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SOMATIC COUNTERTRANSFERENCE EXPERIENCES OF NURSE THERAPEUTIC TOUCH PRACTITIONERS: A CONTENT ANALYSIS PART 3: EMOTIONAL ISSUES

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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 emotional healing of trauma, experienced during the verbal and nonverbal communication of one group of nurse TT practitioners in interaction with traumatized clients.*

KEYWORDS: somatic countertransference, countertransference, trauma therapy, emotional issues, somatic communication, embodiment

INTRODUCTION

Trauma is any experience that has threatened the health or well-being of an individual. A catastrophic event need not be involved (Brewin, Dalgleish, & Joseph, 1996; Scott & Stradling, 1994, 2011). Traumatic experiences involve the whole person's emotions and feelings (mind, body, and spirit) (van der Kolk, 1994). These experiences can include an event such as a natural disaster or accident; an illness; bereavement; or, loss of an interpersonal relationship. Patients with trauma histories are therefore widespread in clinical practice (van der Kolk, Spinazzola, Blaustein, Hopper, Hopper, Korn, & Simpson, 2007). The cost of their health care is staggering, as is the loss of work productivity.

Standard treatment approaches for PTSD are currently exposure-based (Foa, Keane, & Friedman, 2000). Conventional psychotherapy has been critiqued for bringing memories to consciousness without resolution (Csordas, 1994; Johnson, 1999). Experts confirm that re-exposure of trauma deters patients from treatment. Nor has confronting memories been found to be universally effective (Lewis, 2003). Only half of patients improve with current first-line treatments (Bradley, Green, Russ, Dutra, Westen, 2005). These include cognitive behavioral therapy (CBT), virtual

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reality exposure (VRE), and eye movement desensitization reprocessing (EMDR; Shapiro, 2001). Many clinical settings exalt CBT with the belief that "cognitions and rationality are more reliable conduits to therapeutic improvement than affective ventilations and somatic experiences" (Feltham, 2007, p. 135, as cited in Athanasiadou & Halewood, 2011).

Despite insufficient evidence and given side effects, medication usage for PTSD continues (IOM, 2007; Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). Non-exposure-based complementary and alternative medicine (CAM) modalities such as energy healing (e.g., Therapeutic Touch) have been posited as a welcome treatment alternative (Bleiberg & Markowitz, 2005). Since veterans are also among those widely using CAM therapies, including Therapeutic Touch Energy Medicine (TT; Krieger, 1979a, 1979b, 1987), Slater (2004) states it is reasonable to assume that TT holds promise as adjunctive treatment of PTSD. Through the phenomenon of somatic countertransference (SCT), 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).

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

Energy healing - not requiring a patient's re-traumatization – holds important implications for both patients and clinicians. The residual effects of trauma are removed (Janet, 1925/1973), in part, by the practitioner's experience and somatic countertransference (SCT) phenomenon. Also called embodied empathy, SCT contains inherent self-regulatory processes that help to diminish VT in the healthcare provider (Raingruber & Robinson, 2007). Effective use of somatic empathy of both the therapist's and client's bodies helps to prevent and lessen the severity of VT by returning the symptom(s) to the client - instead of the providers taking it on themselves (Rand, 2003). Essentially, an awareness of SCT may produce more effective self-care that, in turn, can lead to greater productivity (Clarke, 2007), while also serving as a guide to clinical work (Davis, 2011).

A newly articulated phenomenon (Shaw, 2004a; 2004b), SCT is distinct from Freud's (1910) traditional notion of countertransference (CT; Schroder, 1985). In contrast to the negative effects of CT, SCT can positively affect both the clinician and the client (Puckey, 2001). The latter construct is drawn on infant studies and the work of the phenomenological philosopher, Merleau-Ponty (1962). He considered the therapist's body a surrogate for the client's trauma-related thoughts and images in search of a body (Merleau-Ponty, 1962). As initially conceptualized, trauma is stored in somatic memory - at the receptor level of cells (Pert, 1997). Cellular intelligence is connected to the conscious and unconscious processes of mind and emotions. The body can reveal the forgotten areas of experience embedded within it. Orbach and Carroll (2006) defined

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SCT as, "the therapist's awareness of their own body, of sensations, images, impulses, and feelings that offer a link to the client's healing process" (p. 64). 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). Memory processes that are emotionally driven and unconscious can sometimes be made conscious through SCT experienced by the therapist. Hence, TT allows access to bodily-stored memory and cellular intelligence.

The purpose of this qualitative investigation was to address paucity in the literature. Further articulation of SCT will strengthen TT's adjunctive role in trauma therapy. This Part 3 research report presents the SCT and emotional experiences described by nurse TT practitioners during their work with traumatized clients.

THEORETICAL UNDERPINNING

A qualitative research design was chosen 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 (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. CA of narrative descriptions proved a suitable research methodology; therefore, its use was supported in this study.

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).

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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).

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). Further description of the SCT 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 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 questions #5 and #6. Other findings have been reported elsewhere.

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LITERATURE REVIEW

An exhaustive review of the literature on SCT, including emotional issues, achieved theoretical saturation. Somatic phenomena in the CT have undergone minimal empirical investigation despite evidence of their common occurrence in the therapeutic encounter (Vulcan, 2009; Athanasiadou & Halewood, 2011). Theoretical research has predominated. 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, Freud's (1923) traditional psychodynamic concept (Rumble, 2010). Since classically-trained psychodynamic therapists have been taught to regard CT reactions as detrimental to healing (Hart, 1997), they may have felt reticent to speak about them (Shaw, 2004). Therefore, a negative stereotype of interference with the therapeutic alliance previously prevailed. Another challenge has been the perceived inadequacy of language to describe SCT – one similar to the expression of the non-linear experience of TT and human memory (Samarel, 1992).

Trauma Therapy

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

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

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

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Embodiment & Embodied Empathy

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

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. Concerned with the phenomenology of perception, Wilde (1999) described embodiment as "how we experience the world – perception, emotion, language and movement through our bodies" (p. 27) (Merleau-Ponty, 1962, 1968). Gale (2011) described it as the phenomenological lived body/self. The term "body-talk" means the body can communicate its distress and need. In bodywork, or embodied psychotherapy, the practitioner does not necessarily touch a client (Shaw, 2003, 2004). Instead, in understanding their countertransferential responses, therapists assume the roles of "witness" and "mover"; thus, enabling mutual responses and projections that engender the emergence of unconscious contents (Vulcan, 2009). Therapists draw on their own experiences with pain, anxiety, and memories of profoundly upsetting life experiences in hopes of understanding the client's psychic trauma. Empathy enters the phenomenal reality of the trauma victim to understand the internal working schema of the trauma experience and its effects on intrapsychic processes (Wilson & Thomas, 2004).

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).

Mirror Neurons

Empirical evidence now demonstrates that early childhood trauma confers an added strength to clinicians (Cohen, 2009). The discovery of "mirror neurons" (Gallese & Goldman, 1998; Gallese, 2001, 2004; Rizzolatti, 2005) opened additional empirical routes to independently test that personal experience may confer added sensitivity to therapists' understanding of similar experiences in their patients (Iacoboni, Woods, Brass, Bekkering, Mazziotta, & Rizzolatti, 1999). "Mirror Neuron Theory" allows for a simulation theory of mind-reading and empathy (Grotstein, 2005). Stern (2004) described the process as "a nonvoluntary act of experiencing as if one's center of orientation and perspective were centered in the other. Rather than knowledge of the other, it is participation in their experience – a capacity that makes imitation and empathy possible.

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Vicarious Traumatization (VT)

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

Forester (2007) later explored therapists' SCT experiences during their work with dissociative and traumatized patients. Intending to contribute to the dialogue between body-oriented and psychoanalytic approaches to the psychotherapy of trauma, Forester (2007) found that SCT plays a central, facilitating role in body and movement psychotherapy. SCT experiences, or "deputy perception" (Stoerig & Cowey, 1997) provide a critical window into patients' material and dynamics, and lessen VT of the therapist (Forester, 2007).

Thomas (2011) noted more attention still needs to be paid to intrapsychic variables which may influence therapists' capacity to sustain a therapeutic presence without succumbing to the detriments of "witnessing the suffering of others" (p. 5). More recently, Jakubowski (2012) conducted an exploratory descriptive study to examine the body's role in implicit communication during clinical work with trauma survivors. Qualitative content analysis revealed that clinical functions, such as ability to attune, choice of interventions, assessment, ability to maintain boundaries, and prevent VT were used by the participants.

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.

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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 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

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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).

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

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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.

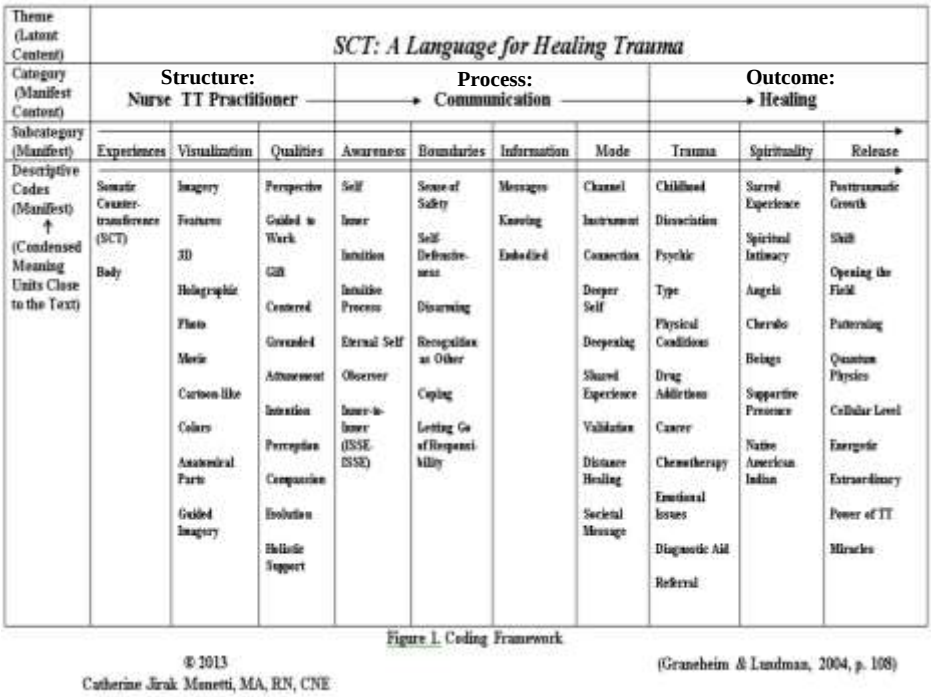

Figure 1. Coding Framework

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 Structure-Process-Outcome constructs in

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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).

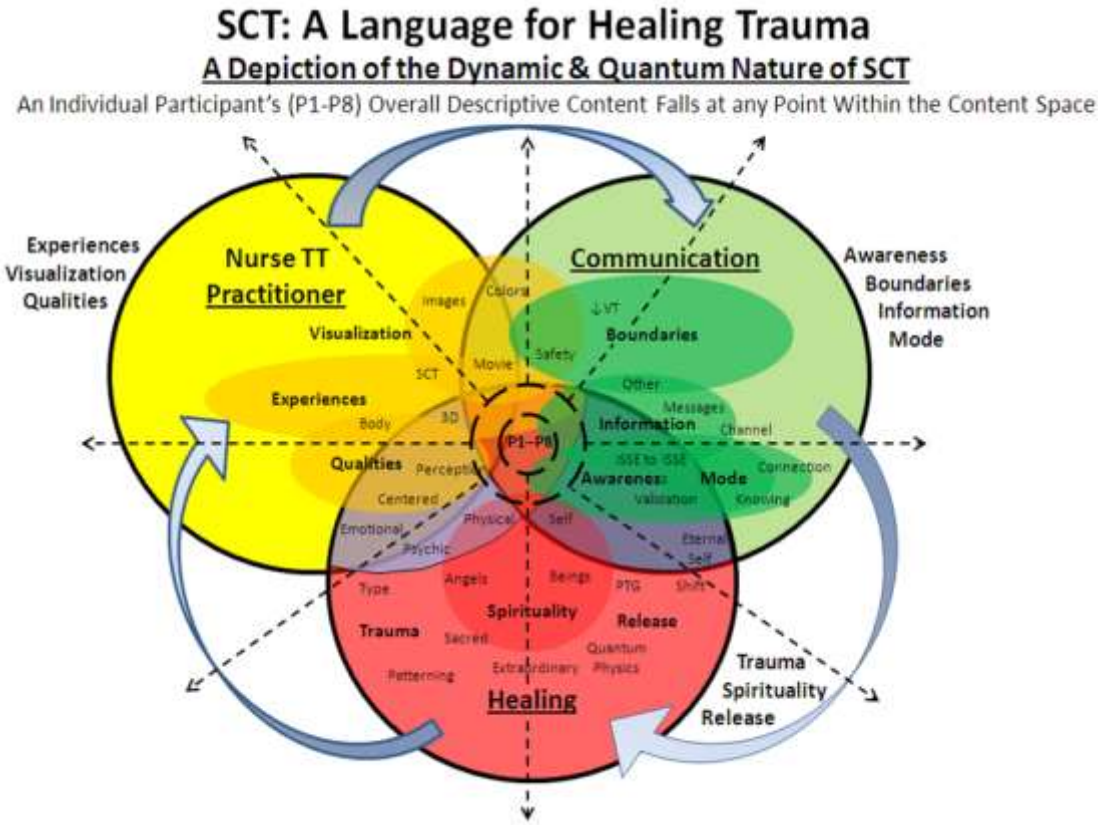

Figure 2: Conceptualization of Major Theme

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Methodological Rigor

As reported elsewhere (Monetti, Ezomo, & Nwanonyiri, 2016), qualitative rigor was demonstrated through clarity in the data collection and data analysis processes. 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

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

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Research Question(s) & Selected Findings

Major Theme

The major theme inductively emanated from the latent content of the text is that SCT can be interpreted 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 patients 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 (SCT) and prompt questions #2 (body), #5 (emotional issues), and #6 (extraordinary).

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

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

II. Communication (Process)

A communication process occurs between the nurse TT Practitioner and traumatized patients during the nurse-client encounter. Four subcategories comprised this category: Awareness, Boundaries, Information, and Mode. Study participants described their experiences in response to the main research question (SCT) and prompt questions #2 (body), #5 (emotional issues), and #6 (extraordinary).

A. Subcategory – Boundaries – Sense of Safety, Self-Defensiveness, Disarming, Recognition as Other, & Coping Codes

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 they have inside, that big wound 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…I do sense*

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with people, of a person that's been so traumatized. Gentle, you're always gentle, but with more of the expression, more of bringing out and letting them talk or letting them be, allowing them to emote if they need to emote, and letting them feel safe to emote."

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

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

To guard against negative SCT (i.e. vicarious traumatization), the need to "recognize as other" was emphasized. Participant 2 exemplified, *"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."* Similarly, Participant 1 stated, *"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 added, *"I want to really make sure 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 6 related, *"I see many cancer patients, especially breast cancer, undergoing chemotherapy. I see them on the day they receive chemotherapy."* She emphasized, *"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."*

Use of humor as a coping strategy 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* (Laughs)*."*

In contrast, 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."*

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B. Subcategory – Mode – Validation Code

Providing an example of validation during her clinical work, Participant 2 recalled, *"So, after the assessment, that's when I checked in with him to say 'How are you doing? My sense is there's a lot of fear here,' and that's when he revealed his history of two other car accidents and one that had been quite severe. So we worked again to clear that feeling."* In discussing her validating experience during distance healing with a university shooting victim, Participant 4 recounted, *"The Tech one is an extraordinary incident because I had the validation…At a point when you know the exact time frame, and you have documentation on national television that what you did actually happened in real time." "The most interesting part of this story is what happened on the news the next morning…another patient was interviewed on television…he was being evaluated for a heart attack in the bed next to hers. He ripped off his electrodes and tore out his IV and ran over to her at the exact minute that I finished doing the TT treatment...Therefore, I certainly associate the fact that I had finished and she was totally calm at the moment that this friend took her hand in the emergency room."*

III. Healing (Outcome)

Healing is the outcome of the communication process between the nurse TT Practitioner and clients who have been traumatized. Three subcategories comprised this category: Trauma, Spirituality, and Release. Study participants described their experiences in response to sub-research (prompt) question #5 (emotional issues).

A. Subcategory – Trauma – Emotional Issues Code

Participant 7 exemplified: *"probably, I've perceived every emotion that people experience at one time or another."*

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

In addition to grief, fear and anxiety were emotions also perceived by several of the nurse TT practitioners. Participant 6 shared, *"there have been times, one in particular, a woman who seemed very happy and jolly, no problems at all; when assessing and treating her, I got this image: it was over her heart chakra that she had a broken heart. It persisted. I said something to her, and she started to cry. She revealed that she was in the process of thinking about getting a divorce."* Participant 8 described her perception of fear, *"And so, the emotional field is really the easiest field to access on an outward level…With different people I feel different things, but we're talking about post-traumas. I've already connected, but then, how deep do I go with it? How deep do I let them open up? But, I sense it. I sense the depth of their despair and darkness, the dark, dark space*

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they are in and their fears, and their need to keep them in. Or, their need to let some of that out a little bit." Participant 4 shared her experience of fear. She said, *"And I could just feel the shock, the fear, just the whole chaos of the entire situation was just bombarding me with all of these feelings…And so I just immediately could sense the terror…I could feel that she was just so frightened by the whole situation and just that she was so shocky…She felt so alone…and my psyche resonates with that because I often feel that way…no one should be alone then."* Providing a specific clinical example of PTSD, Participant 2 recalled, *"I was working with a gentleman who had been in multiple car accidents, and that was definitely a time that the fear, it was definitely something that I knew it wasn't mine. And the intensity of the fear, the accident that he had been in and that I thought I was working with was not that bad of an accident. But it turned out that the two accidents before were very severe, and so the level of fear that I felt in my body didn't correspond in my mind. So I checked in with him. So what he was doing was he was reliving the fear of the initial big accident, but it had been retriggered or re-stimulated by the current accident"*. Participant 2 also provided a clinical example *"and it comes in a sense of I guess you'd call it information." "I think the piece of information that came to me over time…initially there was a reoccurrence of cancer, and this is something that she articulated, the fear of dying…And so, I don't know that necessarily my work was what shifted her, but the information came to me during a TT treatment. That was for sure." Expounding more fully, she said, "So it's like in a moment, as you're assessing, it's like it takes your breath away. It's like there's this sudden feeling of … and you know that it's not happening to you so it must be information that you're getting."*

Participant 6 spoke about depression: *"How I pick up depression is that their field becomes contracted. Also, after working on them, they may release some of this by becoming teary-eyed. And they may release some of the grief and depression. I just pick up when patients are anxious or sad."* Explaining, she said, *"You see, I sit and talk to the patient. So it's not only the Therapeutic Touch but I also sit and talk to them and see what's going on with them."* She concluded with, *"Happy go-lucky people usually don't come to me. They don't need Therapeutic Touch."* And, *"It's like I'm always doing Therapeutic Touch because there are people who have pain, they hurt themselves. I really don't get involved too much with people who have emotional, extraordinary emotional issues."*

Describing her experiences with anger, Participant 8 said, *"I feel in my body also the sensation of whether they are angry, or not angry. I feel the depth of that emotion."* Recalling a particular experience with a patient with a leg amputation, she said, *"And I asked him, because I sensed anger…around this pain, and around the amputation, and I said, 'how do you feel? What emotion are you feeling with this leg?' And he just said, 'I'm mad. I'm angry. I'm, you know…' He didn't use any bad language, but you could just sense that he wanted to."* A feeling of resentment was perceived by one of the nurse TT practitioners. Recalling an experience with a Vietnam veteran, Participant 7 said, *"He had his jolly face on, but my emotion…I could feel them being pulled down into resentment. I was prompted to just kind of confront him directly on that. 'Well, you're looking happy but it doesn't feel like you're feeling happy. Do you want to tell me about the resentment that I'm sensing?' And then he was able to go ahead and talk about what was going on in his marriage."*

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

Regarding positive emotions, Participant 7 described, *"Sometimes the playfulness, or the joyful person that's there even though that may not be what's happening in emotion to them right then. So you can kind of see both…But the joy and glee are frequently related to the age and stage, which is not the person at that moment in time. It's contextual."* Participant 3 concluded with, *"I always feel energized after giving a treatment. It does my body as much good as it does the client. I've never felt drained or exhausted. I've felt rejuvenated, relaxed, and just a sense of well-being that this is what I'm supposed to be doing. So, be sure to include that in your study."*

A. Subcategory – Trauma – Physical Conditions Code

Describing her clinical work, Participant 2 provided 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."*

B. 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."*

C. Subcategory – Release Cellular Level & Energetic Codes

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

D. Subcategory – Release – Extraordinary Code

In response to sub-research question # 6, "What experiences do you consider extraordinary, if any?" Participant 3 replied, *"I consider all of these experiences I've told you about extraordinary."* Providing an overview of them, she exemplified*: "There are no words to describe the feeling in that room when that lady finally went to sleep, the feeling when her husband told me she never had another esophageal spasm the remaining days of her life. The excitement when I see the improvement I could make in my mother within just two weeks, the satisfaction with the torn*

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Achilles tendon not having to have a third surgery, and the fact that that mother of six children and twenty grandchildren is still alive and just running herself crazy…So, the work is extraordinary, without a question."

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

Participant 5 presented another clinical vignette: *"Another extraordinary experience was when I worked with a woman who developed behavioral problems and three different personalities after a fall. I intuited she needed a separate TT practitioner for each personality. Each practitioner lived in a different state and did distance healing with her. After a year her behavior became normal again. When she died, two of the three TT practitioners knew the exact moment, even though they lived in different states."*

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

DISCUSSION

The relationship between the emotional and physical is not yet fully understood. The findings from this study offer further elucidation.

Regarding somatic countertransference (SCT), as a newly articulated phenomenon (Shaw, 2003, 2004) a paucity of empirical research has prevailed (Vulcan, 2009). A possible impediment has been the perceived inadequacy of language to articulate the phenomenon (Shaw, 2004). Knoblauch (2005) discussed the limitations of language in providing accurate symbolization for a client's experience, and proposed incorporating nonverbal embodied communication in addition to language as a gateway into the unconscious meaning in therapeutic interactions.

As described in this study, the mutual dialogue between the nurse TT practitioners and their clients allowed the body to communicate (Grotstein, 2005). Involved was implicit, or non-conscious, communication. Multiple responses from different participants evoked Eagle's (1993) conceptualization of a corrective emotional experience for clients resulting from mutual implicit

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communications and interpretations. Validated was previous discourse that communication need not be explicit in order for it to function therapeutically.

For example, the role played in clinical work with trauma survivors was investigated. In Jakubowski's (2012) study, one participant described their physiological response as "a kind of naturalistic mirroring" (p. 31). Agreeing that emotional and physiological CT is linked, another said, "It is largely unconscious, until you have to write about it or talk about it" (p. 36). Regarded as a clinical tool, another therapist stated, "For me it is non-verbal, when I can pay attention to that and keep it separate from my own anxiety about, or my own stuff, it is really helpful. It gets you right to it; it goes right to the heart of it really…I think of it as just pure amygdala-to-amygdala 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).

The conceptualization of SCT as "A Language for Healing Trauma" also corroborated Quinn's (1989) previous research. She had stated that human beings are capable of perceiving incredibly subtle inputs from the environment at both conscious and unconscious levels; thereby, creating a theoretical foundation for the role of non-verbal communication. Easter (1997), in her integrative review of the literature on TT from 1981 to 1996, described it as a form of nonverbal communication, an integral part of the nurse-patient interaction. The findings in this study further 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). As per extant literature, SCT was found to be a two-way process between energetic connection and non-verbal communication (Lude, 2003). By articulating their heightened awareness of SCT and emotional experiences while working with traumatized clients, a language for the communication of clients' body knowledge was revealed.

The findings of this study therefore support the possibility that the phenomenon of SCT can be attributed to the client's unconscious, bodily-stored material. Shaw (2004) posited that the SCT phenomenon described by the therapists in his study arose from experiences within their own bodies, and not from their clients' bodies. Using an example given by one therapist (e.g., "I think what I was doing was picking up the unconscious body memory of the client."), he emphasized verification with the client. This practice of validation was described by several nurse TT practitioners. Unlike Schroder's (1985) position, 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. Similarly, participants' responses contrasted to Field's (1989) work, in that they described their SCT experiences as related to the client's material rather than as unrelated or in contradiction to the client's manifest material. The majority of the findings indicated agreement with Orbach and Carroll's (2006) more contemporary view of SCT that defines it as the "therapist's awareness of their own body, of sensation, images, impulses, and feelings that offer a link to the client's process" (p. 64).

It is therefore crucial to find ways of articulating and researching the language of the body (Vulcan, 2009). Immersion in non-verbal relating can bypass language and lead to new and deeper

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dimensions that allow the client's body to tell its story, rather than putting words to the client's experience (Lude, 2003). In this study, participants viewed SCT within the framework of TT, illustrating a view of nurse TT practitioners' experiences and use of SCT during therapy with trauma survivors as experiences of what the literature calls SCT. Much further evidence is needed.

Regarding trauma, when asked what emotional issues they perceived in traumatized clients (i.e. sub-research question #5), Participant 8 exemplified with, "the emotional field is really the easiest field to access on an outward level." The nurse TT practitioners described perceiving many different types of emotions, both positive and negative. The latter is aligned with 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).

The findings of this study also lend support to Pert's (1997) prior endorsement of TT, within the context of her work on cellular intelligence. She noted that cellular intelligence is connected to the conscious and unconscious processes of mind and emotions, concluding that the bodymind can reveal the forgotten areas of experience embedded within it (Pert, 1997). She initially conceptualized trauma as being stored in somatic memory at the receptor level of cells. As corroboration, Participant 2 in this study stated, "And I have found that when people can identify the feeling and almost bring it to their awareness, and then you clear, it supports their ability to actually clear, because they've got that on a cellular level. It's in their body, energetically. I mean you look at it energetically, and so you clear, and then it can begin to actually release."

Contemporary research by Panhofer (2011) demonstrates the importance of non-languaged ways of knowing to express the lived, embodied experience. Wager's (1996) and Panhofer's (2011) views are aligned with Schulz's earlier (1999) discussion of the brain as the chief interpreter and processor of intuition. According to Schulz (1998), 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. Panhofer (2011) recently concluded that crossing over brain hemispheres allows access to valuable, and even unconscious, material during clinical work. It is possible that during TT, as in EMDR trauma therapy (Shapiro, 2001), both brain hemispheres are stimulated bilaterally Corroborating this and Corbin's (1969) original discourse, in this study the nurse TT practitioners' descriptions of their emotional experiences could be viewed as representing a non-languaged way of knowing (Panhofer, 2011) that expresses the nonverbal, perhaps unconscious, memories stored in the body. The concepts of cellular intelligence and bodymind communication (Pert, 1997) were therefore illuminated.

Study Strengths

The research design and methodology of this study incorporated the rigor of qualitative inquiry. 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

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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, 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.

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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).

IMPLICATIONS FOR RESEARCH & PRACTICE

Research

Significant opportunities exist for future research on SCT – especially with nurses and therapists who incorporate TT into their practices. Additional studies are needed to test treatment approaches for PTSD, especially those incorporating embodied healing (Ray, 2009). More rigorous qualitative research (e.g., phenomenological, grounded theory, and comparative studies) will help understand the roots of the SCT phenomenon, and further develop the concept to explore its impact on nurses and patients. Quantitative content analyses will deductively analyze the frequency of the experience of SCT. Since there are currently no quantitative measures of SCT, studies need to be designed that will aid in instrument development. In addition, intervention studies will need to be designed and conducted to evaluate best practices and policies to incorporate TT therapy into trauma treatment. Research funding should be allocated to investigate the beneficial use of TT in trauma therapy.

Practice

The study findings contribute to the discussion about alternatives to traditional exposure-based therapies in treating trauma and PTSD (IOM, 2007; Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). Psychological exposure is a component of established PTSD treatments, including Cognitive Behavior Therapy (CBT), Virtual Reality Exposure (VRE), and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001). To mitigate retraumatization, some alternative therapies also use brief psychological exposure. Collectively referred to as "energy psychology" (Gallo, 2002), these approaches include Thought Field Therapy (TFT), Tapas Acupressure Technique (TAT), and the Emotional Freedom Technique (EFT) (Feinstein, 2010). In exposure protocols, anxiety- or fear-producing memories are provoked as a form of information processing (Feinstein, 2010). For traumatized individuals, fully re-experiencing symptoms may be disconcerting or even frightening (Ogden & Minton, 2000).

Feinstein (2010) notes that although CBT combined with psychological exposure is still considered the treatment of choice for PTSD, half of the patients do not respond, few therapists

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are trained in it, and few patients receive it. The dominance of CBT within mental health nursing educational and practice settings may also be a narrow application of therapy interventions (Hurley, Barrett, and Reet, 2006). This may demonstrate a partial incongruence with the core values of mental health nursing. An incorporation of therapy approaches beyond the cognitive behavioral model is therefore recommended (van der Kolk, 1994). Despite the fact that many symptoms of traumatized clients are somatically-based, traditional psychotherapy lacks techniques that work with these physiological elements (Ogden & Minton, 2000). Integrating somatic body memory treatment with cognitive-based narrative therapy is therefore recommended in PTSD (van der Kolk, 1994).

Many experts have expressed strong interest in fostering the evidence base for energy healing approaches in PTSD (Strauss, Coeytaux, McDuffie, Williams, Nagi, & Wing, 2011). A non-exposure based therapy, such as TT, can potentially offset the heavy reliance on psychopharmacology. 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). Sometimes during TT, as described in this study, a practitioner becomes aware of the patient's problems in an intuitive way, without the need for conversation (Wager, 1996). 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).

Regarding nurses and mental health practitioners, the findings of this study have implications for the prevention of burnout and vicarious traumatization (VT) that can occur as a result of exposure to patients with trauma histories. Descriptions of participants' work with traumatized clients demonstrated increased SCT experiences, ability to maintain boundaries and decrease negative effects on their physical health. These findings are in contrast to Jakubowski's (2012) finding that SCT increased negative effects on therapist participants. As described by the nurse TT practitioners in this study, the meditative experience of centering, their own self-awareness, and recognition of experiences as belonging to clients helped them to detach from their clients' traumatic experiences. Furthermore, as described, TT is beneficial to nurse colleagues because SCT experienced during TT facilitates the recognition of "feelings of exhaustion, being overwhelmed, and intensely overburdened" in them. TT is also beneficial to nurses in that it fosters feelings of rejuvenation, relaxation, and well-being. Additionally, somatic complaints, such as migraine headaches, are relieved.

Germane to psychiatric mental health nursing, the findings of this study can further contribute to evidence-based practice. Hill and Oliver (1993) had found teaching patients to use a combination of visualization and TT on themselves can be an effective strategy in mental health recovery. A significant reduction in anxiety was found in thirty-one inpatients of a Veterans Administration psychiatric facility who received TT (Gagne & Toye, 1994). The researchers concluded that since patients may lack the abilities needed to benefit from extensive visual imagery techniques, and anxiety is a key component of many disorders, especially those which are trauma-related, development of a passive anxiety reduction technique such as TT would be invaluable for clinical mental health. Hughes, Meize-Grochowski, and Duncan Harris (1996) concluded that as a nursing

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intervention, TT offered a holistic approach to care. Specifically, the term body/mind connection emerged as one of two themes to describe seven hospitalized, adolescent psychiatric patients' experience of receiving TT.

Woods Smith, Arnstein, Cowen Rosa, and Wells-Federman's (2002) found that TT lowers emotional distress (Quinn & Strekauskas, 1993; Samarel, Fawcett, Davis, & Ryan, 1998) and may be a useful adjuvant to CBT for people with chronic pain. MacNeill (2006) addressed "the value of TT to expand nursing practice" (p. 40), and found TT to be an effective nursing intervention to treat adult tension headache pain. She emphasized that students need to be introduced to complementary methods of pain control other than narcotics.

Veterans are among those receiving benefit for common conditions such as fatigue, headaches, insomnia, depression, anxiety, sleep disturbances, and relationship problems (Eisenberg, Davis, Ettner, Appel, Wilkey, van Rompay, & Kessler, 1998). Woods and Dimond's (2002) investigated the effect of TT on agitated behavior (i.e. vocalization and pacing) and cortisol in persons with Alzheimer's disease. Schwab and colleagues (1985) found a decrease in the use of psychotropic medication and noisy behavior in persons with dementia, but they did not assess the efficacy of TT alone. Hagemaster (2000) examined the efficacy of TT as a complementary therapy in prolonging periods of abstinence in people who abuse alcohol and other drugs. They reported a trend (p=.068) toward decreased depression among participants treated with TT. Larden, Palmer, and Janssen (2004) found that TT promoted lower levels of anxiety in pregnant inpatients with a chemical dependency compared to nursing presence alone or standard care. They concluded TT is a holistic, simple and inexpensive way to improve compliance with chemical dependency treatment protocols (p. 330).

TT has typically been withheld from mental health arenas due to uncertainty about its clinical value (Vickers, 2008). Nonetheless, psychotherapists are already incorporating energy-based healing modalities, including TT, into their practices (Macecevic, 2008). As mental health expenditures rise, and more people besides veterans are diagnosed with trauma-related psychiatric and medical disorders, the augmented use of TT may be highly beneficial to both clinicians and patients.

CONCLUSION

The results of this study demonstrate the phenomenon of SCT 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. This further articulation of SCT also increases the limited expression of the non-linear experience of TT (Samarel, 1992).

All humans experience some level of trauma. Without resolution, it can predominate over one's life. The frequent encounter of patients in clinical practice comes at considerable cost. Current trauma treatment is only palliative and does not cure. Nor are the prevalent use of exposure-based therapies and pharmacotherapy universally effective. More efficient, cost-effective approaches

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that do not re-expose the client are needed. Energy healing that does not require a patient's re-traumatization has important implications for both patients and clinicians. Slater's (2004) suggestion that energy healing techniques and TT hold promise for victims of PTSD and trauma is further supported.

In conclusion, the language of the SCT phenomenon that emerged from this study demonstrates that SCT during TT is a source of intuitive information that guides the therapeutic process (Shaw, 2003, 2004; Vulcan, 2009). As an adjunct to talk therapy, TT may allow patients to bring unconscious feelings and perceptions to conscious awareness followed by healing and release. Since, as the findings of this study show, feelings are stored in the body, TT may provide the nurse with an opportunity to assist the patient in releasing emotional energy blocks. Given the multitude of trauma experiences in the clinical population, findings will contribute to knowledge about the SCT phenomenon and the role TT plays in trauma treatment. Further description and research is needed.

Bio Sketch:

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