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SOMATIC COUNTERTRANSFERENCE EXPERIENCES OF NURSE THERAPEUTIC TOUCH PRACTITIONERS: A CONTENT ANALYSIS PART 2: IMAGERY

Catherine Jirak Monetti**,** PhD, RN, CNE, QTTP
Doris Ezomo, MSN, MPA, RN
Dorothy C. Nwanonyiri, MSN, RN-BC

ABSTRACT:*This Part 2 qualitative research report describes somatic countertransference (SCT) imagery experiences of nurse Therapeutic Touch practitioners. Defined by Orbach and Carroll (2006), SCT is "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). Though a common phenomenon, imagery during SCT has been poorly articulated or explicitly investigated. Use of purposeful sampling recruited eight experts. Audiotaped sixty-minute face-to-face in-depth interviews were conducted using a semi-structured interview guide with six open-ended questions. Sandelowski's (2010) preferred method of latent content analysis produced codes and subcategories grounded exclusively in the saturated data (Krippendorff, 2004). Ten subcategories and three categories were inductively generated. Consensus on coding and data analysis led to the emergent theme, "A Language for Healing Trauma." Consistent with social science communication research (Krippendorff, 1989), SCT imagery was found to be a factor in the healing of trauma, experienced during the verbal and nonverbal communication of one group of nurse TT practitioners in interaction with traumatized clients. Study findings contribute to the academic debate about the self/other distinction in neuroscience, nursing, psychology, and philosophy.*

KEYWORDS: somatic countertransference, imagery, embodiment, Therapeutic Touch practitioners, trauma therapy

INTRODUCTION

All humans experience some level of trauma – with or without a catastrophic event involved. Patients are frequently encountered in clinical practice at considerable cost. Current trauma treatment is only palliative and does not cure. Prevalent use of exposure-based therapies and pharmacotherapy are not universally effective. More efficient, cost-effective approaches that do not re-expose the client are needed. Further studies are warranted to test treatment approaches for PTSD, especially those incorporating embodied healing (Ray, 2009).

A newly, yet poorly, articulated phenomenon (Shaw, 2004a; 2004b), somatic countertransference (SCT) is distinct from the traditional notion of countertransference (CT; Freud, 1910; Schroder, 1985). Orbach and Carroll (2006) have defined SCT as, "the therapist's awareness of their own body, of sensations, images, impulses, and feelings that

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offer a link to the client's healing process" (p. 64). Used by therapists as a clinical tool, body sensation and body knowledge are regarded as valuable communication from the client's body manifestations and unconscious messages (Jakubowski, 2012). Through the phenomenon of SCT imagery, in part, TT practitioners access clients' bodily-stored trauma without their re-exposure to it. Psychotherapists are already incorporating TT into their practices (Macecevic, 2008).

Despite evidence of their common occurrence in the therapeutic encounter (Vulcan, 2009; Athanasiadou & Halewood, 2011), somatic phenomena in the CT have undergone minimal empirical investigation. Nor have imagery experiences during SCT been explicitly investigated. The perceived inadequacy of language to describe SCT has posed a challenge similar to the expression of the non-linear experience of Therapeutic Touch (TT) and human memory (Krieger, 1979; Samarel, 1992).

Purpose of the Study

The purpose of this qualitative investigation was to address paucity in the literature. Its aim was to more fully illuminate the nature of the SCT imagery phenomenon as described by a purposive, but small, group of expert nurse TT practitioners. This Part 2 research report recounts their imagery experiences during their work with traumatized clients. Description of SCT imagery experiences will further its definition and elucidate prior research in the fields of cognitive and social neuroscience, psychology, and philosophy. Clearer articulation of SCT will also strengthen TT's adjunctive role in trauma therapy.

THEORETICAL UNDERPINNING

A qualitative research design was chosen for this study because the nature of the SCT phenomenon is lived human experience. The interpretive paradigm was viewed most suitable because of its potential to generate new understandings of the complex multidimensional and human phenomenon of SCT.

Krippendorff (1980) emphasized the relationship between the content of texts and their institutional, societal, or cultural contexts (Weber, 1985). Krippendorff (1989) later noted "Content analysis (CA) is indigenous to communication research and is potentially one of the most important research techniques in the social sciences." He added, "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). In this study, CA occurred within the context of nurse TT practitioners' interaction with clients; description of their SCT experiences; and, the meanings they attributed to them (Krippendorff, 1989). Analysis of the content of the texts was also situated within the institutional, societal, and cultural contexts (Krippendorff, 1980) of current trauma treatment.

As per Krippendorff's (2004) definition, the goal of this qualitative CA was "to provide knowledge and understanding of the phenomenon under study" (p. 314). In common with interpretive approaches, CA required a close reading of textual matter (Krippendorff, 2004). In this exploration of the distinctly human phenomenon of SCT, the researcher remained as

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faithful to its essence as possible. A systematic classification process of coding and identification of subcategories, categories, and a theme comprised the subjective interpretation of the text data generated from interviews with study participants (Hsieh & Shannon, 2005). In a reflexive and interactive manner, treatment of the data was continuously modified to accommodate new data and new insights about it (Sandelowski, 2000).

The SCT imagery experiences described were initially explored with Orbach and Carroll's (2006) definition of SCT. Study participants were asked to provide a description of any thoughts, feelings, body senses or sensations, images, perceptions, and all other forms of inner life subjectively experienced (Bugental, 1976). They were allowed to describe what they believed are experiences of SCT, including the receipt of imagery (Raingruber & Kent, 2003). The method of latent CA, described by Sandelowski (2010), allowed for a description and preservation of nurse TT practitioners' unique SCT imagery experiences in their own words. CA revealed the underlying meaning in the TT participants' interactions with traumatized clients as they glimpsed into their reality. Its use in this study was therefore supported.

Further description of the SCT imagery phenomenon will 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 health care practitioners in ways to increase its effectiveness. Study findings can also contribute to the academic debates about the distinction between traditional CT and the more recently articulated SCT, and the origins of imagery in the therapist.

Reflexive Stance

This study was undertaken as a quest to identify the phenomenon consistently experienced for twenty years by the researcher, her nursing students, and professional colleagues while practicing TT. Specifically, the aim was to locate in the literature experiences of unsolicited, spontaneous imagery reported by other practitioners. Of her thirty-three years as a Registered Professional Nurse, twenty-six have been spent in Nursing Education. Trained in TT by Dolores Krieger, PhD, RN, she is a certified Qualified TT Practitioner (QTTP), holds a Post Masters certificate in Gestalt Psychotherapy, and is a certified Clinical Nurse Educator (CNE). In this study, the researcher's pre-existing expectations and self- and others' experiences were acknowledged and then kept in abeyance (Patton, 1980).

Research Questions

The research questions and objectives reflected the researcher's own interest regarding how SCT and related imagery is subjectively experienced and understood by other TT practitioners and professionals. They were intentionally broad and open-ended to protect the qualitative potential for new insight on SCT imagery to arise directly from the data. Semi-structured in-depth research questions for this study were:

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***Main Research Question #1*:**

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

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

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?"

This Part 2 research report presents findings related to the main research question and sub-research question #4. Other findings have been reported elsewhere (Monetti, Ezomo, & Nwanonyiri, 2016).

LITERATURE REVIEW

To achieve theoretical saturation, the researcher undertook an exhaustive review of the literature from several disciplines: nursing, counseling psychology, neuroscience, and philosophy. Terms synonymous with CT and SCT were searched: body-centered CT, embodiment, embodied CT (Jakubowski, 2012), embodied simulation, embodied empathy embodied transcendental empathy (Macecevic, 2008), kinesthetic empathy (Pallaro, 2007), and mind-body connection (Paley, 2004). Research conducted on CT has been more theoretical than empirical in nature. Empirical research on SCT is in its infancy. Vulcan (2009) attributed the paucity to controversy surrounding the definition of the SCT 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 CT, the traditional psychodynamic concept (Rumble, 2010). Therefore, a negative stereotype of interference with the therapeutic alliance previously prevailed. The literature search revealed no studies investigating SCT imagery exclusively. Any references located were deeply embedded in qualitative text. Since research on SCT imagery is scarce, this investigation was warranted.

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Guided Imagery

The type of SCT-related imagery explored in this research study is distinct from the traditional use of guided imagery (GI) in nursing (Heinschel, 2002). The benefit of GI has been well established in psychiatric mental health (PMH) nursing (e.g., Jallo, Bourguignon, Taylor, & Utz, 2008). Farr (1990) developed a specific type of GI, designed to facilitate the generation of spontaneous imagery in clients during counseling. For five female clients she reported the intervention facilitated exploration and disclosure of deep emotional material that may not have been uncovered for many sessions with verbal interaction alone.

Countertransference (CT) & Imagery

Casement (1985) stated the clues to recognizing CT reactions are sometimes experienced as feelings, moods, or thoughts; sometimes as unbidden, or spontaneous, images, fantasies, or sounds. In other words, as appearing to embody something that "belongs" to the patient.
Samuels (1985) examined the CT experiences of twenty-six psychotherapists, covering fifty-seven cases. Stimulated by communications from the patient, all were regarded as images, true even of the embodied or feeling responses. This was because they were active in the psyche in the absence of a direct stimulus.

Regarded as a clinical tool by participants in Jakubowski's (2012) study, CT, including physiological responses, was exemplified 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 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).

A careful scrutiny of the literature on TT revealed only a few results deeply embedded in the text. Quinn (1989) provided an example of an experience of resonant imagery between a TT practitioner and recipient. 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." 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. The baby just slept, filled with love and peace…the patient appeared to be asleep during the session" (p. 24).

Heidt's (1990) qualitative descriptive study also reported experiences of resonant imagery. Combining TT with psychotherapy techniques to help in patients' healing processes, Heidt (1991) noted "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). She alluded to nurses picking up on a client's unconscious material while focused on patients' involvement in the creative imagery that emerged. Similarly, Csordas (1994) described the phenomenon of separate, but complementary images, experienced simultaneously by both the healer and client. His

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phenomenological study explored the experiences of CT-related imagery in a group of Charismatics (*n* = 587) in southeastern New England who practiced TT. Merleau-Ponty's (1964/1968) philosophical ideas were used to understand an embodied process of perception as "embodied imagery." Csordas' (1994) research findings presented the role of spontaneous imagery as tapping unconscious processes. He indicated revelatory imagery in the healer was experienced as a nonverbal sensory image, signifying healing is occurring. Two hundred eighty-seven examples of symbolic images reported by healers were interpreted as the enduring consequences of traumatic events, subcategorized in terms of origin in childhood or adulthood.

Embodiment, Embodied Empathy, & Embodied CT

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). The holistic process of Authentic Movement, used in individual and group dance therapy settings, was 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.

Panhofer (2011) examined the extent to which the lived, embodied experience can be worded. Building on the idea of an embodied cognition and the embodied mind, he demonstrated the importance of nonlanguaged ways of knowing. He concluded that crossing over modalities, and thus brain hemispheres, allows access to valuable, and even unconscious, material from the clinical work. Examining the challenges of doing holistic trauma work, Ben-Shahar (2012) further explored relational perspectives and their relevance for body-oriented psychotherapy. He posited 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. Blum (2015) proposed 'embodied mirroring' (an experiential, relational, body-based technique) is particularly useful with traumatized clients or those with problematic attachment histories. Helping clients unfold preverbal stuck points, it is therapeutic for those who present with limited adaptive resources, lack words to describe their experience and are affectively shut down or disconnected. He presented three case examples illustrating how the therapist consciously, explicitly, and intentionally mirrors a client somatically to promote the therapist's embodiment of the client's experience and foster the emergence of conscious SCT experiences. His findings were discussed in the context of theory and mechanisms underlying embodied mirroring: mirror neurons, infant intersubjectivity, affect attunement, and regulation, attachment, and relational dynamics.

Dalziel (2014) explored the empathy experience of eight psychotherapists, each with a substantial personal practice of mindfulness meditation. Semi-structured interviews were used to collect data. A qualitative, phenomenological analysis provided the framework to categorize,

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organize thematically, and review data in the context of current literature. Receptivity as an underlying and unifying intention emerged as a theme. Mayer (2015) identified the embodied nature of the therapeutic relationship as being a much under-researched area. Using an Interpretative Phenomenological Analysis (IPA; Smith, 2008) approach of the participant interviews, he qualitatively explored four bodywork practitioners' lived experiences of embodied relating during therapeutic relationships while working in complementary healthcare.

Somatic Countertransference (SCT) & Imagery

In psychoanalytic theory the body has been explored as a "tool," offering a kind of portal into the psyche of the patient through the operation of various forms of SCT (e.g., Orbach, 2004; Stone, 2006; Dalziel, 2014). To this researcher's knowledge, however, there are no studies that have explicitly investigated the imagery aspect of SCT exclusively.

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 (van Manen, 1990) 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. Using quantum physics, Smyth (1995, 1996) conducted a hermeneutic phenomenological study to explore the healing phenomenon during TT. Participants 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.

Forester (2007) also noted that SCT can sometimes be recognized by feelings, moods or thoughts and sometimes by spontaneous images. Macecevic (2008) discussed embodied CT as involving the meeting of two individuals in the realm, the *mundus imaginalis* (Corbin, 1972) where images take the place of language, enabling the therapist to gain "in-sight." It can be experienced through the eyes, the body, or the emotions (Schwartz-Salant, 1991). Macecevic (2008) observed 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.

Dalziel (2014) exemplifies, "There are sometimes moments when understanding of the other deepens beyond what I can easily explain. I seem to experience the other's feelings directly in my own body or recognize patterns, history, or meanings that do not appear to come from interpreting the words and gestures that are exchanged" (p. 112). Though this experience may be combined with aspects of the therapist's own unconscious material, it can nevertheless, with careful discernment and management, become fertile content in the psychotherapeutic process, and a legitimate and useful component of empathic exchange.

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Mirror Neuron System (MNS), Empathy, & Intentionality

The research on mirror neurons and empathy is in its early stages. The role the mirror system plays in intention understanding is still unclear as to its nature and extent (Arizmendi, 2011). He elaborated, "The complex process of relating along implicit, nonsymbolic and/or nonverbal symbolic pathways is one only beginning to be comprehended" (p. 417). He stated the therapist must *imagine* the perspective of the patient, and tune into the ubiquitous current of nonverbal communication. Linking images and empathy, Arizmendi (2011) noted physiological and emotional synchrony are automatic processes driven primarily by the brain's mirror system and constitute necessary but not sufficient conditions for empathy. At the same time, voluntarily imagining, when necessary, may enhance our ability to self regulate, preventing a loss of self-other differentiation. He concludes it is imperative that we attend carefully to the evoked imagery that is generated within the intersubjective consciousness of the two participants (Arizmendi, 2011).

To exemplify he presented a clinical vignette recounting the imagery of the therapist and its relationship to both the empathic process and emotional contagion. He illustrated how "the affective involvement of the therapist with his patient leads to the formation of images – 'mental signals' that are informative as to the emerging, moment-to-moment experience of both participants "(p. 411). He recounted how during one session he grew aware of unpleasant smells in the room – when there were none. Attempting to explain his olfactory images, he asked the patient if this held any significance for her. In response, she described the adverse childhood effect her father's obsession had had on her. Arizmendi (2011) states examples of nonverbal communication such as these are not uncommon in the literature (Arizmendi, 2008). In the case presented, he conjectured his "olfactory image equates to a medium of communication between him and the patient whereby the latter's nonsymbolic experience of shame and humiliation was 'made known' to him" (pp. 405-406). Elaborating further, he stated, his "sensorial images are not random…the images the therapist experiences are 'critical' as a means of communicating *his version of the patient's experience*" (p. 413). He further observed, "As the experiences of both patient and therapist reverberate in enhanced states of resonance, the imagery continues to move toward greater specificity" (p. 415).

Dalziel (2014) also rendered a clinical description to illustrate the extent to which a therapist's experience of resonance with a client can inform his understanding of the other. One of his study participants recounted, "I was working with a client and was really there with them, and suddenly I had an image of a fire! Taking a risk, I told the client, and then asked, 'How does that fit for you?' The client just started to cry, and then talked about their family, and how their house had burned down…this opened up a whole other body of feeling for them" (p. 112).

Corradini and Antonietti (2013) concluded a "vast array" of empirical data now appears to confirm that "mirror neurons are the neural basis of our empathic capacities" (p. 1152). The mirror neuron concept was originally limited to imitation (thus, intention-informed) of motor action. A study investigating mirror neuron function in empathy shifted the focus from simple motion to emotion. Aragona, Kotzalidis, and Puzella's (2013) eidetic study

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demonstrated the phenomenon of empathy is characterized as an intentional act similar to a perception. In Dalziel's (2014) exploration of empathy, five participants expanded their previous descriptions of empathically "sensing" the other to include subjectively embodied experience that often relates in specific ways to the content of a client's disclosures. One therapist, for example, suggested her felt sense of the other's experience arose from her capacity to access a "body resonance." This frequently offers her important, sometimes quite literal, information about the client's experience (Dalziel, 2014).

METHODOLOGY

This study used a qualitative descriptive design to examine the SCT imagery experiences of expert nurse TT practitioners. Within the interpretive paradigm, a semi-structured interview guide helped elicit their descriptions, in their own words, of their SCT and imagery experiences during healing work with their traumatized clients. Deductive CA initially formulated the research questions; coded the narrative data; and, identified subcategories (Patton, 2002). Inductive latent CA produced categories and a theme (Sandelowski, 2000, 2010). These, in turn, offered further description of the minimally articulated and researched aspects of SCT phenomena, including imagery, experienced by the practitioner.

Research Setting and Sampling

Naturalistic in design, the phenomenon of SCT imagery 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. The goal of the researcher was to reach 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). Data saturation was achieved after eight interviews. The purposive sample of eight nurse TT practitioners were voluntarily recruited from: 1) the professional organizations, Therapeutic Touch International Association (TTIA), and the American Holistic Nurses Association (AHNA) subsequent to receipt of respective Agency Letters of Permission; 2) public listings on the internet; and, 3) word-of-mouth (snowball sampling) (Thomas & Pollio, 2002). 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.

Inclusion Criteria

Criterion sampling (Creswell, 2007) was utilized to select participants who met the pre-determined inclusion criteria of significance (Patton, 2002): 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). 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

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engagement with healing is less a matter of time practicing (Hemsley & Glass, 2006) than intention to do so (Krieger, 1979a, 1979b).

Procedures for Data Collection

Ethical approval for protection of human subjects was obtained from the Rutgers University Institutional Review Board (IRB). Two Informed Consents were signed: one for study participation and one for Audio Taping. There were no anticipated physical risks to study participants due to the exploratory nature of the 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. Study participants were told verbally and in writing 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.

Participants' confidentiality was maintained through the use of a separate, new blank audiotape for each interview. Verbatim transcriptions were completed by a third party 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, and then shredded.

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. 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. Additional questions or prompts 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.

In addition to data collected from the semi-structured interview, three types of data were generated: the transcript file, a field notebook, and a reflective journal. The latter included observations; 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 (Minichielllo, Aroni, Timewell, & Alexander, 1995).

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Analysis of Data

Since prior research about SCT is limited and further description of the SCT phenomenon is needed, a directed CA 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. An inductive approach was then used to code the data, formulate the subcategories and categories, and generate a theme (Sandelowski, 1995, 2010).

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).

Coding of Qualitative Data

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, 2008). All data were taken into account in the analysis process (Sandelowski, 1994).

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 Figure 1. SCT: A Language for Healing Trauma.

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

Figure 1. Coding Framework

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(Graneheim & Lundman, 2004, p. 108)

Figure 1. Coding Framework

Conceptualization of the Manifest Content

Analysis of the interview transcripts identified three main categories that led to the emergent theme, SCT: A Language for Healing Trauma. The Structure-Process-Outcome constructs in Donabedian's Model (Donabedian, Wheeler, & Wyszewianski, 1982) were used to link the manifest content in the text. The first two constructs contain indirect measures that influence the third direct construct, outcome, with all three linked. The nurse TT practitioner, as Structure, defined quality. It influences the human component in health care and also describes the context in which nursing care was delivered (Lorentz & Finnegan, 2013). The Nurse TT Practitioner category was subcategorized as: Experiences, Visualization, and Qualities. Communication, as Process, denoted the transactions between clients and TT providers during the delivery of healthcare (Lorentz & Finnegan, 2013). The Communication category was subcategorized as: Awareness, Boundaries, Information, and Mode. Healing, the Outcome, is the endpoint of the communication process. This assumes the highest priority for the trauma population-at-large (Choi, Flynn, & Aiken, 2011). The Healing category was subcategorized as: Trauma, Spirituality, and Release (See Figure 2).

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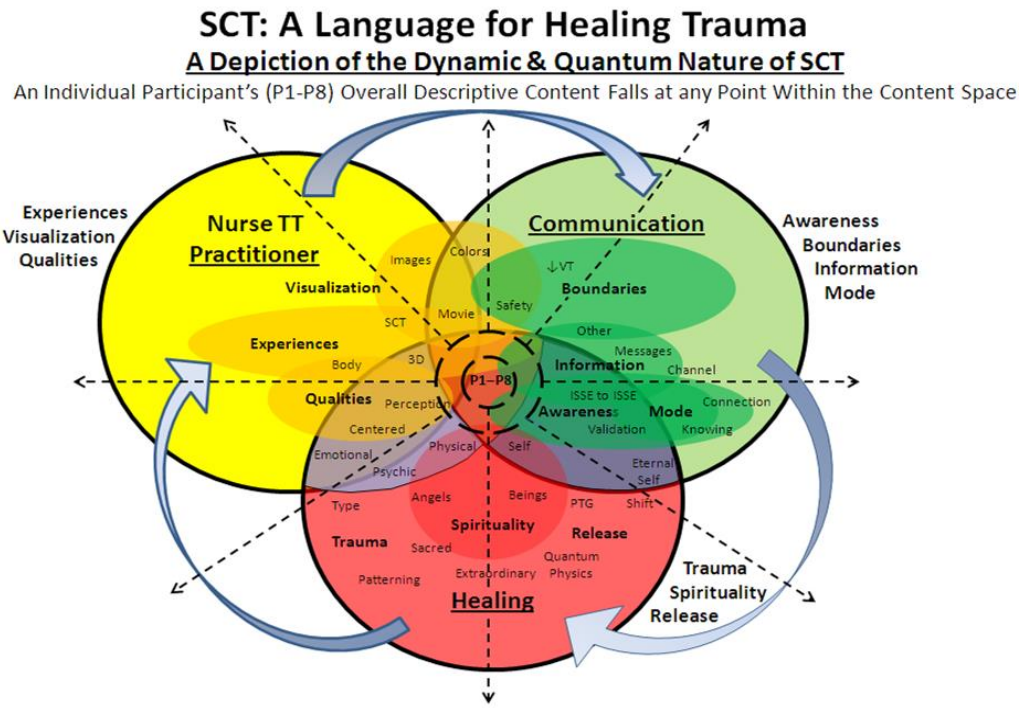

Figure 2: Conceptualization of Major Theme

Methodological Rigor

Rigor was demonstrated through clarity in the data collection and data analysis processes. Trustworthiness of the data was assured by addressing issues of credibility, transferability, dependability, confirmability, and authenticity (Guba, 1981; Lincoln & Guba, 1985; Denzin & Lincoln, 1994; Morse & Field, 1995). Credibility was enhanced by creating a purposeful sample of eight nurse TT practitioners who could represent the SCT phenomenon under study through a vivid and faithful description of their experiences of it. In-depth descriptions, in participants' own words, of SCT experiences were included in the final text. Participants' validation of the exhaustive descriptions achieved credibility (Dobbie, 1991). This also enabled a better understanding of the concept of SCT (Creswell, 2007; Hsu, 2006). Additionally, the researcher worked closely with members of her dissertation committee to achieve consensus on coding and results of data analysis; hence, representativeness of the data. (Sandelowski, 1986). During the "Memoing" phase of the audit trail (Forman & Damschroder, 2008) the researcher's early thoughts and hunches were recorded on the transcripts. Described were subcategories and the connections among them developed through inspection of the data. Categories and themes that begin to emerge were identified, coded, and honed. This trail of the researcher's analytic processes added further credibility to the final analysis and conclusions (Forman & Damschroder, 2008).

Confirmability was achieved through the study findings being shaped by the participants' own descriptions of their SCT experiences, rather than from the researcher's biases (Polit &

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Beck, 2008). Similarly, both investigator and methods triangulation (Denzin, 1970; Roe, 2013) were used. The researcher's analysis of the same qualitative data was read by another researcher, and the findings discussed. Methods triangulation included the use of fieldnotes which also included participants' feelings or moods expressed during interviews. The context was described sufficiently so that readers can judge for themselves the applicability of the research findings to their own contexts (Seale, 1999). 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.

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). 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 own practices (Polit & Beck, 2008).

RESULTS/FINDINGS

Demographics of Study Participants

The purposive sample of eight nurse TT practitioners was recruited from across the United States: Arizona, Utah, California, Oregon, Indiana, and New Jersey. They comprised a homogenous sample of experts. Their ages ranged from 61 to 78 years (*M* 67.13, *Md* 66). 100 % were female. 75 % were white. They were well-educated (50.0 % Masters degree, 12.5 % Doctoral degree), and 87.5 % had been practicing both nursing and TT for more than 16 years. 62.5 % of the participants held TT Qualification. 87.5 % engaged in holistic practices other than TT (See Table 1).

Table 1. Demographic data gathered during face-to-face interviews: Nurse TT Practitioners (*n*=8)

Partic-ipant #	Age[a]	Marital Status	TT[b] Practice	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

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[a] years of age at the time of the interview
[b] years

Research Question(s) & Selected Findings

Major Theme

The major theme 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, it was found to be a regularity developed through condensed meaning units. The theme is consistent with communication research in the social sciences (Krippendorff, 1989).

Categories

I. Nurse TT Practitioner (Structure)

The nurse TT Practitioner during the nurse-client encounter with traumatized clients provides the structure for the SCT phenomenon. Three subcategories comprised this category: Experiences, Visualization, and Qualities. Study participants described their experiences in response to prompt questions #2 (body), #3 (perception), and #4 (visualization).

A. **Subcategory – Experiences – Body Code**

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."* Similarly, another nurse TT practitioner stated, *"less body experience comes with more experience, and is replaced by more images, sight, light, feelings, and thoughts."*

B. Subcategory – Visualization – Imagery Code

Describing the TT distance healing with the victim of a university shooting, Participant 4 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."*

Referring to her work 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."*

Work with paraplegic or stroke patients was described: *"seeing them swinging or skiing, engaged in something they formerly loved to do."* This was interpreted as, *"helping them to get in touch with a place of wholeness, timelessness, and joy."*

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."*

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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, *"…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?'"*

Discussing other 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."*

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."*

C. Subcategory – Visualization - Features of Images, Holographic, Movie, & Cartoon-like Codes

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 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."*

Participant 1 spoke of the photographic-like quality of her imagery. She 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 described her imagery as having a movie-like quality: *"There are times when*

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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."*

Participant 1 spoke about the cartoon-like quality of her imagery. She 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."*

D. Subcategory – Visualization – Colors Code

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."*

Participant 8 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.*

E. Subcategory – Visualization – Anatomical (Body) Parts Code

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."*

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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."*

F. Subcategory – Visualization – Guided Imagery Code

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."*

II. Communication (Process)

A. Subcategory – Trauma – Childhood, Dissociation, & Psychic Codes

Participant 7 shared, *"I have seen incidents of sexual abuse or physical abuse to people when they were children or young adults."* Participant 1 described a clinical experience: *"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 also mentioned dissociation. She said, *"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.

B. Subcategory – Trauma – Type Code

Describing her experiences with veterans who have had an amputation, Participant 5 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."* Participant 8 spoke similarly about amputations: *"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 8 added, *"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."*

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C. Subcategory - Trauma – Physical Conditions Code

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."*

Participant 7 described her clinical experience: *"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."* Similarly, Participant 2 related, *"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."*

D. **Subcategory - Trauma – Diagnostic Aid Code**

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."*

E. Subcategory – Spirituality – Angels, Beings, & Supportive Presences Cods

Participant 7 shared: *"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, 'So did I' and she got a clean bill of health within a month. That was undoubtedly the most dramatic."*

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*

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angelic presences and other helpful Beings at other times. That's something to explore more."

Describing Supportive Presences, Participant 2 shared: *"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."*

DISCUSSION

Therapeutic Touch (TT)

TT is currently defined by the Therapeutic Touch International Association (TTIA; 2017) 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 in all aspects of the individual: body, mind, and spirit." (http://www.therapeutic-touch.org). TT is derived from the ancient practice of human touch or laying-on of hands. It 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 (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). In humans, *context* seems to be critical in the comprehension of intentions (Arizmendi, 2011). In the context of psychotherapy, therapist mindfulness also implies an intention and a skill set that closely align with a traditional understanding of therapeutic empathy (Dalziel, 2014). In this study, the participants worked in the context of TT, utilizing both compassion and intentionality in their practice of it.

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, mental health and home care. Administered to people of all ages, veterans are among those benefiting from TT. 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), including substance abuse treatment (Hagemaster, 2000; Larden, Palmer, & Janssen, 2004). A February 14, 2017 American Holistic Nurses Association Press Release announced that the North American Nursing Diagnosis Association – International (NANDA-I) has approved a rephrased "Imbalanced Energy Field" nursing diagnosis (previously known as "Disrupted Energy Field" (www.ahna.org). This nursing diagnosis will support registered nurses performing energy modalities in documenting their clients' responses.

As related to TT, Schulz (1998) discussed the brain as the chief interpreter and processor of intuition. 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 (Schulz, 1998). Panhofer

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(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 both brain hemispheres are stimulated bilaterally. The nurse TT practitioners' descriptions of their SCT imagery experiences could be viewed as representing a non-languaged way of knowing (Panhofer, 2011) that expresses the lived, embodied experience of nonverbal, perhaps unconscious, memories stored in the body.

Mirror Neuron System (MNS) & Embodied Simulation

Deconstructing the emotional relationship between patient and therapist is a formidable task (Arizmendi, 2011). Embodied therapy throws into question the separation between world and perceiving subject, as well as between one subject and another (Totton, 2015). Other-awareness requires external perception. This is the assumption that the mental life of others can only be given to us in a mediated fashion. The Mirror Neuron System (MNS) mediates this process at the neural level (Arizmendi, 2011).

Gallese (2003) introduced the notion of "'embodied simulation' wherein the observer (therapist) automatically and nonconsciously can 'penetrate the world of the other'" (p. 174). For Iacoboni (2008), MNS theory presumes that "embodied simulation functions as a prereflexive mechanism operating involuntarily and out of awareness, an '*effortless*, automatic and unconscious inner mirroring' that generates a 'first-hand,' felt sense of the other's world" (p. 120). This perspective permits the self/other distinction to be overcome, solving the old problem of where the 'I' and 'you' perspectives of human experiences meet each other (Balugani, 2008). Gallese (2006) conjectured through this mechanism a *shared manifold* would emerge as an *interpersonal space* in which our skills of sharing experiences with others can take place. This is very close to the concept of empathy, even if 'being in the other's shoes' means the self predisposition to reach their phenomenological horizon, rather than *really* feel their emotion (Balugani, 2008; Gallese, 2014).

Arizmendi (2011) remarked" the process helps to inhabit states that increasingly approximate that of the patient (empathy), but it can also be useful in the self-regulation process when the therapist intentionally creates an internal state(s) that essentially distinguishes herself from the patient. This, therefore, creates or reinstates a healthy self-other boundary" (p. 416). Study findings may help further refine theories of embodied simulation as related to the MNS.

Use of Touch in Therapy

The use of TT as a nursing intervention 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. New empirical evidence suggests the first-person experience of being touched on one's body activates the same neural networks activated by observing the body of someone else being touched (Blakemore, Bristow, Bird, Frith, & Ward, 2005). According to Aragona, Kotzalidis, and Puzella (2013), the overlap of brain regional activity during action, emotion or ideation between two persons, one of whom is just observing or imitating the other, offered to clinicians and philosophers dealing with empathy a "brain

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signature" of the phenomenon. The observation of someone being touched or suffering in a body part is translated in an embodied simulation of them in the mirror system of the observer. Even the simple imagination of being touched or suffering in that body part elicits a similar embodied simulation (Balugani, 2008; Gonzalez-Liencres, Shamay-Tsoory, & Brune, 2013). Taipale (2015) states perceiving gestures is akin to perceiving the intentions of others. Arizmendi (2011) discussed the controversy over whether the brain's automatic mirroring system allows us to understand not only actions but the *intentions* of those actions. He notes the role the mirror system plays in intention understanding is still unclear as to its nature and extent.

For clients who have experienced complex trauma (exposure to multiple traumas or prolonged exposure to extreme levels of stress), there is a clear body/mind split that might best be addressed as it is prior to attempting an integration. Trauma is felt and held in the body; therefore, to avoid or "block out" feeling any part of the trauma, clients also avoid or "block" their embodied experience. Under these circumstances, even mindfulness applied as *attention to* the body can feel overwhelming and possibly re-traumatizing. Tantia (2012) proposes mindfulness may best begin from outside of the body, rather than start with attention directly to the body. TT practitioners begin by obtaining the unconscious permission of the client, and then immerse themselves in a state of centeredness; in other words, mindfulness.

Information Processing (IP) Theory & TT

Mayer (2015) notes the rapidly evolving contributions from neuroscience, attachment theory and developmental psychology that have seen the introduction of more widespread somatic approaches within psychotherapy. Predominantly, these have been in response to findings that client trauma is often rooted in their preverbal experiencing of the world that hinges on their somatic memory (Mayer, 2015). Some developmental experiences may be unconscious because the child's emotions, behaviors, or relational needs were never acknowledged within the family. This is often the situation with childhood neglect. When there is no conversation that gives meaning to the child's experience, it may remain as physiological and affective sensations but without social language (Cozolino, 2006). Psychotherapy that integrates a focus on body sensations and affect provides can address that which has never been acknowledged by creating a verbal narrative that reflects the body's story (Erskine, 2014). This is particularly relevant for research into trauma and the experiences of children who are not cognitively able to remember the details of their early abusive experience.

Brewin, Dalgleish, and Joseph (1996) argued that trauma recovery must involve the transformation of situationally accessible memories (SAMs) into verbally accessible memories (VAMs). Among Information Processing (IP) theories, dual representation theory distinguishes between conscious and non-conscious processes (Brewin, Dalgeish, & Joseph, 1996; Elzinga & Bremmer, 2002). In this model, conscious VAMs contain information about the sensory features of the traumatic situation, the emotional and physiological reactions experienced, and the perceived meaning of the event. Kenny and Bryant (2006) noted VAM memories are integrated with other autobiographical memories and can be deliberately retrieved, appraised and verbalized when necessary. In contrast, SAMs contain information

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that has been obtained from lower-level perceptual processing of traumatic events and from the person's bodily responses, with 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). They can only be accessed involuntarily and are triggered by internal and external trauma reminders. When triggered, these memories contain strong emotional and physiological responses akin to those experienced during the trauma (Kenny & Bryant, 2006). The conversion of SAMs into VAMs results in trauma memories being available for conscious retrieval and reduces the frequency with which they are triggered by external cues. It also reduces the physiological and emotional intensity of trauma memories (Kenny & Bryant, 2006).

Hypnagogic images which occur while the person is in a relaxed but conscious state are preconscious, preverbal, and visual symbols that have a motion picture quality (Singer, 1974). They can be watched with the mind's eye. In this study, images were similarly described by participants as "movie-like." The state of relaxation during TT may promote the emergence of spontaneous images in the practitioner as one way of accessing and integrating the verbally inaccessible, difficult-to-communicate SAM system. It is therefore reasonable to speculate that the nurse TT practitioners' images, described in this study, may have served to bypass, and compensate for, blocked images and affect in the client. The further elucidation of SCT imagery may contribute to, and help further refine, current IP theory. Study findings offer further evidence.

Academic Debate

There is current discourse and much discussion in the literature about therapists' claims their experience of unsolicited, spontaneous imagery is a manifestation of unconscious material in the client. The legitimacy of attributing thoughts and feelings in the practitioner to the client is a continued source of interdisciplinary and academic debate involving philosophy, psychopathology, and the neurosciences (Aragona, Kotzalidis, & Puzella, 2013). The general reluctance stems from traditional psychoanalytic theory. All CT experience was formerly thought to be attributable to the analyst alone, and viewed an obstacle to psychotherapeutic process. More recently however, theorists have adopted a more liberal view, one that sees the full spectrum of therapist experience as potentially meaningful in terms of the psychic state of the client. Taipale (2015) attributes phenomenologists, over two decades, to having established a firm foothold in this ongoing debate by proposing a direct perception account.

The possibility of immediate access to another's mental life poses formidable philosophical questions (Taipale, 2015). According to Iacoboni (2009), neural mirroring solves the "problem of other minds" by making intersubjectivity possible (p. 653, as cited in Dalziel, 2014). During this state, images are typically not random but emanate from two related but separate sources: (1) the emotional state of the other; and (2) reactions to cocreated intersubjective events evolving in the treatment process. Because the images each person experiences are imbued with his unique autobiographical footprint, we are virtually *never* able to know his precise subjective state; nevertheless, images represent a critical path toward deepening our

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understanding (Arizmendi, 2011). Shaw (2004a; 2004b) had emphasized that therapists' imagery experiences be verified with the client. The nurse TT practitioners described sharing experiences with clients, and receiving validation of them.

STUDY STRENGTHS

The research design and methodology of this study incorporated the rigor of qualitative inquiry; thereby, a strength. First, in this study where the straight description of SCT phenomenon was desired, a qualitative descriptive approach was an appropriate method of choice (Sandelowski, 2000). 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 CA was grounded in the total and actual data. Second, an additional strength was the method of data analysis. Qualitative data from verbatim transcription of in-depth, face-to-face interviews was analyzed using the method of CA described by Sandelowski (2000, 2010), preferred for qualitative inquiry (Sandelowski, 1995). Inductive CA produced subcategories and categories that described the manifest content of what the text said; one main theme expressed its latent content (Sandelowski, 1993, 1995). Third, the theme that emerged from the text, "A Language for Healing Trauma," was consistent with communication research in the social sciences (Krippendorff, 1989). Fourth, the CA 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. 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. Fifth, 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. These sensitizing concepts from the definition (Patton, 2002) initially guided the CA of the manifest content of the interview text. Prior to the gathering of qualitative data, four pilot interviews were conducted 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. Sixth, 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. Seventh and finally, the methodological rigor of this study will lend support to additional studies. The method of data collection and analysis therefore added strength to the study.

STUDY LIMITATIONS

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Although the qualitative findings provided thick, rich description of the minimally understood phenomenon of SCT and related imagery, several limitations were identified. First, although the nurse TT practitioners were experts, 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. Second, the use of purposive sampling could be viewed as a possible limitation because the sample was potentially biased by the selection process. 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. Third, although this research study contributes to existing literature regarding SCT, findings cannot be transferred. Time and financial constraints impacted participant recruitment. The small sample size of eight limits transferability to and representativeness of the larger population. Although data saturation was reached, a larger sample would have provided even greater depth and broader scope regarding the SCT phenomenon. Fifth, data analysis was 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 trauma treatment modality. Additionally, the sample did not include practitioners of other energy healing methods. 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. Sixth and finally, the study participants were all well-educated, older, experienced, and Caucasian females. A more racially and ethnically diverse sample of participants that included males would have the potential to produce more representative data (Jakubowski, 2012).

IMPLICATIONS FOR RESEARCH & PRACTICE

Further research on SCT, imagery, and embodiment in nurses and therapists who practice TT and other holistic modalities is needed.). Subjective accounts of empathy experiences in therapists who have a personal practice of mindfulness and meditation is under researched (Dalziel, 2014). Traumatized patients with PTSD should be included (Draper, 2014As Arizmendi (2011) points out, the process of how mental images actually emerge from neural mappings is not well understood at this point. More rigorous qualitative research will help develop the SCT concept, understand the roots of the imagery phenomenon, and illuminate its impact on nurses and patients. Future quantitative research is needed on outcomes and interventions, and instrument development. Best practices and policies to incorporate TT therapy into trauma treatment should be developed and evaluated. Research on SCT and embodiment will generate less reductionistic, and more holistic and complex ways of knowing that can inform nursing practice (Zahavi, 2013; Draper, 2014). Research funding should be allocated to investigate the beneficial use of TT in trauma therapy.

Regarding practice, psychological exposure is a component of established first-line PTSD treatments: Cognitive Behavior Therapy (CBT), Virtual Reality Exposure (VRE), Prolonged Exposure and Cognitive Processing Therapy**,** and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001) (Hamblen, Schnurr, Rosenberg, & Eftekhari, 2008). A

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non-exposure based therapy, such as TT, can be a useful adjunct to CBT, as one example, for people with chronic pain and emotional distress (Smith, Arnstein, Rosa, & Wells-Federman, 2002). It can also potentially offset the heavy reliance on psychopharmacology.

Many experts have expressed strong interest in fostering the evidence base for use of energy healing approaches in PTSD treatment (Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). Mind-body medicine, including counseling and psychotherapy, are types of integrative healing modalities (Elwell & Waud White, 2014). Psychotherapists are already incorporating energy healing into their practices. Some psychologists 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).

Despite the fact that many symptoms of traumatized clients are somatically-based, traditional psychotherapy lacks techniques that work with physiological elements (Ogden & Minton, 2000). Therapists treating traumatic stress need to become mindful; that is, being a careful observer of internal experience, and noticing whatever thoughts, images, feelings, body sensations, and impulses emerge. Integrating somatic body memory treatment with cognitive-based narrative therapy is recommended in PTSD (van der Kolk, 1994). Furthermore, 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. Mindfulness-based therapies from the Eastern traditions, such as TT, have been shown to be efficacious.

The findings of this study also have implications for the prevention of burnout and vicarious traumatization (VT) in nurses exposed to patients with trauma histories. In contrast to Jakubowski's (2012) findings that SCT increased negative effects on the therapist participants, 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 CT reactions, and lessened VT.

SUMMARY

The study purpose was met. The researcher's quest to identify the imagery phenomenon experienced by self and others during TT was successful. Literature on CT and embodiment was found to be related to SCT and imagery, albeit still scarce at this point. This research is unique in its exclusive focus on SCT imagery and presentation of explicit examples. The study findings contribute to the academic and philosophical debates in neuroscience and philosophy about therapists' claims their experience of unsolicited and spontaneous imagery is a manifestation of unconscious material in the client. A considerable contribution to the ongoing dialogue and research is made by the voices of the participants in this study. Their qualitative descriptions can help answer formidable philosophical and ethical questions. TT, first requiring the unconscious permission of clients, is practiced through compassion and intentionality. Study finding provide input current theories of social cognition, social

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neuroscience of empathy, embodied empathy, the mirror neuron system, and information processing. The study findings can also contribute to alternatives to traditional exposure-based therapies in treating trauma; as such, augmenting evidence-based practice in psychiatric mental health nursing. Expert nurse TT practitioners attributed, imagery, a manifestation of SCT, to increased experience, increased empathy, and decreased negative CT reactions. Their voices have become part of the long-standing dialogue about the self/other distinction.

CONCLUSION

Further illustration of SCT imagery helps to understand the access and integration of the verbally inaccessible, difficult-to-communicate SAM system. The state of relaxation induced by centering in TT facilitates the spontaneous emergence of imagery that may correspond with preconscious, preverbal memory of the client. The nurse TT practitioners' images described in this study may have bypassed, and compensated for, their blocked images and affect without re-exposure to traumatic memories. The study may therefore portend future research on PTSD treatment, as well as further refinement of IP and Mirror Neuron System theories. Heinschel's (2002) recommendation to consider TT practitioners' experience of imagery, the role of the nonordinary state of consciousness in healing, and the nurse's presence was supported.

With their professional expertise, Doctors of Nursing Practice (DNPs) and Advanced Practice Nurses (APNs) are in an excellent position to translate the knowledge generated from this study to evidence-based practice (Edwardson, 2010). They can contribute to finding a solution to treating traumatized clients, a clearly specified clinical population. Given the multitude of trauma experiences in the population, these findings highlight the role TT can play in trauma treatment.

The results of this study demonstrate the phenomenon of SCT imagery 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. Articulation of the body's language through a conceptualization of SCT is both valid and productive since, according to Macrae (2010), TT is "a mode of communication in its own right" (p. 5). This further articulation of SCT enhances the limited expression of the non-linear experience of TT (Samarel, 1992). The study findings therefore advance nursing science.

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Bio Sketch:
Catherine Jirak Monetti, PhD, RN, CNE, QTTP, a Robert Wood Johnson Foundation (RWJF) Scholar, earned her Doctor of Philosophy from Rutgers University in May, 2014. She is trained in Gestalt Psychotherapy and EMDR Trauma Therapy. A former student of Dee Krieger, PhD, RN, she has been practicing TT and teaching undergraduate nursing since 1991; doctoral students since 2015. Her doctoral dissertation research was presented by poster at the 2014 CANS (Council for the Advancement of Nursing Science) State of the Science Congress on Nursing Research: Optimizing Health by Addressing Complexity, Washington, DC, September 17 - 20, 2014. Her research, "Somatic countertransference experiences of nurse Therapeutic Touch practitioners: A content analysis. Part 1. Body will be presented by poster at the Sigma Theta Tau 28th International Nursing Research Congress in Dublin, Ireland, July 27-31, 2017. For further information, please contact Dr. Monetti at cmj@monetti.com.

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