point or near where the zing is, I get it. I feel the sensation of it."			titioner	for Healing Trauma
Finally, Participant 4, a 61 year-old female, said, "There are also times when I am with someone and I hear. I hear a statement about what they need or what's bothering them, and then I can ask an appropriate question that might trigger them to answer it."	Percep- tion	Qualities	Nurse TT Prac- titioner	A Language for Healing Trauma
Participant 3, a 61 year-old female, mentioned her attendance at a Barbara Brennan seminar, "Hands of Light", and familiarity with both Reflexology and Healing Touch before learning Therapeutic Touch. She said: "My hands get really hot. Healing Touch...has this one technique called a pain drain where you hold one hand over the injured part and pump the other hand. After you do that several times, you reverse it so you're draining the inflammation, or the bad energy. And when you go this way you're filling that space now with great cleansing healing energy. And there's never been a time doing that pain drain that my hands don't get just incredibly hot. My sister had a bad case of bronchitis and I was working on her. I could feel something pulling out of her and she said 'oh my gosh, I can feel that crab moving.' I said do you want me to stop and she said 'no, get it out of there, I can feel that.'"	Holistic Support	Qualities	Nurse TT Prac- titioner	A Language for Healing Trauma
Recalling her experience during her practice of Reflexology, Participant 3, a 61 year-old female, reflected, "He said you probably don't remember me; but, you helped my wife that night, she couldn't swallow ... she passed away about four months ago. He said, I have to tell you she never had another episode of those esophageal spasms after you worked on her." And, you talk about a somatic experience, the hair on the back of my neck literally stood straight up, I couldn't even speak to the man. That was so powerful, there was something to this stuff of touching another human being, I couldn't walk away from it."	Holistic Support	Qualities	Nurse TT Prac- titioner	A Language for Healing Trauma
Participant 3, a 61 year-old female, contributed, "And, she is a person who in addition to having the traditional medical treatment was also getting	Holistic Support	Qualities	Nurse TT Prac- titioner	A Language for

Chinese herbal remedies, and she had a naturopath who was supporting her, and a counselor who was supporting her. She really went into the healing process.”				Healing Trauma
Participant 8, a 69 year-old female, spoke about the need to overcome self-defensiveness in traumatized clients. Speaking of one particular patient: “And when I went into her field, I felt a defensiveness. In our society we put up what we call the shield, and we protect ourselves. It’s self-protection. I could sense all around her where her field was smooth and when it wasn’t flowing as well. A lot of beginners say, ‘oh, well, I don’t feel anything, they’re perfectly balanced.’ And, they’re not. It is our defense and holding things, and protecting ourselves against any other emotional things that are going on because we’re already so traumatized by something going on within us.”	Self-Defensiveness	Boundaries	Communication	A Language for Healing Trauma
Participant 2, a 65 year-old female, said, “I have found that when people can identify the feeling and almost bring it to awareness, then you clear; and, it supports their ability to actually clear ... then it can begin to release, that’s my current belief.”	Self	Awareness	Communication	A Language for Healing Trauma
When asked about her self-awareness during a SCT experience, Participant 4, a 61 year-old female, said, “It’s so interesting that you asked that, and that (blinding white light) came right to me.”	Self	Awareness	Communication	A Language for Healing Trauma
Finally, Participant 3, a 61 year-old female, noted, “It’s a good way of learning about yourself. It keeps you humble because we all are vulnerable at one point or another.”	Self	Awareness	Communication	A Language for Healing Trauma
Participant 4, a 61 year-old female, emphasized “Just that I think that it really demonstrates the power of what we do as healers, and how important it is to pay attention to the intuitive process, to not back off when you have this sense that you need to do something. You do need to just do it.”	Intuition	Awareness	Communication	A Language for Healing Trauma
Participant 2, a 65 year-old female, spoke about the “Eternal Self.” She said, “So, as we worked with TT, and as the focus on wholeness, on connecting with that place of inner-self in the client, I think the information I got was that she was actually beginning to understand more about the eternal self. That is something I became aware of first within myself and eventually we talked about it.”	Eternal Self	Awareness	Communication	A Language for Healing Trauma
Participant 8, a 69 year-old female, reflected, “When I observe students, I can see how the field is moving. I don’t necessarily see it the way I wish I did, but I can see the movement. I can see the blockage. I can see where they need to go. And so, that’s the same as when I do Therapeutic Touch. I can see, but it’s so automatic when I’m doing it. I’m not so aware of it when I’m doing it, but I am more	Observer	Awareness	Communication	A Language for Healing Trauma

aware when I'm observing students doing TT with the peers, or when I'm mentoring a person doing TT with someone that's very ill."				
Participant 2, a 65 year-old female, similarly said, "so my inner-self was telling me that she was more deeply connected to her inner-self. I would say it would have been 6 to 7 months into working with her where I felt a shift, and that information where I was getting it from inside me, so my inner-self was telling me that she was more deeply connected to her inner-self."	Inner Self-to- Inner Self (ISSE-to-ISSE)	Aware-ness	Communi-cation	A Language for Healing Trauma
Participant 1, a 67 year-old female, explicitly stated, "It creates a sense of safety."	Sense of Safety	Bound-aries	Communi-cation	A Language for Healing Trauma
In her work with veterans, Participant 5, a 78 year-old female, related, "They're able, they feel safe with me and they're able to share their experiences. They feel safe in sharing their stories with me."	Sense of Safety	Bound-aries	Communi-cation	A Language for Healing Trauma
Participant 1, a 67 year-old female, summed up the issue of coping by saying, "Then letting go of the sense of responsibility."	Coping	Bound-aries	Communi-cation	A Language for Healing Trauma
Several of the study participants discussed messages they received. Participant 8, a 69 year-old female, said, "I will be driving and I will sense somebody or something with me and then I will get the message. All of a sudden, I'm back in that session, that Therapeutic Touch session, ... and this person is saying to me, 'when you experience this sense, this is what was going on with my loved one.' And so, I just continue to get the message in different ways."	Message	Inform-ation	Communi-cation	A Language for Healing Trauma
Participant 4, a 61 year-old female, recalled an Immediate Knowing during the distance healing session with a university shooting victim. She said, "all of a sudden it was like something hit me in the chest, and I just sat back in the chair and I had this moment of just knowing immediately that I had to do something."	Know-ing	Inform-ation	Communi-cation	A Language for Healing Trauma
Participant 2, a 65 year-old female, referred to embodiment when she said "So I'm trying to think of specific things where I have embodied information and/or feeling."	Em-bodied Know-ing	Inform-ation	Communi-cation	A Language for Healing Trauma
Participant 2, a 65 year-old female, responded with, "It's just information coming from somewhere, and it's in my body. And like I said, with the fear, it's, you can definitely identify it in this area because your breath is caught up and you might even have a sudden change in your physical ..."	Em-bodied Know-ing	Inform-ation	Communi-cation	A Language for Healing Trauma
Participant 8, a 69 year-old female, spoke about Knowing. She said, "to be able to express what is	Know-ing	Inform-ation	Communi-cation	A Language

going on and to be able to just know, the Inner Knowing, and the Inner Being being connected with that Inner Knowing of that other Being and how we assume Beings.”				for Healing Trauma
Referring to her ancestor, Participant 7, a 63 year-old female, also shared, “I had a client whose mother taught this man’s work. Our family lived in a different state, and thereafter, every medium that I knew would spontaneously begin to channel him. He would give me instructions about who I needed to go study with, and that I needed to bring this work into the world.”	Channel	Mode	Communication	A Language for Healing Trauma
Participant 7, a 63 year-old female, stated, “That was one of the most amazing experiences of my career. There have been other things, physical things that I have removed, ganglion cysts, or gall stones, or lumps in the breast, but nothing that was that far along. And what it tells me, when those kinds of miracles happen, how little I am doing the work, and how much Creator is working through me. Because we all have the capacity to channel love and healing if we have the desire to help somebody.”	Channel	Mode	Communication	A Language for Healing Trauma
Participant 8, a 69 year-old female, said, “What I recommended, because she couldn’t come frequently to me, was other practitioners, that lived by her would, to do Therapeutic Touch with her. She wasn’t open to it until after she had come to this group and I had done Therapeutic Touch and she saw that it was going to be helpful. So that was another kind of experience that I had that was profound - it was again showing how the different connections come through this somatic countertransference.”	Connection	Mode	Communication	A Language for Healing Trauma
Participant 1, a 67 year-old female, summed it up connection in this way: “You realize that...you connect, there’s a sense you connect with the person and you’re doing TT at a distance...and I get some of the same kinds of things, images or whatever.”	Connection	Mode	Communication	A Language for Healing Trauma
Describing a group experience, Participant 1, a 67 year-old female, said, “The instant they centered and came together, it felt like I was being levitated off the bed. It was a sense of a triangle and I was just moving up...it was very clear...we all actually shared...everybody had the same image, experience.”	Shared Experience	Mode	Communication	A Language for Healing Trauma
As another example of validation, Participant 2, a 65 year-old female, recalled, “it’s like you might be doing a treatment and anticipate that feeling, so I have to ask myself ‘am I getting it?’ because I’m expecting it, and I don’t think that’s what’s happening in the cases that I’m remembering. Then what I usually do is check it out with the person. I’ll also wait until I’ve done a second or third treatment and the feeling comes again. I won’t necessarily in the very first time I meet them, I probably won’t	Validation	Mode	Communication	A Language for Healing Trauma

check it out, because I feel sometimes the information is very intimate.”				
Providing a clinical example, Participant 2, a 65 year-old female, recalled, “The one time I’m thinking of most clearly is a woman who had lost her husband and the impression I got ... she was struggling with whether to stay here or to leave...And so I waited, and it came again the next treatment and the next. And, so I checked in with her. I said, you know, this may be something absolutely bizarre, if it is, please just blow it off, but I get this sense that you are in a struggle of whether to continue your life or not. And it’s all, I heard this big sigh, and she was so glad to be able to talk about her feelings.”	Validation	Mode	Communication	A Language for Healing Trauma
Participant 5, a 78 year-old female, similarly shared an experience of validation. She said, “like in one instance, bed time for this one person was difficult, and so I realized that was not a good time to do distance healing because I wasn’t able to connect, or bath time another time, and I realize I could just see that she was having a bath and that was really hard for her. This person was blind from an accident. And when I checked, when I’d see her later with the caregivers, it was a difficult time. So, that’s just, to me, extraordinary when you check and what you’re thinking, like if you’re in a different state, and then you go back and you check and, yes, that happened that day.”	Validation	Mode	Communication	A Language for Healing Trauma
Participant 4, a 61 year-old female, also had this to say about distance healing: “It was quite amazing all in all... I told her father months later that I had done the treatment, I said that I regretted that I did not get your permission ahead of time. And, he said please feel free any time to not get my permission, because that has been an issue about doing distance TT: do you have the patient’s permission to provide this energy. I think you just need to tap into if someone is sending you this signal and you’re receiving it, then I feel that I have their permission to respond to it.”	Distance Healing	Mode	Communication	A Language for Healing Trauma
In describing nurses’ occupational stress, Participant 3, a 61 year-old female, said, “It will continue to go on because we work for people who are not nurses who don’t get it. They have no concept of what this work is all about, what this feels like...That’s the philosophy. That’s the message that not only comes to me, it comes to all these other nurses I work with.”	Societal Message	Mode	Communication	A Language for Healing Trauma
Participant 8, a 69 year-old female, shared, “An example is that, another mother whose son suicided because I work with this type of trauma, people come to me. I will be working with the individual with the trauma and I will sense the person that suicide, and they will be direct sending messages through me to say to the person. Their so sad that	Type	Trauma	Healing	A Language for Healing Trauma

they may no longer be doing certain things that they did. Their so sad that this caused them such grief.”				
Participant 8, a 69 year-old female, added, “And death, the fear of death, trauma does that to us, and any illness that is pre-death sends people into this post-trauma. This was nine months with my husband that he went through this trauma... Regarding people with cancer, they’re fighting for their life and they have this growth inside of them that is eating them away. And the chemo is killing their selves, too. And so, their whole Being is just so traumatized.”	Type	Trauma	Healing	A Language for Healing Trauma
Participant 8, a 69 year-old female spoke about different types of trauma. She said, “People with the phantom pain: being able to reduce or get rid of the phantom pain and the trauma from their amputation. That, to me, is extraordinary. An example is that, another mother whose son suicided because I work with this type of trauma, people come to me. I will be working with the individual with the trauma and I will sense the person that suicide, and they will be directly sending messages through me to say to the person. They’re so sad that they may no longer be doing certain things that they did. They’re so sad that this caused them such grief.” She also said, “The people with the Chronic Fatigue, working with that and seeing them all of a sudden be able to do things they weren’t able to do. That’s extraordinary.”	Type	Trauma	Healing	A Language for Healing Trauma
Regarding the musculoskeleture, Participant 4, a 61 year-old female, related, “does this, because sometimes you might sense that they’re not quite in balance but some people aren’t in balance. Somebody with a leg that’s a little shorter than the other will be a little off balance. I’ll have a sense that they’re in balance but it doesn’t seem exactly in balance. You’ll ask them and they’ll say, ‘oh no, I’m just exactly right.’ And for them, they are exactly right. And that’s because it needs to be or they won’t walk right.”	Physical Con- ditions	Trauma	Healing	A Language for Healing Trauma
Continuing to share, Participant 6, a 73 year-old female, recalled, “and so this one patient, was planning on getting a divorce because her husband was addicted to marijuana; and, now they had a four year old child and she didn’t want him smoking in the house or zoning out now that they had a child. She was planning on divorcing him but then breast cancer was diagnosed so she told me she was going to wait until she was better and then she was going to get divorced. I said to her well have you discussed this with your husband, have you told him; and she said no. I said, well, if he really loves you, maybe he’ll stop; you have to tell him that you’re planning on divorcing him. So anyway, she did do that and he stopped the marijuana and they’re happily married.”	Physical Con- ditions	Trauma	Healing	A Language for Healing Trauma

<p>Participant 3, a 61 year-old female, described a case that involved a patient diagnosed with ovarian cancer. She said, “and the last profound case that just really, really, created a sense of gratitude. I was introduced to a 61 year old patient with ovarian cancer, long family history of women with ovarian cancer, and breast cancer. Fortunately, they found it when she was at Stage 2, which is really unusual with ovarian cancer. So they did a hysterectomy on her, but as the original cancer tumor was on her right ovary, and as they went to take that out, they nicked it, so we were all very concerned about cancer cells being released throughout her body.”</p> <p>Continuing, “So my recommendation to her was that we do Therapeutic Touch at least twice a week, because now she was undergoing chemo, and you know the harsh effects of chemo. So she started the chemo, she had the surgery in March, started the chemo in April. And through April and May, I was working on her about twice a week. In June, she kept cancelling the appointments. And of course, her white cell plummeted and her red cell plummeted, and she had to have a blood transfusion...And with her last lab draw, you see we had an increase from 2.32 to 2.40. She didn’t get any other blood transfusion during this period, not a big increase, but there was some increase there in her red count.”</p> <p>Further, “with her white count, she went from 1.61 to 2.81. That’s more than a full point increase with her white count, which was phenomenal. So again, if you graft that out, you can see this was all over the place. But notice, July 4th, a big plummet in her white count. So go figure. It’s just phenomenal. But here at the end, she’s ready for that last dose of chemo, she has this huge spike. And the most impressive one was the results of her absolute neutrophils. She had almost completely wiped out her neutrophils. She was at .6. Now they weren’t checking the neutrophils as often they were the red and white counts. But a month later, she nearly tripled that neutrophil count, nearly tripled it. That is huge.”</p>	Cancer & Chemo-therapy	Trauma	Healing	A Language for Healing Trauma
<p>Participant 7, a 63 year-old female concluded with, “I also wanted to tell you more about the woman whose breast cancer disappeared before her mastectomy could be done. She came back. I didn’t hear from her again for a year. When she called she had some back problems, but she came in with a new baby that she was nursing. It was just such a joy to see that that faith went on to do something amazing, just amazing. She didn’t expect to have any more children, she was 40-ish. So, it was quite a blessing for her, too, to be able to nurse a baby</p>	Cancer & Chemo-therapy	Trauma	Healing	A Language for Healing Trauma

still.”				
Participant 8, a 69 year-old female, further described her clinical experience with adrenal cancer. She said, “Now, with the adrenal cancer, it set her into such an emotional state because it’s one of the most difficult cancers to help. And she had been having all of these emotions from it: the ‘fight or flight’, and so on, because the adrenals were impacted. With all of this stuff, she had been experiencing she was in a traumatic state. The post-trauma from being diagnosed with this horrible disease of the kidneys and the adrenals and not really having any real recourse. The chemo. At a certain point she knew that it was just to try to help reduce the symptoms. So, the trauma was very intense. And she went away with a sense of, ‘well, how do you know, and how can you feel this? And what do you do?’	Cancer & Chemo-therapy	Trauma	Healing	A Language for Healing Trauma
Regarding chemotherapy-related neuropathy, Participant 2, a 65 year-old female, also said, “Where we work the most for that was the chemotherapy tends to create some neuropathy in the fingers and toes, and that’s something that we worked with to clear. But I actually didn’t, I mean she was experiencing it but I wasn’t picking up, I mean I might have felt a little something like you might call it a smooth static. There was definitely some vibration in the field over her fingers and her toes, but it’s like it wasn’t real profound, let’s put it that way. It’s very subtle.”	Cancer & Chemo-therapy	Trauma	Healing	A Language for Healing Trauma
Continuing on, Participant 7 said, “I can talk about a woman with breast cancer that I treated at one time and her cancer was very, very hard, hot, strong and prickly. I felt she knew she had breast cancer. She was scheduled for surgery in four days. I worked with it. I kept feeling waves of shame and guilt coming from her. So I asked about a family history of cancer. Her son had died of leukemia and her mother of breast cancer. This woman had decided it was her fault, she couldn’t save them. Her statement was, ‘I should have died instead.’ We worked quite a bit and I did some excising of the tumor to the best of my ability, pulling it out of the body, feeling it lighten up a bit, filling the area with light as I excised.”	Cancer & Chemo-therapy	Trauma	Healing	A Language for Healing Trauma
Participant 2, a 65 year-old female, spoke about sadness, fear, and anxiety. She related, “So if all of a sudden I perceive a sense of sadness, or fear, or anxiety, and it’s fairly fleeting, it doesn’t hang there, but is probably ... sadness is probably, I don’t know if that’s the one that comes, if that’s the most easy to identify.” She also mentioned loss: “Certainly when somebody is, has lost somebody... Well, and I think those are the things that I probably do pick up the easiest. I probably pick up emotional feelings more than physical ones in a way. I certainly do pick up	Emotion -al Issues	Trauma	Healing	A Language for Healing Trauma

sadness. I pick up like working with people that are bereft, that sense of loss.” Speaking also about anxiety, Participant 2, a 65 year-old female, also said, “Yes, anxious. So what I felt was like a tremulousness in the field that was this quivering, that I could feel everywhere.” “But there are some things, there are some things that I have felt, and I feel it in the whole field. Anxiety is definitely one of those things that, that has been my own personal experience.”				
Participant 3, a 61 year-old female, discussed anger encountered during two different clinical situations. She recounted one experience: “She had a lot of built-up anger because this thing hadn’t healed properly. And she didn’t know who to blame. She didn’t know whether to blame the surgeon, but she wanted to blame somebody ... but I’d go past her heart, and that’s because she was so angry. That was my interpretation of it. So I sensed a lot of anger there.” Participant 3, a 61 year-old female, also discussed anger encountered in the patient with a torn Achilles tendon. “Well, with the torn Achilles tendon, her emotions were anger, bitterness, frustration, discouragement. So, that was very easy to pick up on.”	Emotion -al Issues	Trauma	Healing	A Language for Healing Trauma
Speaking of emotional issues encountered in patients, Participant 4, a 61 year-old female, also said, “I can feel the pain in their hearts when I’m working with them, and I often do the hand- to- heart chakra movement to clear that congestion. I think that that works very well as far as helping people to release some of the energy that just gets stuck there. It’s like some people describe it as that they just didn’t know how to. It’s like taking a weight off their chest, that they didn’t know just how much they were carrying there until it was gone. It’s pretty powerful that we can do that.”	Emotion -al Issues	Trauma	Healing	A Language for Healing Trauma
Participant 5, a 78 year-old female, spoke of grief and sadness. She stated, “I do always, like the physical is very easy. The emotional, usually, a lot of times when you’re assessing, you think of the physical, but a lot of times what you’re thinking, an imbalance is not really in the physical, it’s more maybe in the emotion, especially over the heart, a lot of times it’s a grief, and then you really don’t say or you might say are you having, is there some sadness or just in a very casual way.” She elaborated further, “And very often, they will start sharing with you because you’ve created a safe place and there’s crying, and that which promotes healing. So that’s mainly over the heart area. Most people have unresolved grief issues, maybe even way, way back. So I do have that, work with that a lot, especially because I work with the dying a lot. And so, and a lot of crying.”	Emotion -al Issues	Trauma	Healing	A Language for Healing Trauma

Finally, Participant 5, a 78 year-old female, mentioned anger: “Well, I guess sometimes anger. I always let them know it’s okay if they want to talk, and sometimes sessions are different. It could be that just to share painful things is very healing. So, I let them know if there’s anger, as long as they don’t hit me, then we can research some healthy ways of dealing with anger.”	Emotion -al Issues	Trauma	Healing	A Language for Healing Trauma
Participant 8, a 69 year-old female, also described experiences with clients’ emotional issues. She said, “I can recall an incident when a woman was having a horrible time after her son suicided. She came to me for Therapeutic Touch because people had recommended that that might help her. I went into the field, you know I relaxed her a little bit, started sensing her feeling. And when I go into the field, I usually pick up the emotional right away. I just sensed this individual was having such a difficult time just getting up, just getting dressed. All she seemed to want to do was just stay in bed. It took so much effort for her to get up and to just start her day, or to function during the day.”	Emotion -al Issues	Trauma	Healing	A Language for Healing Trauma
<p>Participant 8, a 69 year-old female, shared her profound experience with an Angel. She said, “So, you know, I just get the communication from their Guides, from the Angels, and they just tell me what to do and what might be needed. Like I said, they follow me. They don’t necessarily stay during that session.</p> <p>“I had a really profound experience with the Angel of Manhattan. With 911 and after a traumatic event as that, we have, all of us, it impacts us as a collective...And, about the third or fourth year, they had put the PATH back in place, ...I went there and as I went into the PATH and went down under I could look through the fence that they still had up where they were still excavating the sacred spot. And, I just was angry. I was so angry. Why are they putting this back? Why aren’t they just putting this? This whole place is a sacred space. And, as I was looking through this fence, all of a sudden this happened. The whole PATH area which was semi-underground, where it was dark, filled with light.</p> <p>It just filled with light. When I went there I would be sending the Therapeutic Touch, but this time, in the other parts I had been sending out peace and helping the Guides help the people cross, and all of a sudden, this whole place, I was angry, it filled with light. My whole Being just filled with a sense of love, a sense of peace and calm. And, this wonderful Being filled this whole area and I was just surrounded by it and filled with it and it said to me, “it’s ok. It’s not going to be that fast. First, we need to let people realize that life has to go on. And</p>	Angels	Spirit- uality	Healing	A Language for Healing Trauma

life does go on. Second, it's going to take a long time for this to happen, and it will not be a traumatic thing. It's going to be a healing thing." And so, I just was totally, totally overwhelmed with this wonderful feeling: a sense of peace and love and healing in my own Being from this Being. And, it's true. Everything that I was told and what gave me that sense of peace was true. It did take time. It was over a period of time. And, it is a very healing space now."				
Participant 8, a 69 year-old female, also spoke of angels. She said, "I will sense their Guide or an Angel, or I will sense maybe a mother or a father figure that is there. They're the ones that are kind of guiding my hands in a sense. You know, 'go to the heart and fill my daughter with this unconditional love, and I will work through you.' And, often times when I am sensing this and I am sending that love through me from that parent, the person feels it."	Angels	Spirit- uality	Healing	A Language for Healing Trauma
Participant 8, a 69 year-old female, spoke further about Beings, saying, "When I talk about the Being I'm talking about the Being that I'm working with, but I get messages from other Beings. And, I will sense another Being there with me... These Beings, they are the ones that kind of guide me as to what the trauma is. I sense it in the other person, but then it's communicated in my mind, these Beings, to make sense of what I'm feeling with the depth of the trauma; and so, the depth of the trauma." Speaking of the recent death of a loved one, she said, "And, in that room that night was filled with all of these Beings and the Angels. It was so, even though it was dark, that room was filled with light."	Beings	Spirit- uality	Healing	A Language for Healing Trauma
Participant 8, a 69 year-old female, speaking further about Beings, said, "They will want me to relate it. Even after I've done the session, I've had the experience where this Being, as I'm meditating in the evening, or just before I go to sleep, I will get a visitation from this Being. This Being will say, 'please, tell my mother that I am so happy that she has started doing such and such again, or she really needs to have, she really needs support in this area because she's not telling you, but this is what's happening.' And when I say something to the clients, the client will say, 'how did you know that?' So, I just, the connection is there for the Beings that are surrounding the person that is coming for the healing."	Beings	Spirit- uality	Healing	A Language for Healing Trauma
Regarding the presence of Beings during cancer and chemotherapy, Participant 8, a 69 year-old female, shared: "The cancer and somebody's that gone through, the chemo and their body and what it does to their body, it's so traumatic to begin with. You just sense and you feel it and these messages come and you can sense these Beings that are trying to help you help this person. You know, to help the	Beings	Spirit- uality	Healing	A Language for Healing Trauma

nausea, to help the anger, to help these fights, to help them along their way. And then the dying process after the traumatic event of the cancer.”				
As related to her teaching, Participant 8, a 69 year-old female, had this to say about experiences with Beings. She said, “So, you know, we just need to stay in touch. And, I think for myself it’s deepened my sense of security about the fact that I have these feelings and I feel these other Beings. And, it has helped me with my students when they are kind of weirded out by the fact that they have these senses or feelings, and just validate it. And, when I have the group, they feel safe to talk about these senses and what they feel and what they can see. Sometimes they see the Beings and I see the Beings, too. If not them, their shadow, or in my mind’s eye I will see. And, I feel the Angels all around me.”	Beings	Spirit-uality	Healing	A Language for Healing Trauma
A recent experience was related by Participant 8, a 69 year-old female. She said, “Recently, I had the experience where I was teaching a class, and one of the student’s mother had just died. Now, this mother seemed to be connecting to them through me. And I just went to the person and I said, ‘I really sense, feel your mother, and she is really feeling sad for you because you’re having such a hard time with this.’ And so, I did Therapeutic Touch with her, and as I’m doing TT with her, she said, ‘I’m feeling my mother. My mother’s communicating through you. I feel my mother.’ So, this, when the class was finished I was just driven to go over and give this lady a hug. And so, I came and I gave the lady a hug, and she said, ‘my mother. That’s how my mother hugged me.’ And she said, ‘I feel my mother.’ And I told her, ‘well, it is your mother. Your mother has guided me to come to give you this hug to send you the love that she feels and the reassurance that she’s ok.’ And, it was beautiful. So, I do sense these Beings. They guide me and I feel it’s almost as though they communicate through me to their loved ones. I communicate that when I feel it’s appropriate. I will communicate in different ways.”	Beings	Spirit-uality	Healing	A Language for Healing Trauma
Participant 5, a 78 year-old female, shared, “Sense, more than feel, presences. And I can almost, I guess it’s empathy. Sometimes they’ll actually have, I can’t think of the word, they’ll go back in not kind of a hallucination, just at times to their battles, and I can sense being present with them during their memories of that, and be part of that, just in, because if I’m in a centered state I’m not going to be part of that but I can participate in that way as they go through different. I haven’t been there but I can be a participant in their hallucination.”	Supportive Presence	Spirit-uality	Healing	A Language for Healing Trauma
Participant 7, a 63 year-old female, described her experiences with Native American Indians. She said, “The most dramatic sense of an angel in my	Native American	Spirit-uality	Healing	A Language for

practice, and there have been a lot of angels hanging around, and a lot of Native Americans that I have seen off to the side and my clients have seen... So, anyway, it was this Indian that was always in my office that people commented on all the time. I finally found a picture that looked very much like him and put it up and people would say to me, 'oh, yeah, that's him!'. ”	Indians			Healing Trauma
Participant 7, a 63 year-old female, recalled, “Recently I was called into a home where a 12-year old boy was seeing spirits, and he was frightened by one that he saw in his TV room. And so, while I was saging the room and chanting and walking around and feeling the energy, I had a very strong image of a young man who looked like he might have passed in the 50s, but was an adolescent dressed in a tough kind of garb, of a 50s type of kid that like to fight, that’s the best I could say about it. And so I talked with him and asked what it was, why he was here. And he said, ‘I’m just so jealous that there’s so much love in this house, and I never knew that. So, I want to be around it.’ So, I told him he was frightening the child with his demeanor, and if he wanted to watch it and experience it, he needed to step back so that people weren’t afraid. And, I called the mother after my session, a couple of days after I called to see how this boy was doing and she said, ‘Oh, he’s been great. He walked into the TV room and played games for the next three hours after you left, and he hasn’t complained since.’ That was a visual, internal visual response to another entity.”	Native American Indians	Spirituality	Healing	A Language for Healing Trauma
Participant 4, a 61 year-old female, described her extraordinary experiences in this way. She said, “So, I think the extraordinary moments are when you get this intuition that you need to do it right away, and that being able to make a difference that the energy travels.”	Extraordinary	Release	Healing	A Language for Healing Trauma
Participant 8, a 69 year-old female, also shared an extraordinary experience. She stated, “When my husband was dying, I did Therapeutic Touch with him. He was in the end stages and semi-conscious and when I did the hand-to-heart with him, I felt his mother and his father, and his aunt and his uncle, his favorite aunt and uncle and brother. I just communicated through him. I communicated what they communicated. They communicated that they had been waiting for him and he wasn’t ready. And, I communicated through this hand-to-heart to him that I know that they’re waiting for you, that they’re going to take you and you’re going to be ok. Even though he was not wanting to go, he was fighting it the whole way with the cancer, but he was at the state where I could sense that he knew they were there. And they communicated to me that he did know. And that they had been there, but now he was	Extraordinary	Release	Healing	A Language for Healing Trauma

in the state where he had to let go. So, you know, their communication was, 'He is ready. He needs to let go.' So, I communicated to him that I know they're there, and I know that you're going to be ok. And, a few hours after that he did go. So, I felt ok that they were there. I wasn't happy that he went, but I knew that he was with loved ones that, you know. He hasn't seen his dad since he was fifteen and I just sensed when he was gone this beautiful reunion. I could feel it in his field. In his body, the field wasn't there, but in the energy he left behind on the bed, the warmth that was still in his field. I could feel that he was ok."				
Participant 2, a 65 year-old female, replied, "well, probably the most extraordinary for me is when I actually feel the presence of somebody working with me, whether it is the experience of a presence almost like overlaying me like from behind and just supporting me or just feeling the presence of somebody that supports the person that I'm working with. I suppose that's about as extraordinary as, but it doesn't surprise me."	Extra-ordinary	Release	Healing	A Language for Healing Trauma
Participant 6, a 73 year-old female, also described an extraordinary experience. She recalled, "I was doing a demonstration at a hospital ... a one hour talk, and then I pull someone from the audience who I didn't know... For some reason, I picked this woman who was way back in the room. While I was doing TT on her, I realized that she had had breast surgery. I also realized that she was going to start to cry and emote, and I didn't want that to happen in front of the large group. So I, with Therapeutic Touch, I just calmed her and grounded her, and stopped the treatment. She said to me after that 'I felt like you reached down to my soul', and so of course now I realize that that was my ISSE speaking to her ISSE. But what was extraordinary about it was that she had left the place, she had left a job where I had just started, and I was sitting at her desk."	Extra-ordinary	Release	Healing	A Language for Healing Trauma
A summary of her extraordinary experiences was provided by Participant 8, a 69 year-old female. She said, "Well, I just consider the whole process of doing TT with someone and their feeling and sensing, seeing and feeling their body just become balanced. That, to me, is extraordinary. Every time I work with somebody with severe pain and they say that the pain is reduced, or gone, that, to me, is just extraordinary. And being able to connect with the pranic, the whole pranic flow, and the depth of our being able to connect our prana with their pranic flow, our sense of heart and love with their sense of anguish and then helping it change, this is all very extraordinary to me." "What is even more extraordinary to me is being able to teach it and to have the students with their 'aha's', their 'wow, this	Extra-ordinary	Release	Healing	A Language for Healing Trauma

person really improved. I was able to facilitate balance in this other being.' So, the whole process to me is what I consider extraordinary."				
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Vita

Catherine Jirak Monetti

1956	Born December 26 in Manhattan, New York
1974	Graduated from Newtown High School, Honors, Elmhurst, New York
1981	B. S., Nursing, SUNY, Downstate Medical Center, Brooklyn, New York
1983-1984	Employed by Memorial Sloan Kettering Cancer Center, NY, Staff Nurse
1985-1987	Employed by NY Hospital, Cornell Medical Center, NY, Charge Nurse
1986-1987	Federal Title II Grant, New York University, New York
1988	The Graduate Students Organization Service Award, New York University
1991	M.A., New York University, School of Education, Health, Nursing, and the Arts Professions, New York, New York
1991	Arch Award, New York University, New York
1991	Chancellor's Service Award for Leadership, New York University, New York
1992	Part Time Faculty Award, New York University, New York
1991-1995	Employed by New York University, Nursing, New York, Adjunct Clinical Instructor
1996-1997	Employed by County College of Morris, Nursing, Randolph, New Jersey, Assistant Professor
1997-2014	Employed by Rutgers University, College of Nursing, Newark, New Jersey, Clinical Nursing Instructor, Part-time Lecturer
1997	"The Use of Gestalt in Nursing Practice"; County College of Morris; Randolph, New Jersey, Continuing Education Presentation(s)
2001	EMDR Trauma Therapy, Level I, University of Rome, Italy
2002	EMDR Trauma Therapy, Level II, Brooklyn, New York
2004	Post Masters Certificate, Gestalt Psychotherapy, The Gestalt Center for Psychotherapy and Training, New York, New York
2004-2007	"Intrapsychic Therapeutic Touch"; Continuing Education Presentations: NJ Student Nurses Convention, Atlantic City, NJ; St. John's Riverside Hospital, Holistic Nursing Department, Yonkers, NY; Jersey City Medical Center, Jersey City, NJ; The Gestalt Institute of New Orleans/NY: Metairie, LA; The Gestalt Center for Psychotherapy and Training, New York, NY
2009	College of Nursing-Educational Opportunity Fund Faculty of the Year Award, Rutgers University, Newark, New Jersey, 2008-2009
2009	NJ Nursing Initiative, Robert Wood Johnson Foundation Scholar
2012	An Exploration of <i>Intrapsychic Touch</i> ™ on the Practitioner and Recipient, Council for the Advancement of Nursing Science (CANS), Washington, DC, Poster Presentation
2013	Needs, concerns, strategies, and advice of daily home hemodialysis caregivers. <i>Clinical Nursing Research</i> , 1-20. DOI: 10.1177/1054773813495407
2014	Inducted, Honor Society of Nursing, Sigma Theta Tau International
2014	Ph.D., Nursing, Rutgers University, Graduate School, Newark, NJ