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SOMATIC COUNTERTRANSFERENCE EXPERIENCES OF NURSE THERAPEUTIC TOUCH PRACTITIONERS: A CONTENT ANALYSIS. PART 1: BODY

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ABSTRACT: *This qualitative study describes somatic countertransference (SCT) 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). 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 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.*

KEYWORDS: trauma therapy, somatic countertransference, Therapeutic Touch practitioners, nurse-patient relations, integrative medicine, communication

INTRODUCTION

A ubiquitous human experience, trauma need not involve a catastrophic event. This qualitative descriptive study explored somatic countertransference (SCT) experiences of nurse Therapeutic Touch (TT) practitioners (Krieger, 1979) during their work with traumatized clients. A newly articulated phenomenon (Shaw, 2004a; 2004b), 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 offer a link to the client's healing process and the intersubjective field" (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 (Miller, 2000; Jakubowski, 2012). Through the phenomenon of SCT, in part, TT practitioners access clients' bodily-stored trauma without re-exposure to it. Psychotherapists are already incorporating TT into their practices (Macecevic, 2008).

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Despite evidence of their common occurrence in the therapeutic encounter (Vulcan, 2009; Athanasiadou & Halewood, 2011), however, somatic phenomena in the CT have undergone minimal empirical investigation. The perceived inadequacy of language to describe SCT has posed a challenge similar to the expression of the non-linear experience of TT and human memory (Samarel, 1992). The purpose of this study therefore was to address noted gaps in the literature, a paucity which led to this qualitative investigation. Further articulation of SCT will strengthen TT's adjunctive role in trauma therapy. This Part 1 research report presents the SCT and Body experiences described by nurse TT practitioners.

THEORETICAL UNDERPINNING

A qualitative research design was chosen because the nature of the SCT phenomenon is lived human experience. 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 (1980, 1989, 2004) definition, the goal of this qualitative CA was "to provide knowledge and understanding of the phenomenon under study" (p. 314). In this exploration of the distinctly human phenomenon of SCT, the researcher remained as faithful to its essence as possible. In common with interpretive approaches, CA required a close reading of relatively small amounts of textual matter (Krippendorff, 2004). The method of latent CA, described by Sandelowski (1993a, 1993b, 1995, 2000, 2010), allowed for a description and preservation of nurse TT practitioners' unique SCT experiences in their own words.

In this study, the researcher's pre-existing expectations were acknowledged and then kept in abeyance (Patton, 1980). 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).

CA revealed the underlying meaning in the TT participants' communication (Chang, 2001) with traumatized clients. This offered a glimpse into the vast reality that nurse TT practitioners tap into as they bear witness to human suffering (Vaillot, 1966); thereby attempting to lessen its burden (Thomas & Pollio, 2002).

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The specific aim of the study, therefore, was to obtain a description of SCT phenomenon from a purposive sample of nurse TT practitioners. The SCT experiences described by them during healing sessions with traumatized clients 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, 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 emotional issues 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).

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. CA of narrative descriptions proved a suitable research methodology; therefore, its use was supported in this study. Further description of the SCT phenomenon during work with traumatized clients 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 effectiveness of trauma therapy.

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. Semi-structured in-depth research questions for this study were:

***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 research report presents findings related to the main research question and sub-research

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questions #2 and #3.

LITERATURE REVIEW

Theoretical saturation was achieved by undertaking an exhaustive review of the literature on the SCT phenomenon being studied. More theoretical than empirical research on countertransference (CT) has been conducted. A relatively small body of empirical research on SCT phenomena, as related to TT practice in nursing, in particular, was identified. This current paucity reveals the need for more empiricism.

Countertransference (CT) & Somatic Countertransference (SCT)

Recent literature reviews (Vulcan, 2009; Rumble, 2010; Athanasiadou & Halewood, 2011) noted that somatic phenomena in the CT, despite evidence of their common occurrence in the therapeutic encounter, have historically received minimal attention – in 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-relationship" 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 CT, 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.

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. 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).

Regarding SCT specifically, only seven qualitative studies 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 CA (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

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"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. Gallese (2001) and Macecevic (2008) also hypothesized SCT as having links to "mirror neurons". They conjectured SCT 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.

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 "noticing how the body has been forced to act out feelings that could not be consciously known or transmitted" (p. 4). 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 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 concluded 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 (2004a) grounded theory study explored psychotherapists' somatic experiences during the therapeutic encounter. His study was the first in its explicit exploration of the phenomenon of SCT. Drawing on the philosophical work of Merleau-Ponty (1964), 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. Shaw (2004) concluded 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.

Forester (2007) explored therapists' SCT experiences during their psychotherapy work with dissociative and traumatized patients. The findings revealed that SCT phenomena play a central, facilitating role in body and movement psychotherapy; i.e., they provide a critical window into patients' material and dynamics, and lessen vicarious traumatization of the therapist. Finneran's (2009) Masters thesis investigated the efficacy of the therapeutic use of touch in psychotherapy with trauma victims. 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

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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 findings revealed that people with significant trauma histories found therapeutic touch modalities to be helpful in the recovery process (Finneran, 2009).

Using a grounded theory methodology like Shaw (2004), Athanasiadou and Halewood (2011) explored twelve therapists' somatic experiences in the CT. 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. 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 CA, Jakubowski (2012) found 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.

Embodiment & Embodied Empathy

In addition to somatic CT, the physiological aspects of CT have also been termed body-centered CT and embodied CT (Jakubowski, 2012). Phenomenological approaches have focused 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 & Winninger, 1994).

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). 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).

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 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. Key constituents delineated the essential meaning structure of ETE and included: psychotherapists' bodies are integral to the ETE experience for information gathering and empathic expression; during a mutual space interpersonal boundaries are less defined and the psychotherapist perceptually experiences the client's experiences; and, a transformation or breakthrough occurs on the part of the client (Macecevic, 2008).

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TT and PTSD

TT has not been investigated in PTSD per se. However, 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. Olson, Sneed, Bonadonna, Ratliff, and Dias (1992) had studied TT in post-hurricane Hugo survivors. 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).

METHODOLOGY

This study used a qualitative descriptive design to examine the SCT 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 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, further described the minimally articulated and researched aspects of SCT phenomena.

Research Setting and Sampling

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. 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

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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 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 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. 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

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questions; and, reflections and insights related to the research that potentially influenced its directions (Minichielllo, Aroni, Timewell, & Alexander, 1995).

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, 2004). 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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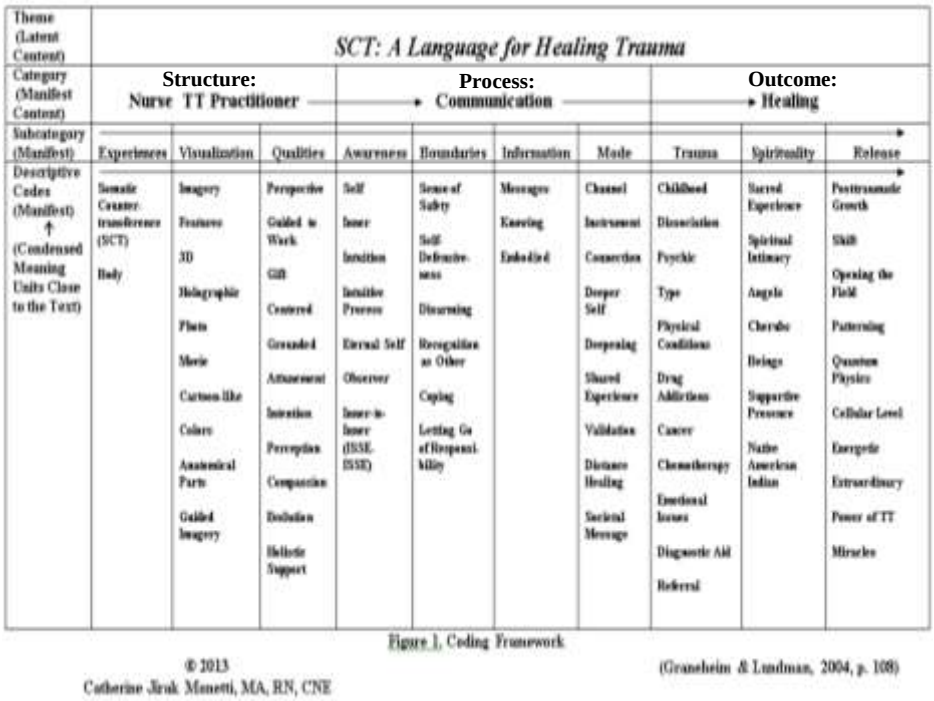

Figure 1. Coding Framework

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 main categories related to SCT experiences described by nurse TT practitioners during their work with traumatized clients were: Nurse TT Practitioner, Communication, and Healing. For this study, the constructs in Donabedian's Model (1982) were used to categorize the manifest content: Structure = Nurse TT Practitioner; Process = Communication; and, Outcome = Healing. The first two constructs contain indirect measures that influence the third direct construct, outcome, with all three linked. 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 Figure 2).

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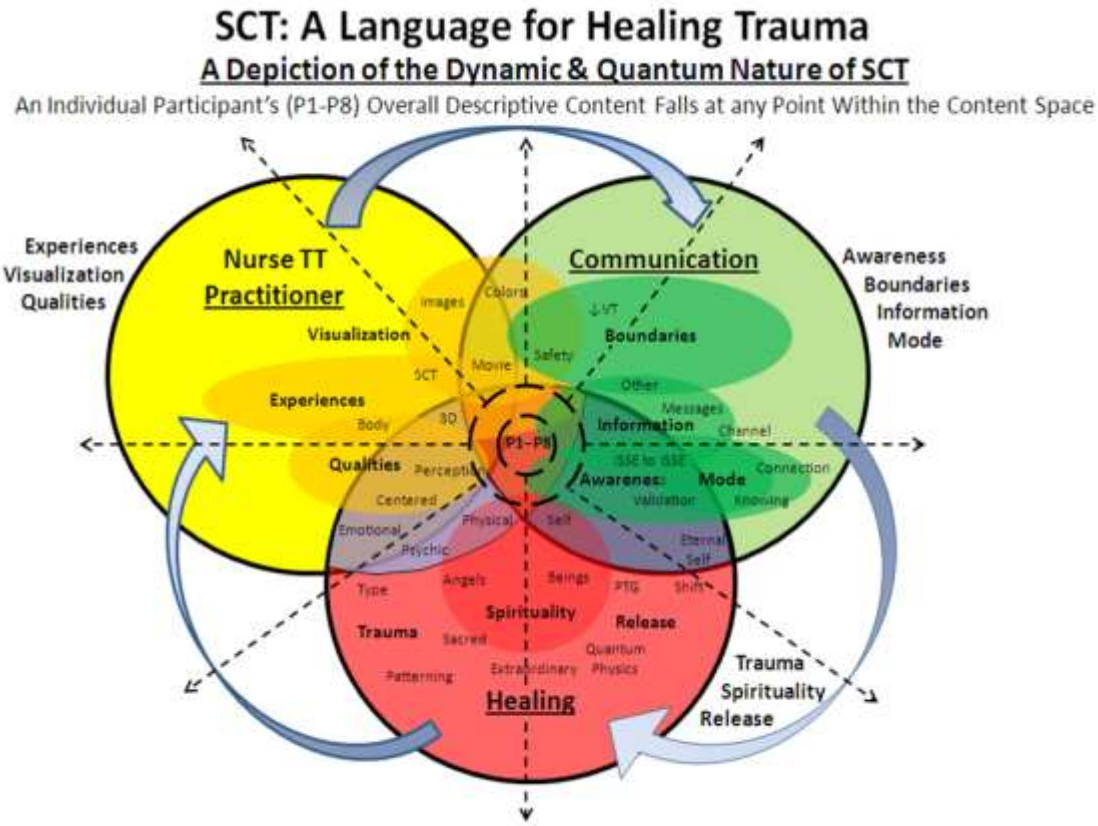

Figure 2: Conceptualization of Major Theme

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 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, 1994; 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. (Guba & Lincoln, 1981; 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

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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 & Beck, 2008). The use of both investigator and methods triangulation (Denzin, 1970; Roe, 2013) also strengthened confirmability. 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).

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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

[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) 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.

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Categories

I. Nurse TT Practitioner (Structure)

The nurse TT Practitioner during the nurse-client encounter working 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 the main research question addressing SCT (i.e., question #1), and prompt question #2 regarding their body experiences. What the study participants perceived was addressed in prompt question # 3. Due to space constraints, only the findings of the SCT and body experiences are presented.

A. Subcategory – Experiences – SCT Code

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

Centeredness facilitated their mutual field interactions. As one example, Participant 8 said, *"…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."*

Participant 4 described her SCT experience that co-occurred during distant TT with a nationally televised traumatic event. She related, *"…the best example for this study… involved a shooting at a university. I had my television on…was instantly alert. I was riveted to the scene of the description…all of a sudden it was like something hitting me in the chest…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…had to be done right then…And I could just feel the shock, the fear, the whole chaos of the entire situation just bombarding me with all of these feelings."*

Participant 8 noted the therapeutic impact of SCT on patients. She said, *"you know, the opposite of anger is love and peace. So let's send love and peace to this pain and this area. 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 shared: *"It's just that I probably carry more trauma baggage than the patients 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."*

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B. **Subcategory – Experiences – Body Code**

Sub-Research Question # 2: "What sort of experiences do you experience in your body during TT sessions, from everything you can think of?"

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."* Similarly, Participant 1 said, *"around the central sternum, lower probably, mid-chest, and something about her."* Participant 2 added, *"Most of my experience of what I perceive to be is this kinesthetic feeling inside my body, and it's usually around my heart."*

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

The nurse TT practitioners mentioned other areas of their body. Participant 3 stated, *"My hands get really hot."* 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."* Providing a specific example, Participant 7 shared, *"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."*

Participant 2 described her experience with a patient with drug addiction: *"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 didn'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."*

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*

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well-being that this is what I'm supposed to be doing."

C. **Subcategory – Qualities – Perception Code**

Sub-Research Question # 3: "What do you perceive, if anything, during TT sessions?"

Participant 2 recounted, *"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."*

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 who said, *"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*

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to channel energy to it there's almost a shudder that moves through my body. 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 added, *"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. In general, I have found that prickling sensations (in my hands) come only from cancer."*

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."*

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."*

Describing her work with veterans, Participant 5 said, *"I have a great deal of compassion for veterans 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."*

II. Communication Category (Process)

A. Subcategory – Boundaries – Coping Code

Use of humor as a coping strategy during work with traumatized clients was described by . Participant 7: *"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."*

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B. **Subcategory – Boundaries – Recognition of Other Code**

To guard against negative SCT, the need to "recognize as other" was emphasized. 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 also 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."* Participant 7 also distinguished between what belongs to the client, and what belongs to her: *"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."*

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."*

C. **Subcategory – Boundaries – Safety Code**

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 they have, and this protectiveness and this trauma they had, I go along a little more gently with some, and with some more openly with others and talk about it...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 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."*

D. **Subcategory – Boundaries – Disarming Code**

Participant 8 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*

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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."

III. Healing Category (Outcomes)

A. Subcategory Trauma – Childhood Mode

Participant 7 said, *"I have seen incidents of sexual abuse or physical abuse to people when they were children or young adults."*

B. Subcategory Trauma – Dissociation & Psychic Trauma Modes

Participant recalled 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 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.

C. Subcategory – Type Mode

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."* Similarly, Participant 8 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."* She 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."* 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."*

D. Subcategory Trauma – Physical Conditions Mode

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."* She further stated: *"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*

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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."*

Participant 2 also provided clinical examples:*"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."* Similarly, Participant 3 contributed: *"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 dehisced, 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."*

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."* 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'."*

Further describing her work with a client recovering from 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."*

E. Subcategory Trauma – Cancer & Chemotherapy Modes

Sharing, 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 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*

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diagnosed. I had people go in and have it taken care of." Adding her experience 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."* Participant 6 added, *"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."*

F. Subcategory Release - Posttraumatic Growth Code

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."*

G. Subcategory Release – Shift, Quantum Physics, & Cellular Level & Energetic Codes

Participant 1 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."* In relation to distance healing with TT, Participant 1 said, *"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."* Participant 2 shared, *"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."*

DISCUSSION

Theoretical Linkages

Using the constructs in Donabedian's Model (Donabedian, Wheeler, & Wyszewianski, 1982), Tthe nurse TT practitioner, as Structure, defined quality because it influences the human component in health care and also described the context in which nursing care was delivered

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(Lorentz & Finnegan, 2013). Communication, as Process, denoted the transactions between clients and TT providers during nurse-client interaction, the delivery of healthcare (Lorentz & Finnegan, 2013). As the endpoint of this process, Healing, as Outcome, makes the release of trauma the highest priority (Choi, Flynn, & Aiken, 2011). This implies relevance for the trauma population-at-large.

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

Like Geach and White's (1974), Puckey's (2001) position was corroborated in that CT is a natural part of the therapeutic relationship that yields deeper empathetic understanding of the patient. The results of this study demonstrate a need for more systematic study of nurses' understanding and use of CT as either a therapeutic or nontherapeutic factor in nurse-patient relationships (Geach & White, 1974).

The study findings were aligned with Yontef's (1979) view that "the client's and therapist's wisdom is revealed through sensory awareness in the Gestalt here-and-now" (p. 30); Schroder's (1985) that the client's past was found to enter into the here-and-now aspects of the nurse-client relationship; Hirose's (1999) phenomenological findings that embodiment in the nurse psychotherapist helps the patient to live more in the here and now; and, Ogden and Minton's (2000) findings that mindfulness of the nurse TT practitioner is a state of consciousness that directs awareness toward the here-and-now experience.

This study supports Irvine's (1988) findings that CT, 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 application to 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).

Lude's (2003) posit that effective use of SCT, when used effectively, is a two-way process between energetic connection and non-verbal communication was supported. 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). 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. 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 validated.

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Study findings were also consistent with Jakubowski's (2012) exploratory descriptive study findings that therapists use their physiological responses in work with trauma survivors. The TT practitioners in this study described similar proclivities; that is, the ability to attune, assess, maintain boundaries**,** and prevent vicarious trauma.

The conceptualization of SCT as "A Language for Healing Trauma" corroborated Quinn's (1989) prior research. She had stated 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 also described TT as a form of nonverbal communication that is an integral part of the nurse-patient interaction.

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).

Unlike Schroder's (1985) position, however, CT was not found to be a strictly unconscious response of the therapist, involving only his/her own attitudes and feelings originating in the past. Also, in contrast to Field's (1989) findings, the nurse TT practitioners in this study described their SCT experiences as related to the client's material rather than as unrelated to or in contradiction to it. 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" (p. 64).

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). 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. Healing in the context of TT comprised subcategorized descriptions of trauma, spirituality, and release. The SCT experience described by the nurse TT practitioners in this study incorporated somatic, emotional, and spiritual themes. 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.

Body Experiences

The findings from this study support previous research on somatic, or body, experiences, and embodiment. Similar to Orbach and Carroll's (2006) more current definition, the experiences of SCT described corroborated Casement's (1985) as appearing to embody something that "belongs" to the patient. Gale's (2011) reference to embodiment as the phenomenological lived

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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). 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.

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). She concluded the TT treatment is a reciprocal communication process, with Openness emerging as a key variable (Heidt, 1990).

Unlike Rogers' (1990) Science of Unitary Human Beings (SUHB), the theme, "A Language for Healing Trauma," includes the concept of nurse-client interaction. The study findings also contrast to Rogers' (1990) view that TT is not a body of knowledge in its own right. Results were more aligned with Meehan's (1988) contention that TT is a nursing health patterning modality (Malinski, 1993). The findings of this study may therefore contribute to TT's unique body of knowledge, and to its place among adjunctive nursing modalities to treat trauma.

STUDY STRENGTHS

The research design and methodology of this study incorporated the rigor of qualitative inquiry; thereby, contributing to its 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

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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, and future research will lend 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.

STUDY LIMITATIONS

Although the qualitative findings provided thick, rich description of the minimally understood phenomenon of SCT, several limitations were identified. 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. 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 treatment modality. Additionally, the sample did not include practitioners of other energy healing methods such as Reiki or Healing Touch, exclusively. 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).

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IMPLICATIONS FOR RESEARCH & PRACTICE

Recommendation is made for future research on SCT experiences in nurses, in general; and, in nurses who practice TT and other holistic modalities, in particular. 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. 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. More in-depth interviewing of nurse TT practitioners and therapists who practice from a multitude of therapeutic frameworks is also recommended. Research funding should be allocated to investigate the beneficial use of TT in trauma therapy.

Regarding practice implications, The IOM (2007) recommended development of alternatives to traditional exposure-based therapies for PTSD. Many other experts have also expressed strong interest in fostering the evidence base for energy healing approaches in PTSD (Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). 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).

Multiple important themes for mental health professionals, including Nurse Practitioners (NPs) and Doctors of Nursing Practice (DNPs), have been herein illuminated; thereby, contributing to evidence-based practice in psychiatric mental health nursing. The Clinical Nurse Specialist (CNS) role is over fifty years old. NPs now provide initial management or referral to psychiatric mental health professionals for evidence-based treatments. Findings from this study therefore contribute to the role of the NP in the psychiatric mental health field. Also, as of 2010, the Institute of Medicine (IOM) cited a current lack of evidence on DNP outcomes (Croenwett, Dracup, Grey, McCauley, Meleis, & Salmon, 2011). Unlike most psychotherapies for PTSD, interpersonal psychotherapy is not exposure-based. DNPs can recommend TT as an augmentative holistic modality. 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). Articulation of the body's language through a conceptualization of SCT may be particularly productive since, according to Macrae (2010), TT is "a mode of communication in its own right" (p. 5).

Findings from this, and future, study are in keeping with global initiatives on Complementary and Alternative Medicine (CAM) and Integrative Medicine and Health (IMH). Nurse TT practitioners can make an important contribution to the ongoing dialogue and research.

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CONCLUSION

The results of this study demonstrate 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. In other words, TT can access the knowledge of the body beyond the use of words. The findings validate Leddy's (2004) conclusion that actual physical touch and exchange of energy are not needed for energetic healing. This further articulation of SCT increases the limited expression of the non-linear experience of TT (Samarel, 1992). Given the multitude of trauma experiences in the clinical population, these findings contribute to knowledge about the phenomenon of SCT and the significant role TT plays in trauma treatment. Of course, further description of SCT is needed, as well as related outcomes.

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