A Complementary Health Approach to Facilitate Healing and Integration Among Adult Survivors of Childhood Sexual Abuse: The Shamanic Practitioner's Perspective

Author: Martha W. Healey

Boston College

William F. Connell School of Nursing

A COMPLEMENTARY HEALTH APPROACH TO FACILITATE HEALING AND INTEGRATION AMONG ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE: THE SHAMANIC PRACTITIONER'S PERSPECTIVE

a dissertation

by

MARTHA W. HEALEY

submitted in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

December 2016

Acknowledgements

I am profoundly grateful to all who encouraged and supported me to successfully complete my dissertation:

- Danny G. Willis, D.N.S., RN, FAAN., Department Chair and Associate Professor William F. Connell School of Nursing, Boston College, my committee chair, exceptional thinker, teacher, mentor, and spiritual being who guided me throughout the dissertation process;
- Judith Vessey, Ph.D., CRNP, M.B.A., F.A.A.N., Lelia Holden Carroll Chair in Nursing, William F. Connell School of Nursing, Boston College, my committee member, editor and champion who helped me to think and reach beyond my comfort zone;
- Jane M. Flanagan, PhD., ANP-BC., Associate Professor William F. Connell School of Nursing, Boston College, my committee member, editor and professor who kept me grounded in the discipline of nursing;
- Judith Shindul-Rothschild, PhD., RNPC, Associate Professor William F. Connell School of Nursing, Boston College, my advisor, who was a constant source of support and encouragement;
- Allison B. Morse, my partner, friend, editor and APA expert, who patiently and lovingly helped me to successfully complete my dissertation, I am indebted to you;
- My family and family of friends who were patient, loving, kind and supportive throughout this journey, you are the best

- Marilyn Hajer, LICSW, my sage, who challenged me to stay curious and evolve;
- Kate Gray, an extraordinary Shamanic Healer, who introduced me to shamanic healing and guided me on this path;
- Shamanic Healers, who embrace ancient healing traditions to promote healing and elevate universal consciousness;
- Shamanic Healers who participated in this research and provided the insight and data to make this dissertation possible;
- My classmates: Tania Strout, Rachel DiFazio, Douglas Schlichting, Brian French, and Lisa Wolf – a phenomenal group of intelligent people who listened, challenged and inspired me through this process, thank you for your love and support, I am forever grateful.

Dedication

I am honored to dedicate this work to all who have endured childhood sexual abuse; I am awed by your fortitude. I encourage you to move beyond victim consciousness to an empowered life in which you may live your destiny.

A Complementary Health Approach to Facilitate Healing and Integration Among Adult Survivors of Childhood Sexual Abuse: The Shamanic Practitioner's Perspective

Martha W. Healey

Dissertation Chair: Danny G. Willis, D.N.S., RN, FAAN

Abstract

Childhood sexual abuse (CSA) survivors are at risk of suffering from myriad physical, emotional, relational, spiritual, and energetic aftereffects. Scant research has addressed healing of spiritual and energetic aftereffects, especially sense of fragmentation/soul loss. No published research has addressed shamanic healing for CSA survivors. Thus, the purpose of this qualitative descriptive research was to describe the use of shamanic healing as a complementary health approach for adult CSA survivors from the perspectives of shamanic healers.

A qualitative descriptive design was used in this research. In-depth semi-structured individual interviews were conducted with a purposive sample of 15 shamanic practitioners. Interviews focused on the shamanic practitioners' perspectives of CSA healing from western and shamanic viewpoints, shamanic methods of assessment, intervention, evaluation of outcomes, and benefits for adult CSA survivors. Interview data were analyzed using conventional qualitative content analysis, including coding, sorting, and categorizing.

Shamanic practitioners described the Western viewpoint on CSA healing as limited in scope by not adequately addressing energetic and spiritual aftereffects, with the potential to leave the survivor stuck in victim mode. In

contrast, the shamanic perspective was described as an expanded paradigm for CSA healing, extending beyond the individual to multigenerational healing. CSA was framed as an event in the survivor's life that served as a teacher of life lessons, inviting the survivor to live up to one's full potential and not be defined by CSA. The findings indicated that shamanic healing has the potential to facilitate transformative integrative healing of the adult CSA survivor by addressing the relational, spiritual, energetic, and multigenerational impact of CSA. Shamanic healing involved integrating the survivor's perceived lost soul parts (vital energy) back into consciousness, clearing toxic energy, and restoring energy flow.

The findings have implications for nursing education, theory, practice, research, and policy. The findings can serve as a foundation for designing future research on shamanic healing to address the full spectrum of healing needs of adult CSA survivors.

Table of Contents

Chapter 1: Overview of the Study

Introduction

Current data-driven and theoretically based integrative healing modalities for providing quality, humanistic, person-centered care for adult survivors of childhood sexual abuse (CSA) (hereafter referred to as adult CSA survivors) are limited in both number and efficacy. Despite traditional individual psychotherapeutic approaches and use of mood-altering psychotropic medications which may have numerous untoward side effects for individuals, many adult CSA survivors continue to experience a myriad health challenges (Kalsched, 2013). An adult CSA survivor's sense of being an integrated whole human being is continuously challenged as the survivor experiences and manifests physical, emotional, cognitive, relational, and spiritual sequelae related to CSA (Kalsched, 2013; Shengold, 1989). Survivors often turn to integrative healing practitioners for help that they cannot get within the medical model of psychiatry (Price, 2005). One of the more intractable health challenges that adult CSA survivors struggle with is a sense of fragmentation or a splitting of oneself as a result of CSA whereby the survivor strives for a holistic sense of integration (Kalsched, 2010, 2013; Shengold, 1989).

Unfortunately, little is known about non-traditional integrative healing modalities for ameliorating adult CSA survivors' sense of fragmentation within conventional western medicine. In fact, one of the major gaps in the science of CSA healing is knowledge about integrative healing modalities and their influence on the health of CSA survivors; yet, integrative modalities are holistic in nature and specifically structured to address human responses to CSA referred to in the literature as fragmentation. Fragmentation is analogous to the phenomenon of dissociation

in conventional mental health medicine (psychiatry) and the phenomenon of soul loss described in the Shamanic healing traditions (Ingerman, 2008; Kalsched, 2013; Villoldo, 2005).

This proposed research will explore shamanic practitioners' perspectives on the use of integrative shamanic healing modalities as a complementary health approach for adult CSA survivors struggling with a sense of fragmentation/soul loss. This research is a logical next step in building a substantive body of knowledge in nursing science on myriad health strategies for facilitating healing using integrative health modalities targeted toward health challenges faced by the adult CSA survivor. Specifically, this study will focus on shamanic healing modalities used by shamanic practitioners for aiding adult CSA survivors in the process of healing from perceptions and feelings of fragmentation /soul loss. At the outset, this researcher acknowledges that shamanic healing is a complementary health approach that some adult CSA survivors are known to use to facilitate healing from a sense of fragmentation/soul loss in conjunction with conventional biomedical approaches. This acknowledgement and the dissertation researcher's personal experiences studying shamanic healing in Peru have provided the impetus for proposing this scholarly inquiry.

In the remainder of this dissertation proposal, Chapter One provides an overview of the proposed research. The background and significance of the problem of childhood maltreatment, specifically CSA as a form of maltreatment, is reviewed. The overview includes statistics related to the scope of the problem, the cost burden, the sequelae of CSA and CSA treatment options. Also included is an overview of dissociation, a common human response to CSA, and a brief orientation to the phenomenon of fragmentation/soul loss. Next, a brief synopsis of shamanism as a potential complementary health approach (CHA) for facilitating healing and integration in the aftermath of CSA is offered. In closing chapter one, the purpose of the research, research

questions, specific aims, operational definitions, nursing framework, and research design are briefly outlined. The significance of the proposed research to the discipline of nursing is discussed.

Chapter Two provides an overview of childhood maltreatment (CM) and an in-depth literature review on the topic of CSA. Moreover, the concept of holism is reviewed in relation to the discipline of nursing as well as the profession of medicine. An overview of complementary health approaches is provided. Literature on Shamanism is reviewed as a specific complementary health approach that may be beneficial for facilitating healing and integration for the adult CSA survivor.

Chapter Three outlines: (1) proposed research design (qualitative descriptive), (2) setting, (3) sampling approach, (4) inclusion/exclusion criteria, (5) proposed sample size, (6) procedures, (7) human subjects research protection, (8) data collection, (9) data analysis, and (10) qualitative research rigor.

Background and Significance of the Problem

Childhood maltreatment (CM) is a global epidemic that transcends culture, race and socioeconomic status. On the most basic level, it is understood as any harm caused to a child whether intentional or not (Health and Human Services, 2013). Childhood maltreatment is classified as sexual, physical, or emotional abuse, and/or neglect and it has a tremendous impact on the individual survivor, and in turn, on society. In 2008, the CDC estimated the annual lifetime cost associated with CM to be $124 billion dollars (Fang, Brown, Florence, & Mercy, 2012), using an inflation rate of 9.7% the estimated annual lifetime cost in 2015 would be approximately, $136 billion. This enormous sum, includes costs that are incurred on multiple levels of society: productivity lost, engagement of law enforcement, subsequent legal processing

through the judicial system, costs of suffering, and physical and mental health care (Children's Bureau, n.d.; 2009; Fang, et al., 2012; Rovi, Chen, & Johnson, 2004; Zielinski, 2009).

In 2012, Child Protective Services in the United States (US) received 3.4 million referrals involving approximately 6.3 million children requiring investigation of CM. From those referrals, they estimated 686,000 children suffered from CM (Health and Human Services, 2013). On a national and international scale, reporting bias presents a major challenge in detailing the epidemiology of CM in all of its forms; the numbers are likely an underrepresentation of the actual number of child cases. While impossible to determine the actual rate of CM, the health sequelae are devastating and insidious throughout the course of the survivor's life. According to various scholars, sequelae include physical, psychological, and behavioral effects which are associated with all types of CM. Physical effects include burns, cuts, fractures, brain damage, and sometimes death; psychological effects include feelings of dissociation, fragmentation, shame, decreased self-confidence, anxiety, depression, difficulty developing trust, difficulty forming intimate relationships, post-traumatic stress disorder; and behavioral effects include eating disorders, re-victimization, addiction, risk taking behavior, low academic achievement, delinquency, and engagement in violent crimes (Arias, 2004; Children's Bureau, n.d.; Collishaw et al., 2007; Gilbert et al., 2009).

Childhood sexual abuse (CSA). The following section will focus specifically on childhood sexual abuse (CSA), its epidemiology, sequelae and both conventional treatment modalities and complementary health approaches. In 2012 in the US, 62,936 cases of CSA were reported(Health and Human Services, 2013). Older statistics reported in 2005 by Finkelhor and colleagues (Finkelhor, Ormrod, Turner, & Hamby, 2005) indicated 1 in 12 children was a victim of CSA. According to The National Center for Victims of Crime (2012), girls are

disproportionately affected; teenagers are more often affected than younger children; 28% of youth ages 14 to 17 have been sexually victimized; and 20% of women and 5-10% of men as adults self-reported having experienced a CSA incident (Finkelhor, 2012). CSA is known to have sequelae and myriad effects (described above) on the individual across the lifespan; they can be immediate or delayed, obvious or insidious, mild or devastating (Cougle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010; Kendall-Tackett, 1993).

The sequelae of CSA have been described by psychiatrists and trauma specialists in relation to a coping response that they have traditionally labeled 'dissociation': an involuntary psychological means of separating and protecting one's self from the experience of violation and trauma (D. R. Wilson, 2010). Dissociation has been specifically conceptualized as fragmentation of the self during traumatic sexual abuse experiences (Herman, 1992a; Shengold, 1989; van der Kolk, Bessel, van der Hart, Onno, & Marmar, 2007).

Psychiatrist and traumatologist John Briere and colleagues (Briere, 1996) further describe dissociation as a "correlate of trauma exposure, which is considered to be an avoidance response to the extent that dissociation alters awareness, distracts, anesthetizes, produce distress-incompatible states or temporarily forestalls negative experiences thereby redirecting attention away from otherwise overwhelming emotions" (p. 767). Kalsched, another traumatologist, explained dissociation as an innate psychological defense that protects from pain and fear by preserving "a sacred core of personality from immanent violation and destruction" (Kalsched, 2010, p**.** 283)**.** The traumatologist went on to describe the fragmented self or the split part of the self as the 'lost inner child'. With regard to this notion of the lost inner child, conventional medicine and therapies do little to acknowledge the importance of reintegrating the self or retrieving the lost inner child in the treatment of adult survivors of CSA (Kalsched, 2010).

The concepts of dissociation, lost inner child, and the phenomenon of fragmentation described by trauma specialists are analogous to the notion of soul loss in the Shamanic healing tradition – the focus of this proposed research. Within the shamanic healing tradition, the shamanic treatment modalities and processes of soul journeying and soul retrieval are of potential benefit in facilitating the CSA survivor's healing and integration toward a sense of wholeness. These shamanic healing modalities are intended and designed so that they can assist CSA survivors with integration of their perceived lost soul parts which conventional medicine, psychopharmacology, and individual psychotherapy do not conceptualize and adequately address.

Presently, the health sequelae associated with CSA are primarily treated using a variety of conventional therapeutic modalities such as psychopharmacology, psychoanalysis, psychodynamic therapy, cognitive behavioral therapy, and dialectical behavior therapy (Courtois & Ford, 2009; Feliciano, 2009; Herman, 1992a). Kalsched (2010) described that while these modalities are beneficial to many CSA survivors with regards to: emotional regulation, cognitive behavioral reframing, and developing insight into the past and its influences on present behavior and functioning, some adult CSA survivors are left with a lingering sense of fragmentation of their being (Kalsched, 2010); or a sense of soul loss as described in shamanic traditions. Healing therapies beyond what conventional health or medicine approaches can provide is a fertile domain for discovery, research, and scholarship regarding CSA healing and complementary health approaches.

Categorizing Healing Therapies: Complementary Health Approaches

The term "complementary health approaches" has been adopted by the National Center for Complementary and Integrative Health (NCCIH) at the National Institutes of Health (NIH) to

capture three distinct areas of healing therapies: complementary, alternative and integrative. Thus, in this proposed research, the term complementary health approaches (CHA) will be used. The terms complementary, alternative, and integrative medicine or health care are widely used interchangeably to indicate methods of treatment that are outside western conventional medicine according to the NCCIH. The NCCIH defines complementary as a non-mainstream approach together with conventional medicine. Alternative therapies are non-mainstream approaches used instead of conventional medicine, while integrative therapies indicate the use of non-mainstream approaches with traditional medicine by health care providers or within their practices (National Center for Complementary and Integrative Health, 2015, para. 3).

Complementary health approaches have been divided into two subcategories: natural products and mind and body practices. Natural products include botanicals, herbs and dietary supplements. Mind and body practices include a wide variety of procedures or techniques such as acupuncture, massage, yoga, a multitude of meditation techniques, breathing exercises, guided imagery, muscle relaxation methods, tai chi, qi gong, healing touch and hypnotherapy that are performed by trained practitioners or teachers (National Center for Complementary and Integrative Health, 2015, para. 3).

According to a National Health Institute Survey conducted in 2012, the most commonly used mind body practices are chiropractic and osteopathic manipulation, massage, yoga, progressive relaxation, and guided imagery (National Center for Complementary and Integrative Health, 2015). In addition to the two broad subcategories of products and practices, NCCIH also recognizes the practices of traditional healing including shamanic healing, Ayurvedic medicine, traditional Chinese medicine, homeopathy and naturopathy under the umbrella of complementary health approaches (National Center for Complementary and Integrative Health,

2015). Relevant to this NCCIH classification of complementary health approaches, shamanism "represents the most widespread and ancient methodological system of mind-body healing known to humanity" (Harner, 1990, p.40).

Shamanism as a complementary health approach. Complementary health approaches are often associated with holistic care and bringing about perceptions and experiences of integration and wholeness which may offer benefit in the treatment and healing for adult CSA survivors experiencing a sense of fragmentation/soul loss. As noted above in the NCCIH classifications, Shamanism, one of the earliest traditional healing methods, is consistent with the concept of holistic healing as conceptualized in health sciences, nursing, and medicine, in that it considers the integrated human being including, mind, body, spirit and the environment when addressing health and well-being (Academy of Integrative Health and Medicine, 2015; American Holistic Nurses Association, 2015).

According to anthropologist and shamanic healer Dr. Michael Harner, a leader and scholar in bridging the gap between Shamanism and western medical awareness, Shamanism can be traced back thirty thousand years using archeological and ethnological evidence (Harner, 1990). The term *shaman* originates from the language of the Tungus people of Siberia. Another noted anthropologist, shaman and scholar of Peruvian shamanism, Dr. Alberto Villoldo, explained that the term shaman refers to "medicine men or women who are the healers, teachers and sages. Shamanism is an ancient spiritual and healing practice found throughout the Americas and all traditional cultures in the world – India, Tibet, Russian, Central Europe and practiced most actively today in the Americas" (Villoldo, 2015b, para. 3). The practice of shamanism is prevalent amongst indigenous cultures around the globe: Central Asia, Siberia, Europe, Africa, Australia, and North and South America. Shamanic assumptions and healing

methods are remarkably similar throughout the world despite vast geographic distance between specific societies and tribes (Harner, 1990). Within this ancient healing system, shamanic healers engage multimodal healing methods to restore the health of the individual, community, nature, and the universe. Historically, within nomadic tribal cultures, shamans were thought of as general practitioners responsible for the overall health of the community. They were responsible for healing their community and the earth, determining when to plant and harvest crops, and deciding the direction of travel on behalf of the tribe (Kalweit, 2000; Walsh, 2007). Healing modalities included the use of herbs and other botanicals, energetic healing, and spiritual healing, and are based on the notion of a living universe – or 'animism'.

Animism. Shamanic traditions are based on the principle of *animism.* That is, the notion of a living, conscious, communicative universe. Specifically, animism posits a universe in which everything is spirited. Thus, healing is achieved when the shaman communicates with and comes into balance, harmony, or what Incan shamans refer to as *Ayni* – the sense of being in the right relationship with spirit (Harner, 1990; Ingerman, 1991; Villoldo, 2005). *Ayn*i, balance, harmony, and/or being in right spiritual relationship with oneself, community, and nature may facilitate those suffering with the aftereffects of CSA – particularly the aftereffect of sense of fragmentation/soul loss – to experience healing and a sense of integration/wholeness as shamanic healers facilitate healing, integration, harmony, and sense of wellbeing.

From within the varied perspectives, goals, and the knowledge base of the discipline of nursing, the phenomenon of healing is a major focus (Willis, Grace, & Roy, 2008). Knowledge about healing can be expanded and refined with new discovery and research related to the ancient healing system and modalities of shamanism specifically with regards to the phenomenon of healing. While this research is not based on any one particular theory or

predetermined concepts within nursing theory, the findings will provide knowledge about healing and may have potential fit with several nursing theoretical systems including Martha Roger's Science of Unitary Human Beings (Rogers, 1994) that conceptualizes human beings and the environment as energy fields in mutual process, and for which non-invasive healing modalities are paramount. This dissertation research may also fit with Margaret Newman's Theory of Health as Expanding Consciousness that posits health challenges as a potential catalyst for an evolution of consciousness in terms of the expanded information capacity of the human system toward unbinding and choice and freedom (Newman, 1994).

Purpose of the Study

Grounded in the scientific literature and well-established conceptualizations of the phenomenon of fragmentation/soul loss in the aftermath of CSA, this research aims to investigate shamanic healing from the perspective of practicing shamanic healers as a complementary health approach to facilitate healing and integration for the adult CSA survivor.

The research design for this study will be qualitative descriptive. The researcher will conduct in-depth individual interviews with practicing shamanic healers to collect their descriptions of shamanic methods of assessment, intervention, evaluation of outcomes, and benefits of shamanic healing in relation to the adult survivor of CSA. Specifically, the researcher will recruit shamanic practitioners who have completed the 7-course shamanic healing curriculum and certification program of the Four Winds Light Body Energy Medicine School entitled "The Shaman's Journey" (The Four Winds Society, 2015b). The researcher will invite practitioners for individual interviews who self-identify as possessing professional shamanic practice experience specifically providing the healing care of soul journeying and soul retrieval for adult CSA survivors who experience sense of fragmentation/soul loss. A semi-structured

interview guide including probes for obtaining additional information and for clarification purposes will provide the structure for the interviewing process.

Specific Aims

1. To explore the shamanic practitioners' perceptions on the nature of shamanic healing and the role it has in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/ soul loss.
2. To provide a comprehensive summary of the assessment methods used by the shamanic practitioner to determine the aftereffects of CSA trauma, specifically related to sense of fragmentation/soul loss.
3. To discover the perspectives of shamanic practitioners regarding their use of specific shamanic techniques including soul journeying and soul retrieval for facilitating healing of adult CSA survivors experiencing fragmentation/soul loss.
4. To describe evaluation methods shamanic practitioners use to evaluate healing specifically in relation to sense of fragmentation/soul loss and improvement in sense of wellbeing for the adult CSA survivor?
5. To describe shamanic practitioners' perspectives associated with healing and integration for adult CSA survivors based on their identification and evaluations of survivors who have engaged in the process of shamanic healing from sense of fragmentation/soul loss.

Research Questions

1. What are the shamanic practitioners' perspectives on the nature of healing and the role of shamanism in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/soul loss?

2. What assessment methods are used by the shamanic practitioners to determine the aftereffects from CSA trauma, specifically related to sense of fragmentation/soul loss in the shamanic tradition?
3. What are the perspectives of shamanic practitioners regarding the use of specific shamanic healing techniques including soul journeying and soul retrieval for issues related to sense fragmentation/soul loss, to facilitate healing and integration?
4. What are the evaluation methods shamanic practitioners use to evaluate healing in relation to sense of fragmentation/soul loss and improvement in sense of healing and integration for adult CSA survivors?
5. What are the effects of shamanic healing on sense of fragmentation/soul loss as perceived by shamanic practitioners based on their evaluations of adult CSA survivors healing from fragmentation/soul loss in their practices?

Definition of Terms

The variables and concepts in this study are defined using the current literature. The following definitions are used for the purposes of this research:

- **Trauma: A** stressful event or situation that is experienced as emotionally painful and distressing. The event or situation overwhelms an individual's ability to cope (Allen, 2004; Herman, 1992b).
- **Childhood Maltreatment:** An act or series of acts of commission or omission by a parent or other caregiver that result in harm, potential for harm, or threat of harm to a child. Acts of commission include physical, sexual and psychological abuse. Acts of omission include the failure to provide for a child's basic physical, emotional or educational needs (Health and Human Services, 2013).

- **Childhood Sexual Abuse**: The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct (Children's Bureau, n.d.).
- **Soul:** The vital essence of a person, which is immortal and transcendent of material existence (Lanza, 2011).
- **Soul Loss:** The departure of part of the vital essence of a person from the corporeal to non-ordinary reality, as a survival mechanism in response to trauma (Ingerman, 2008; Kalsched, 2013; Villoldo, 2005).
- **Soul Retrieval:** A shamanic healing modality in which the shamanic practitioner enters an altered state of consciousness to locate lost soul parts and return it to the body in order to facilitate healing and integration (Ingerman, 1991).
- **Shamanism**: A widespread and ancient methodological system of mind-body healing, which engages multimodal healing methods to restore the health of the individual, community, nature and the universe. Examples of these methods include, spiritual, energy, and herbal therapies, soul journeying and soul retrieval (Harner, 1990; Ingerman, 1991; Walsh, 2007).
- **Shaman:** Keepers of ancient knowledge and techniques, they are intermediaries or messengers between the human world and the spirit worlds who treat ailments/illness by mending the soul, restoring energetic balance and wholeness to the individual, community, nature and the universe (Eliade, 2004; Harner, 1990; Ingerman, 1991; Walsh, 2007).

- **Shamanic Journeying:** Shamanic journeying is the inner art of traveling to the invisible worlds beyond ordinary reality to retrieve information for change in every area of our lives from spirituality and health to work and relationships (Ingerman, 1991).
- **Consciousness:** an adequate philosophical, scientific, or psychological consensus on the definition of consciousness remains elusive. For the purpose of this research, consciousness "consists of a narrow, dynamic stream of everything we are presently aware of—our perceptions of the external world and bodily sensations, together with our thoughts, actions, emotions, and memories" (Costandi, 2011, para. 6).
- **Altered States of Consciousness:**

  "Altered states of consciousness are temporary, reversible conditions in which one's pattern of subjective experience, and sometimes the ability to control one's own behavior, appear to be different than in one's normal waking state. Among the altered states are sleep and dreaming, hypnosis, meditative and mystical states, and states induced by psychoactive drugs and by restricted environmental stimulation" (Farthing, 1992, p. 2, para. 2).

Nursing Conceptual and Theoretical Influences

This research is grounded in the ideals of holism, nursing, and Shamanism. This research is founded in the philosophical notion and moral/ethical ideal of holistic nursing care dating back to the era of Florence Nightingale and the nursing care she promoted, practiced, and explicated (Nightingale, 1860). In keeping with the focus on nursing established by Nightingale, the American Holistic Nursing Association (AHNA) defines holism as "a healthcare philosophy that focuses on unity, wellness and the interrelationship of human beings, events and the environment" (American Holistic Nurses Association, 2015, para. 2).

Holistic nursing emphasizes "protecting, promoting, and optimizing health wellness, preventing illness and injury, alleviating suffering, and supporting people to find peace, comfort, harmony, and balance" (American Holistic Nurses Association, 2015, para. 4). In addition to the concepts of holism, the contemporary definition of nursing espoused by Willis et al. (2008) grounds this researcher's qualitative exploration and discovery of knowledge about healing from CSA within the context of complementary health approaches. These authors define nursing as: "a healthcare discipline and healing profession, both an art and science, which facilitates and empowers human beings in envisioning and fulfilling health and healing in living and dying through the development, refinement, and application of nursing knowledge for practice" (p. E33). Thus, this proposed research helps to explicate certain concepts described by Willis et al. (2008) as the central unifying focus for the discipline of nursing, namely "facilitating humanization, meaning, choice, quality of life, and healing …" (p. E.33). Moreover, given the topic of this doctoral dissertation, this research is also undergirded by shamanic teachings originating in the ancient wisdom and healing traditions of the Andes and Amazon, to be further described.

This research explores and, perhaps, expands the range of possibilities for holistic nursing in the 21st century by drawing on shamanic healers' knowledge, expertise, and intuition, some of whom are licensed as nurses and practice shamanic healing based on their completion of the Four Winds Society curriculum. Nurses and shamanic practitioners are therapeutic journeying partners with the people in their care. Nurses are educated to "recognize the totality of the human being: the interconnectedness of body, mind, emotion, spirit, social/cultural, relationship, context, and environment*"*(American Holistic Nurses Association, 2015, para. 2). Holistic nursing is an attempt to facilitate balance of mind, body, spirit in relation to the individual, the

individual and others, and the individual and the universe, to promote a human being's sense of well-being; this is similar to the notions of balance and harmony described earlier in the shamanic healing tradition. Holistic nursing requires the nurse to be self-reflective, practice self-care, self-responsibility including spirituality in his/her life. These practices allow for the nurse to achieve an expanded sense of awareness of the interconnectedness/integrality of oneself, others, nature, and spirit, which may facilitate self-awareness and the healing process (American Holistic Nurses Association, 2015).

Likewise, the traditions of Shamanism, in particular those of the Peruvian Andean and Amazon lineage, serve as the foundation this research. Shamanism holds the distinction of being both a traditional healing modality and the oldest of the healing professions. With the onset of contemporary western healthcare, it has been categorized as a complementary health approach as defined by NCCIH. Shamanic healing facilitates health and well-being of the individual, society and nature through the use of a variety of techniques; herbalism, energy therapies, and spiritual therapies that have the effect of connecting the material and immaterial worlds: worlds of matter and energy that create balance, harmony and a sense of well-being. These practices take into account the whole individual, mind, body and spirit and their interaction with the universe.

Research Method

This research will use a qualitative descriptive research design. This type of qualitative research will provide a rich description of the experience of shamanic healing related to the facilitation of healing for the adult CSA survivor as perceived and practiced by shamanic healers providing care for adult CSA survivors. According to Sandelowski (2000), qualitative descriptive research is underpinned by the tenets of naturalistic inquiry, whereby researchers examine and understand complex experiences, events and/or behaviors in their natural settings

versus experimental approaches or control of certain pre-determined variables. Data obtained in qualitative descriptive research is generally gathered from in-depth interviews by the researcher and/or direct observation or focus group interviewing (Sullivan-Bolyai, Bova, & Harper, 2010).

For the purpose of this doctoral dissertation, the researcher will conduct individual in-depth interviews with shamanic practitioners. Interviews will be digitally recorded, and transcribed. The researcher will crosscheck the data transcripts with the digital recordings for accuracy. In keeping with several analytic options when conducting qualitative descriptive research, data analysis will focus on conventional content analysis and coding systems (Hsieh & Shannon, 2005; Miles & Huberman, 1994) that call for the researcher to analyze and interpret data without transforming it. This means that the findings will be reported using common everyday language that provides a clear description and representation of the perspectives of the shamanic healing participants in this study.

Significance of the Study and Nursing Implications

Childhood sexual abuse (CSA) is a pervasive social and health problem that results in diminished quality of life, suffering, and disruptions in systems of meaning and integration (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The sequelae of CSA manifest as physical, emotional, and behavioral problems over an extended period of time and the effects are often debilitating and affect adult functioning. Current data-driven and theoretically based treatment modalities for addressing the sense of fragmentation/soul loss for adult CSA survivors are limited. Shamanic healing as a complementary health approach may benefit the adult CSA survivor by facilitating healing of the survivor's sense of fragmentation/soul loss, ameliorating suffering, or in a westernized worldview of medicine, resolving specific symptoms associated with the aftermath of CSA. However, more research is needed to explicate this type of

integrative healing approach specifically in relation to adult CSA survivorship, the phenomenon of healing, and shamanistic approaches' relevance for holistic nurses and for holistic nursing theory development, extension, and revision.

As holistic practitioners, nurses address the physical, psychosocial, and spiritual well-being of their patients. The American Nurses Association's Code of Ethics (American Nurses Association, 2015) empowers nurses to focus on health restoration yet we do not have adequate descriptions and understanding of shamanic integrative healing approaches that may well add to nursing's range of health restoration. Thus, this research is novel and significant for advancing the foundation of knowledge for holistic nursing practice. Given nursing's holistic framework and its ethical obligations, nurses are well suited to aid human beings in their healing journeys. A variety of alternative and complementary integrative healing approaches may be required to address the complex manifestations of suffering, health, and sense of wellbeing for adult CSA survivors.

Chapter Two: Review of the Literature

Introduction

The purpose of this research is to investigate shamanic healing, from the perspective of practicing shamanic healers, as a complementary health approach to facilitate healing and integration for the adult CSA survivor. The following chapter presents a brief review of the literature related to childhood maltreatment (CM) and an in depth review related to childhood sexual abuse (CSA) including definitions, statistical data, economic burden, sequelae, and conventional treatment modalities. The literature review continues with a focus on holism, the roots and pioneers of holistic nursing, and complementary health approaches including the ancient healing tradition of shamanism. This review exposes gaps in the literature regarding the use of shamanic healing as a complementary health approach to integrate and heal the sense of fragmentation/soul loss experienced by adult survivors of CSA.

Childhood Maltreatment

Childhood maltreatment (CM) is briefly reviewed below as it represents all forms of childhood abuse and neglect in which CSA is included. A definition of CM is provided followed by an overview of general statistical data, information related to the economic burden to society and associated sequelae of CM.

Childhood maltreatment: definition. CM is a global epidemic that effects children of every demographic of society; transcending culture, race and socioeconomic status; and has been widely described in the scientific literature. The Centers for Disease Control and Prevention (2014) define CM as an "act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child. Acts of commission include physical, sexual and psychological abuse. Acts of omission include the

failure to provide for a child's basic physical, emotional or educational need"(CDC, 2014a; Health and Human Services, 2013).

Childhood maltreatment: statistical data. Data revealing the true impact of CM is challenging to obtain. Shame and fear experienced by the victims of CM may lead to inaccurate reporting that negatively affects the epidemiologic data; disparate definitions of terms may cause confusion when comparing data across studies; and incidence studies, which examine the number of occurrences over a specific time period (generally one year) and within a defined population, can obscure the rates experienced throughout childhood. In addition, statistics provided by the U.S. government are based only on unique cases that have been investigated and determined to meet the criteria of CM. They do not address the issues of repetitive abuse or those unique cases left uninvestigated. Therefore the statistics provided from research findings and governmental reports of CM likely underestimate the true occurrence of the problem (Finkelhor, Turner, Shattuck, & Hamby, 2013; Townsend & Rheingold, 2013).

Finkelhor and colleagues conducted the *National Survey of Children's Exposure to Violence*, a telephone interview to assess the estimates of CM, which occurred over the prior year. The initial study, conducted in 2008, was repeated in 2011. Over 4,500 individuals, caregivers and youth aged 10-17 were interviewed for each study. The results from the 2011 survey indicate 41.2% experienced a physical assault. Another 2% experienced sexual assault in the past year with the rate among girls greater than boys. The highest percentage of assaults occurring in those aged 14-17 years and 13% experienced maltreatment by a caregiver. A comparison of the 2008 and 2011 surveys did not indicate any significant changes (Finkelhor, Hamby, Ormrod, & Turner, 2009; Finkelhor et al., 2013).

In 2012, Child Protective Services (CPS) received 3.4 million reports of childhood maltreatment. Of the cases that were actually investigated, 686,000 (9.2 per 1,000) children were confirmed to have suffered CM (Health and Human Services, 2013). CPS indicated 78% were victims of neglect; 18% suffered physical abuse; 9% were sexually abused; and 11% endured other forms of maltreatment such as, emotional or threatening, caretakers abuse of drugs and alcohol or inadequate supervision (Health and Human Services, 2013). Of these victims 47% were less than 5 years of age, with those under a year having the highest rate of victimization. Rates regarding ethnicity indicated African American, American Indian/Alaska Natives, and multiracial children were more affected than non-Hispanic whites and Asian children. The statistics indicated girls were victimized more frequently than boys (Health and Human Services, 2013). In addition, cases of CM were more likely to be reported to CPS if the child had low performance on standardized development assessments, was one among several children in the family, or had a mother with depressive symptoms, who used drugs, or did not hold a high school degree (Dubowitz et al., 2011).

Childhood maltreatment: economic burden. Estimates of the economic burden associated with childhood maltreatment (CM) are significant. Fang, et al., (2012) indicate the total lifetime cost resulting from new cases of fatal and nonfatal CM in the United States is estimated in 2008 to be 124 billion dollars and the average lifetime cost per non-fatal victim is $210,012 while the cost per fatal victim is $1,272,900. Using a 9.7% rate of inflation, for the same number of fatal and nonfatal cases of CM, translates to approximately 136 billion in 2015 dollars. The economic burden extends far beyond the victim of CM to include, law enforcement, the judicial system, health and mental health care systems, and industry through the loss of

productivity due to illness, unemployment and under employment (CDC, 2014b; Fang et al., 2012; Franey, Geffner, & Falconer, 2001; Rovi et al., 2004; Zielinski, 2009).

Childhood maltreatment: sequelae. Despite the challenge of accurate epidemiologic reporting of CM and its cost to society, the research clearly describes a devastating impact to an individual and a population over a lifetime. The sequelae may include physical, psychological, and/or behavioral effects, and they may occur immediately after an incident (acute onset) or later in life. There is agreement among scholars researching CM and health consequences that adult survivors of CM experience more physical health conditions when compared to their peers without history of CM (Golding, 1999; Golding, Taylor, Menard, & King, 2000; Golding, Wilsnack, & Cooper, 2002).

In a recent study focused on the effects of CM on subsequent health, Hagar, et al., (2012) interviewed 235 women (aged 18–59 years) about self-report CM, perceived stress, coping strategies, and health status. Their study examined issues related to physical health, emotional wellbeing, and physiological response to stress. They found that a history of CM led to poor health outcomes, particularly when survivors had increased perceived stress and emotion-focused coping, defined as "strategies aim[ing] to regulate or control emotional states evoked by stressful situations (e.g., self-blame, wishful thinking, rumination, positive reappraisal)" (Hager & Runtz, 2012, p. 395).

Psychological morbidities associated with CM include feelings of shame, decreased self-confidence, anxiety, depression, eating disorders, difficulty developing trust, difficulty forming intimate relationships, and post-traumatic stress disorder (Briere & Jordan, 2009; Swannell et al., 2012). The behavioral effects include re-victimization (Briere & Jordan, 2009; Collishaw et al., 2007; Dutton & Greene, 2010), addictions, risk taking behaviors, low academic achievement,

delinquency, and engagement in violent crimes (Arias, 2004; Children's Bureau, n.d.; Collishaw et al., 2007; Gilbert et al., 2009). Adult survivors are more likely to have problems with interpersonal relationships and intimacy and they often experience shame, decreased self-confidence and decreased self-esteem (Collishaw et al., 2007). The sequelae of CM are vast and varied; therefore, designing treatment modalities that address the myriad needs of adult survivors of CM presents an enormous challenge.

As indicated above, CM includes acts of commission or omission that result in harm, potential harm or threat of harm to a child. This proposed research focuses on the shamanic practitioner's perspectives on healing and integration for adult survivors of childhood sexual abuse.

Childhood Sexual Abuse

A review of salient literature on childhood sexual abuse is presented including: definitions, statistical data, economic burden, sequelae, and conventional treatment modalities related to CSA. Specific focus is given to the psychological sequelae referred to in conventional medicine as, disassociation, fragmentation, and post-traumatic stress disorder in order to elucidate the similarities between these conventional western terms with the Shamanic concept of soul loss.

Childhood sexual abuse: definition. CSA is one subset of childhood maltreatment, which is unique in that it is a pervasive form that results in physical, emotional, social, psychological, and spiritual after effects. Government agencies, community based programs and scholars use similar yet varied definitions of CSA as shown below.

The U.S. Department of Health and Human Services (USDHHS), the leading data collection agency for childhood maltreatment, defines CSA as:

> the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, molestation, prostitution, or other forms of sexual exploitation of children, or incest with children (Children's Bureau, n.d. p.1,para. 2).

Prevent Child Abuse America, a public health organization focused on child abuse prevention and public policy in the U.S., Canada, Guam, and Puerto Rico, states CSA is:

> inappropriately exposing or subjecting the child to sexual contact, activity or behavior. This includes oral, anal, genital, buttocks or breast contact. It also includes the use of an object for vaginal or anal penetration, fondling, or sexual stimulation. This sexual activity may be with a boy or a girl and is done for the benefit of the offender. In addition, exploitation of a child for pornographic purposes, making a child available to others as a child prostitute, and stimulating a child with inappropriate solicitation, exhibitionism, and erotic material are all forms of sexual abuse(Pereda, Guilera, Forns, & Gómez-Benito, 2009) (Prevent Child Abuse America, n.d. p. 2, para.2).

Whereas Darkness to Light, another national organization committed to protecting children from sexual abuse, defines CSA as:

> a) any sexual act between an adult and a minor or between two minors when one exerts power over the other, b) CSA includes forcing, coercing, persuading a child to engage in any type of sexual act, c) sexual contact as well as non-sexual contact acts such as exhibitionism, exposure to pornography voyeurism and communicating in a sexual manner by phone or internet (Darkness to Light, 2013 p. 4, para. 2).

Researchers, like government agencies and community-based programs, have a unique definition of CSA. Some may include exposure, non-contact and contact abuse while others may only incorporate acts of penetration as part of their definition (Douglas & Finkelhor, 2005). Douglas and Finkelhor (2005) identified the lack of a universal definition as a complicating factor in determining prevalence rates. To maintain consistency with the leading data collection criteria in the US, this proposed research will use the CSA definition of the United States Department of Health and Human Services.

Childhood sexual abuse: statistical data. The same issues that challenge accurate data collection in CM as noted above influence the statistical data related to CSA. Statistics presented in the following review include U.S. government statistics, research results from incidence and prevalence studies, and conclusions based on meta-analyses. The review will begin with an older, classic study and move forward to more contemporary studies.

Finkelhor's (1994) landmark study, a meta-analysis found that between 7% and 36% of women and 3% and 29% of men suffered CSA. Averaging these figures, Finkelhor estimated that 20% of women and 5-10% of men experienced CSA before the age of 18. (Pereda et al., 2009)analyzed data from 100 studies involving sample sizes between 83 and 5,434. The authors estimated that internationally, 7.9% of men and 19.7% of women experienced CSA prior to the age of eighteen (Pereda et al., 2009). The National Center for Victims of Crime (2012) estimated that over the course of one's lifetime, 28% of youth ages 14 to 17 had been sexually victimized and as adults, 20% of women and 5-10% of men self-report a childhood sexual abuse incident (The National Center for Victims of Crime, 2012). The US Department of Health and Human Services' Childhood Maltreatment Report (2013) reported an estimate of 3.5 million referrals alleging CM of 6.4 million children were received by childhood protective agencies (CPS) in

fiscal year 2013. Of the 6.4 million children referred to CPS, 3.2 million children were screened in to receive an investigation by CPS and 679,000 were found to be victims of CM. It was estimated that the 9.3% (63,000) of the total childhood maltreatment victims (N = 679,000) experienced childhood sexual abuse (Health and Human Services, 2013).

A large community-based study was conducted by Pérez-Fuentes et al.(2013),whereby face-to-face interviews were performed with more than 34,000 adults in the U.S. population between 2004 and 2005. Based on their results, the authors estimated 10.14% of the population had experienced CSA prior to age 18. Among the group of adults who experienced CSA, nearly 75% were women and 25% were male. Those with a history of CSA, were more likely to be black or Native American, utilize public insurance, and have not completed high school (Pérez-Fuentes et al., 2013).

Townsend and Rheingold (2013), desired to obtain more accurate and current CSA prevalence data and therefore completed a meta-analysis of U.S. studies from 1992-2011. Their initial review identified sixteen studies of which six that met criteria for inclusion based on the definition of CSA used, the methodology employed by the study and the time period evaluated. Based on the six studies on the final cohort and data collected on subjects aged 14-17, the prevalence rates for contact CSA were 7.5% to 11.7%. Four of the studies in the final cohort reported on both boys and girls, estimated the prevalence rate for girls to be 10.7%-17.4% and the rate for boys to be 3.8% to 4.6%. A summary of the results estimated that 400,000 babies born in the US in 2013 will be sexually abused before they turn 18 years old (Townsend & Rheingold, 2013). These statistics clearly demonstrate that the economic burden is substantial.

Childhood sexual abuse: economic burden. The economic burden of CSA results from the many factors indicated above in the general discussion of CM. Costs relate to law

enforcement, the judicial system, special education needs, physical and mental healthcare costs, and the loss of productivity due to, illness, unemployment and underemployment. As a result the economic impact of CSA is most often reported within the total of CM costs therefore it is difficult to determine the specific costs associated with the subset CSA. Bonomi et al., (2008) contributed to the literature on health care costs by calculating that women with a history of CSA had a 16% increase in long-term annual health care costs compared with women who suffered no form of CM.

Given the physical, psychological, emotional, and spiritual sequelae of CSA, it is not surprising to see an increase in annual lifetime cost of medical, psychological, and emotional care spending for the survivors of CSA. The following section further describes the myriad sequelae, all of which lead to an increased cost burden as compared to an individual who has not experienced childhood sexual abuse.

Childhood sexual abuse: sequelae. The sequelae experienced by a CSA survivor include many of the same after effects experienced by those victimized by other forms of CM. However, research clearly demonstrates that adults with a history of CSA do experience sequelae unique to sexual abuse which can be divided into two broad categories, psychiatric and somatic manifestations, and further delineated into more specific subsets as depicted in Figure 1 (below) developed by Wilson (2010). The categories and subsets developed by Wilson (2010) are used to structure the remaining overview of the sequelae of CSA.

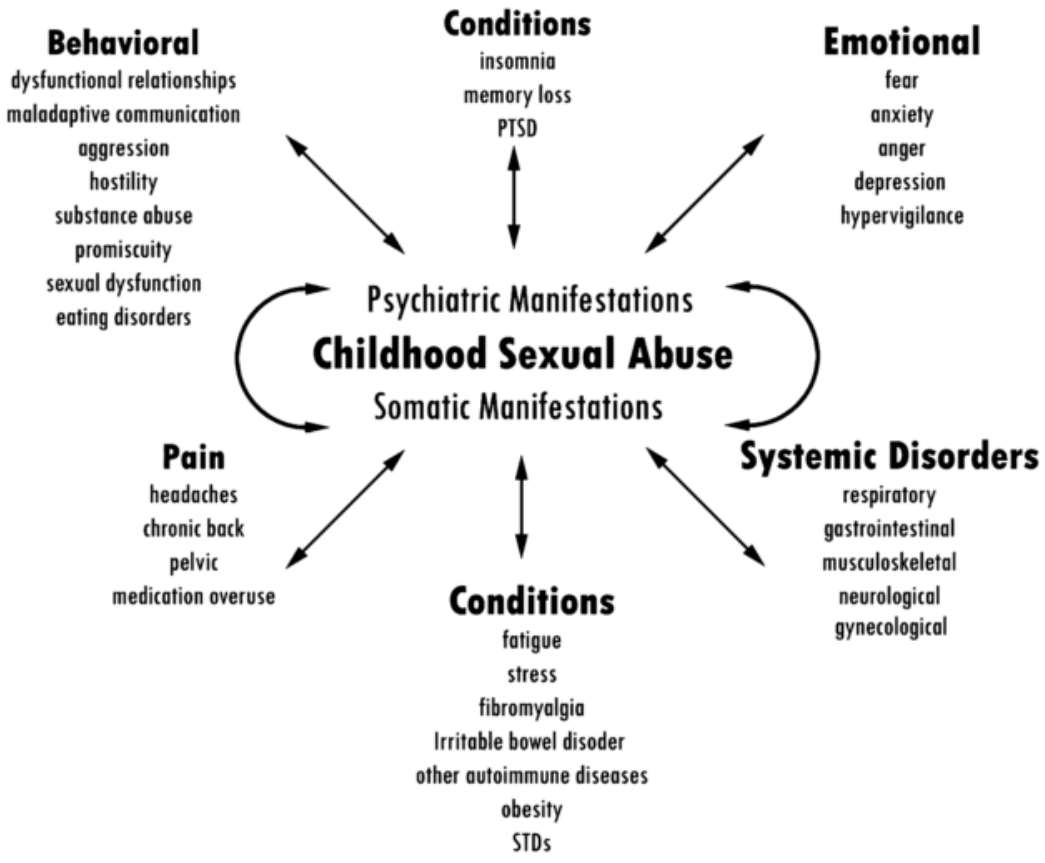

Figure 1. Health Consequences Associated with Childhood Sexual Abuse (Wilson, 2010)

Somatic manifestations. Somatic manifestations or physical after effects of CSA include immediate physical harm resulting from abuse, chronic health conditions, and long-term physiological effects. Immediate physical harm resulting from the abuse may include trauma related to burns, cuts, broken bones, sexually transmitted infections, brain damage, and sometimes death (Health and Human Services, 2013). Chronic health conditions and long term physiological effects are more widely investigated and reported in the literature.

Adult survivors of CSA often encounter increased stress, known to have a significant negative impact on physical health (Thoits, 2010), including decreased health over the lifespan (Golden-Kreutz et al., 2005), physical pain (Oleske et al., 2006), and increased utilization of

health care services (Dobkin, De Civita, Bernatsky, Kang, & Baron, 2003). It is known that allostatic load related to persistent and chronic stress interferes with normal functioning of the endocrine system resulting in cardiovascular problems and changes in metabolism, immune function, and anti-inflammatory responses (Friedman & McEwen, 2004). Stress is also known to increase physical sensitivity or experiences of pain (Kirmayer, Groleau, Looper, & Dominicé, 2004).

Other physical manifestations include, higher rates of asthma; chronic fatigue; abdominal, pelvic or back pain; headache; gastrointestinal disorders; and epileptic seizures (Krug, Mercy, Dahlberg, & Zwi, 2002; Leserman, 2005; M. G. Newman et al., 2000; Paras et al., 2009; Romans, Belaise, Martin, Morris, & Raffi, 2002; Sharpe & Faye, 2006). The literature also suggests a connection between CSA and fibromyalgia (R. Alexander et al., 1998), although recently, these findings have been contested by Paras et al (2009) indicating that significant correlations exist between fibromyalgia and CSA only when the abuse was defined as rape, not other forms of sexual maltreatment such as exhibitionism or fondling.

The psychological sequelae of CSA, a lack of self-advocacy, poor self-care, and issues of trust negatively influence women's physiological health in the aftermath of CSA. Women adult CSA survivors were less likely to seek pre and postnatal care (Leeners, Neumaier-Wagner, Quarg, & Rath, 2006) and were more likely to engage in risky sexual behaviors increasing their risk for HIV, STDs, unplanned pregnancies, and unhealthy pregnancies (Cougle et al., 2010; Johnsen & Harlow, 1996) than women without a history of CSA. Adult male survivors are similarly affected in relation to their physiological health status. Various studies indicate that male CSA survivors who have sex with men in adulthood, have much higher rates of HIV

infection compared to men who have sex with men without history of CSA (Brennan, Hellerstedt, Ross, & Welles, 2007).

Psychiatric manifestations. Psychiatric manifestations or psychological aftereffects include behavioral, emotional, and spiritual effects. Major subsets of psychiatric manifestations include maladaptive behaviors, emotional disequilibrium, and psychiatric disorders. When compared to adults without a history of CSA, research shows that individuals with a history of CSA are more likely to experience emotional and psychological comorbidities; CSA has been associated with 47% of all psychiatric disorders with onset in childhood and with 26% to 32% of adult onset disorders (Green et al., 2010; Wilsnack, Vogeltanz, Klassen, & Harris, 1997).

Maladaptive behaviors among adult survivors include, but are not limited to: substance abuse, eating and sleep disorders, aggression/hostility, delinquency, sexual maladjustment leading to extremes of abstinence or promiscuity, and dysfunctional interpersonal relationships (Rodgers et al., 2004; D. R. Wilson, 2010). Emotional disequilibrium manifests as fear, anxiety, anger, hypervigilance, and poor self-esteem/self-confidence (Bridgeland, Duane, & Stewart, 2001; Cornman, 1997; Hall, 1999, 2000; Knisely, Barker, Ingersoll, & Dawson, 2000; Krug et al., 2002; Roberts, 1996; D. R. Wilson, 2010). Psychiatric disorders associated with CSA include, anxiety, depression, panic, cognitive impairment, post-traumatic stress disorder (PTSD), dissociation, fragmentation, psychosomatic disorders, sexual dysfunction, suicidal behavior, self-harm and an increased risk of re-victimization (Chen et al., 2010; Classen, Palesh, & Aggarwal, 2005; Cutajar et al., 2010; Elliott, Mok, & Briere, 2004; Freshwater, Leach, & Aldridge, 2001; Hornor, 2010; Messman, Moore, Brown, & Koelsch, 2005; Pérez-Fuentes et al., 2013; Sandberg, Matorin, & Lynn, 1999; D. R. Wilson, 2010).

Of the maladaptive behaviors, emotional disequilibrium, and psychiatric disorders experienced among adult survivors of CSA, the phenomena of PTSD, dissociation, and fragmentation are particularly relevant for this proposed research about shamanic healing methods to facilitate healing and integration for CSA survivors and will be further explored.

Post-traumatic stress disorder (PTSD). The predominant diagnostic feature of PTSD is the "development of characteristic symptoms following exposure to one or more traumatic events" (American Psychological Association, 2013, p. 271). The *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 2013) states PTSD is based on a history of an

> exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual: 1) directly experiences the traumatic event; 2) witnesses the traumatic event in person; 3) learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or 4) experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol. (p. 271-272)

For a diagnosis of PTSD, individuals must meet criteria based on four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. While it is normal to experience stress reactions following a trauma, such as, fear or

anxiety, sadness or depression, guilt or shame, anger or irritability, and behavior changes, PTSD is diagnosed when these symptoms causing distress and disrupting daily activities last longer than three months.

The relationship between CM and anxiety disorders is firmly established by decades of research. Cougle et al. (2010) analyzed data from the *National Comorbidity Survey* (N = 4,141) to understand the relationships between anxiety disorders and CSA. A relationship was found to exist between CSA and social anxiety disorder (SAD), panic disorder (PD), generalized anxiety disorder (GAD), and PTSD.

In an early study, using the *Diagnostic and Statistical Manual of Mental Disorders-III*, Rodriguez, Ryan, Rowan, & Foy (1996), interviewed117 help-seeking adult survivors of self-reported CSA. At the time of the study, 72% of participants met criteria for diagnosis of PTSD, 86% of participants met criteria for PTSD diagnosis at some point in their lives, and 6% of participants had chronic issues associated with PTSD (Rodriguez et al., 1996). These figures are consistent with PTSD research conducted ten years earlier involving participants from a variety of clinical settings (Herman, Russell, & Trocki, 1986; O'Neill & Gupta, 1991; Saunders, 1991); the authors noted that age of onset, exposure to multiple forms of trauma, and duration and severity of CSA all contributed to an individual's propensity to develop PTSD. Recent research continues to find evidence of an association between CSA and PTSD, the study examined 2,688 medical records indicating a history of CSA, of the total 627 had received mental healthcare and 108 were diagnosed with PTSD (Cutajar et al., 2010; Pérez-Fuentes et al., 2013).

Dissociation. Dissociation is a response to stressful or traumatic event, which result in alterations of awareness and can cause a lack of connection between thoughts, memory and identity (American Psychological Association, 2013; Sieff, 2008). Within the realm of trauma,

dissociation is analogous to concepts of fragmentation, soul murder and soul loss (Shengold, 1989; Sieff, 2008). In this section, a brief history of the concept of dissociation will be provided and dissociative disorders will be reviewed and juxtaposed with other terms frequently used in association trauma responses.

French philosopher and psychiatrist Pierre Janet introduced the concept of dissociation in the late 19th century in conjunction with his research and experiments using hypnosis to better understand hysteria (LeBlance, 2001; van der Hart & Dorahy, 2005; van der Hart & Horst, 1989). Janet's seminal work in hysteria, hypnosis and the elucidation of dissociative states is the cornerstone of contemporary trauma theory and therapy, He defined dissociation as a lack of integration among two or more "systems of ideas and functions that constitute personality" (Janet, 1907, p. 332). The lack of integration is a result of genetic issues, severe illness, fatigue, and experienced adverse traumatizing events. These can establish different states of consciousness within the human being, with each state having its own sense of self along with feelings and behaviors (Nijenhuis & van der Hart, 2011). These varied states exist, as Janet referred to them, as separate streams, and these 'states' are often unaware of what is occurring from one state to the next; essentially meaning the states are not integrated but are parallel (LeBlance, 2001; van der Hart & Dorahy, 2005; van der Hart & Horst, 1989).

Janet described symptoms associated with dissociation as mental stigmata and mental accidents. Mental stigmata are negative dissociative symptoms that reflect functional losses (e.g., loss of memory, sensation, motor control) and mental accidents are positive dissociative symptoms that involve acute and often transient intrusions (e.g., sensations-pain, movement-tics, and perceptions) (Janet, 1907; Nijenhuis & van der Hart, 1999; van der Hart & Dorahy, 2005). Janet proposed that the more incidents of trauma one is exposed to, the more there is an increase

in symptoms of dissociation. Dissociation is a defense mechanism related to a stressful trauma in which the overwhelming experience is linked with the unbearable nature of the trauma (Schimmenti & Caretti, 2014). The American Psychiatric Association characterizes dissociative disorders as a "disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body-representation, motor control, and behavior" (American Psychological Association, 2013).

Nijenhuis & van der Hart (2011) proposed dissociation as, "a division of an individual's personality, that is, of the dynamic, biopsychosocial system as a whole that determines his or her characteristic mental and behavioral actions" (p.418). They further elucidated dissociation in terms of trauma, which is described not as an event but rather as a psychobiological wound. Psychobiological wounds diminish the individual's integrative capacity leading towards a division of personality (Nijenhuis & van der Hart, 2011 p. 420). The division of personality further inhibits integrative capacity rendering the individual vulnerable to additional trauma, resulting in a cycle of trauma, decreased integrative capacity, and division of personality constantly repeating itself until there is healing and integration (Janet, 1907; Nijenhuis and van der Hart, 2011 p. 420). Likewise, Cardena (1994) suggested dissociation is the "coexistence of separate mental systems that should be integrated in the person's consciousness, memory or identity" (p. 19). Dissociation as a defense mechanism enables individuals to temporarily forget or distance themselves from painful experiences. When individuals dissociate, it can feel like preserving "a sacred core of personality from immanent violation and destruction" Kalsched, (2010, p. 283). Dissociation is a mechanism through which individuals experience fragmentation (Kalsched, 2013).

Fragmentation. A related phenomenon of dissociation, fragmentation, is described when there is a distinguished difference between the abused and non-abused parts of the self (Herman, 1992b; Shengold, 1989; van der Kolk, B. McFarland, A. Weisaeth, 1996; van der Kolk, Bessel, van der Hart, Onno, Marmar, 2007). For example, in an interview conducted by Sieff (2008), Dr. Donald Kalsched, psychologist, describes that initial dissociation is both a miraculous moment and tragic moment. It is miraculous in that the splitting "saves the child's psychological essence in and encapsulated state" and tragic because the "child steps out of the reality and vivacity of his or her life…and the capacity for genuine and trusting human relationships starts to disintegrate" (p. 193). A post-traumatic self-care survival system is established in which the fragmented parts become both the "protector" and "persecutor". Initially protective, this self-care system becomes maladaptive and becomes as Kalsched describes it, a "false god that turns suffering into violence—against the self" (Sieff, 2008, p. 193) Fragmentation can lead to severe psychological disorders such as PTSD, the inability to access or communicate emotions, and an increased likelihood of engaging in self-harm behaviors (Briere & Gil, 1998; Swannell et al., 2012). In the case of CSA, this sometimes involves the splitting off and protecting of a more vulnerable, innocent part of oneself, sometimes referred to as the "lost inner child" (Kalsched, 2010).

CSA: Conceptual approaches to conventional treatment and intervention. Current western conventional treatment modalities for adult CSA survivors are reviewed. The after effects of CSA vary among individuals. Therefore, a number of conceptual approaches have been described and utilized to structure interventions.

The "traumagenic dynamics model" conceptualizes four dynamics that influence the impact of CSA on survivors: powerlessness, betrayal, stigmatization, and traumatic sexualization

(Finkelhor & Browne, 1985). Other conceptual approaches to therapeutic interventions draw from attachment theory, developmental theory, cognitive-behavioral theory, and social learning theory. Attachment theory (Alexander, 1992) as a framework for interventions regards experiences of betrayal and after effects of relationships between victims and others to structure therapeutic approaches focused on developing secure attachments and trust in relationships. Developmental theory (Celano, 1992; Cole & Putnam, 1992), is also relevant in undergirding intervention approaches and places the abuse in context of a lifespan approach, including the impact of the trauma on behaviors in adulthood. Cognitive-behavioral therapy (CBT), focused on thoughts and behaviors rather than emotions to facilitate healing (Shukla, Rai, & Ahmed, 2015). Dialectical-behavior therapy adapted from cognitive-behavioral therapy assists in changing behaviors that are not helpful by learning skills to assist with coping through a combination of CBT and a mindfulness practice (Bass, van Nevel, & Swart, 2014).

CSA is commonly treated using a variety of traditional therapeutic modalities and approaches including psychopharmacology and various forms of individual and/or group psychotherapies (psychoanalysis, psychodynamic therapy, cognitive behavioral therapy, and dialectic behavior therapy) (Courtois & Ford, 2009; Feliciano, 2009; Herman, 1992b). Treatment modalities may be utilized individually or in combination. In an early study, (Finkelhor & Berliner, 1995), reported that 44%-73% of children were offered treatment regardless of symptomotolgy. The authors also noted that while many do, not all adult CSA survivors seek interventional care.

Treatment modalities and interventions used in caring for survivors of CSA are based on general trauma research and theory and not on the specific needs related to CSA (Lev-Wiesel, 2008). Though CSA is a traumatic event that can led to PTSD symptomology, it has been shown

that CSA differs significantly from other forms of abuse and trauma in both the type of trauma and after effects (Forbey, Ben-Porath, & Davis, 2000). In a comprehensive integrative review, Lev-Wiesel (2008) identified four basic therapeutic goals of current treatment modalities utilized for facilitating healing from CSA among children:

> (1) symptom relief, which may be accomplished by encouraging the child to think differently about the event, teaching the child to manage his or her aberrant behaviors, facilitating the expression of negative affect, affirming the child's experience, and providing emotional support (Rust & Troupe, 1991); (2) de-stigmatization, which may be achieved by group affirmation from other child victims and the therapist's supportive stance (Kruczek & Vitanza, 1999); (3) increasing self-esteem through cognitive and interpersonal exercises, role plays, and games (Hill, 2006); and (4) preventing future abuse by changing the victim's environment and/or behaviors and awareness (Lev-Wiesel, 2008, p. 667).

Various methods of general trauma-informed interventions for both child and adult survivors have been discussed in the clinical practice literature (Lev-Weisel, 2008, p 667). As noted, interventions can cover a wide range of cognitive and behavioral phenomena such as exposing repressed or forgotten memories (i.e. psychodynamic psychotherapy and psychoanalysis) (Loftus, 1993) or changing behavior and promoting social adjustment (i.e. behavioral and cognitive behavioral therapies) (Calhoun & Atkeson, 1991). Another major area of research has focused on coping in the aftermath of CSA.

Childhood sexual abuse: coping. Researchers have explored the phenomenon of the coping process to better understand health strategies that benefit and hinder CSA survivors' well-being. Coping methods may be beneficial or detrimental to health outcomes and over-all quality

of life for the adult CSA survivor. Coping strategies that have been found to be beneficial for CSA survivors include: disclosure, positively reframing the abuse (a method of identifying and disrupting negative, irrational or maladaptive thoughts and reframing them into a healthier perspective), and refusing to dwell on the past (Himelein & McElrath, 1996); refocusing, moving on, active healing, and closure (Bogar & Hulse, Killacky, 2006). Social support generally is one of the essential ways that individuals can cope positively, and successfully move forward towards a holistically healthy life (Frazier, Tashiro, Berman, Steger, & Long, 2004; Guelzow, Cornett, & Dougherty, 2003; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001; Runtz & Schallow, 1997; Wyatt & Newcomb, 1990). Thus, a critical step in healing from CSA is seeking social support (Bal, Crombez, Van Oost, & Debourdeaudhuij, 2003; Murthi & Espelage, 2005; Ullman & Filipas, 2005), which often involves disclosure about the CSA. Disclosure may occur to a parent, friend, therapist, or any other trusted person.

This act of disclosure often takes a tremendous amount of courage and bravery on the part of the victim, and research suggests that when disclosure is met openly and positively, this tends to facilitate healing and can help individual's move towards healthier coping strategies, and ultimately towards greater health and well-being (Frazier et al., 2004; Steel, Sanna, Hammond, Whipple, & Cross, 2004). However when disclosure is met with a negative reaction, this dynamic causes harm to an individual's healing process (Filipas & Ullman, 2001; Ullman, Townsend, Filipas, & Starzynski, 2007). Ultimately this can lead to an increase in unhealthy coping mechanisms, all of which involve seeking less social support and withdrawal from relationships with others, and with the self (Griffing et al., 2006).

Scholars have identified unhealthy/harmful coping mechanisms that may hinder a sense of wellbeing for the CSA survivor. These include distancing, self-blame, self-isolation, and a

low-level of seeking social support (Futa, Nash, Hansen, & Garbin, 2003). In relation to, but different from distancing, avoidance and denial (Sigmon, Greene, Rohan, & Nichols, 1996; Wright, Crawford, & Sebastian, 2007) are two more coping strategies that enable a survivor of CSA to disengage from those around them, but which lead to increased self-reported levels of distress and symptomology (Brand & Alexander, 2003; B. K. Johnson & Kenkel, 1991; Leitenberg, Greenwald, & Cado, 1992; Steel et al., 2004). This correlation exists regardless of the severity of abuse (Brand & Alexander, 2003; Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Leitenberg et al., 1992). It is shown, however, that the repetition of severe or multiple forms of abuse may lead individuals towards disengaging (Leitenberg, Gibson, & Novy, 2004) and distancing coping mechanisms (Steel et al., 2004).

Individuals are generally not engaged in exclusively beneficial or unhealthy/harmful coping mechanisms, but instead utilize both. Draucker et al., (2009) advanced a helpful model for understanding the coping and survival mechanisms commonly utilized by those with a history of CSA that advances our understanding to include the notion of 'dialectical synthesis' in terms of coping. That is, they identified after effects in four main domains for which survivors use different coping strategies simultaneously, some which are helpful and others which are destructive to healing, which they referred to as a process of "dialectical synthesis" (p. 371). The four dialectical categories include:

Managing memories:

1. Escaping memories through avoiding, or

2. Being drawn to memories

Relating to important others:

1. Keeping others out, or

2. Seeking out others

Seeking safety:

1. Constricting the life world by staying at home, living vigilantly, and avoiding social situation, or

2. Reforming the life world by seeking justice or revenge, or warning others about a specific perpetrator or general knowledge about abuse

Re-evaluating the self:

1. Protecting one's identity by claiming no harm done by abuse or avoiding help-seeking, among other behaviors or
2. Repairing damaged aspects of self

Summary. Unfortunately, despite research, evidence-based approaches, and well-intentioned providers, traditional treatments often only temper symptoms associated with living through the aftermath of CSA and do not adequately address the holistic needs of survivors or facilitate integrative healing. Given the complexity and magnitude of the after effects associated with CSA on health and well-being, scholars and clinicians have begun to look to holistic and alternative therapies to address the integrative health and healing needs including healing of the spiritual dimension of the survivor's life process in the treatment of CSA and its sequelae. An emergent focus on complementary and alternative approaches begins to fill a gap in the science of CSA healing.

Holistic Nursing, and Medicine

Holism. Holism has been defined as the unity and interrelationship of all things interdependent and inseparable (Erickson, 2007). Holism is an attempt to create balance with the mind, body, and spirit in relation to the individual, the individual and others, and the individual

and the universe, to achieve a sense of well-being. According to Erickson (2007, p. 140), "the mind, body, and spirit were inextricably integrated and must be considered as a dynamic interactive unit with inseparable parts." Within the concept of holism, individuals are considered to be multi-dimensional and when there is an injury to one aspect of the biopsychosocial system, all aspects of the person are affected (Clarke, Black, Stussman, Barnes, & Nahin, 2015). This concept of holism is found in metaphysics and the world views of Hinduism, Buddhism, and Taoism, which speak to the unity and interrelation of all things and events, and an ultimate, indivisible reality (F. M. Sharoff, 2011).

In healthcare, the concept of caring for the whole person as represented by Florence Nightingale and Hippocrates was integral in the development of both nursing and medicine respectively. Advancements in science, technology and medicine however, dimmed the focus on holism, shifting the paradigm to a reductionist, problem focused, curative approach in both the assessment and treatment phases of health (Wilson, 2013). In 2015, this paradigm is shifting to holism especially in conjunction with the increased use of complementary alternative approaches to care. This section will discuss the development of holism within nursing and medicine from their founders through the development of specialty areas of both professions and will review the growing trend of complementary alternative approaches to healthcare in western societies.

Holistic nursing: history. The practice of holistic nursing is clearly depicted in the mid seventeenth century with the Daughters of Charity, founded in France by Louise de Marillac and Vincent de Paul in 1633 (Daughters of Charity, n.d.; Daughters of Charity of Saint Vincent de Paul, n.d.-a). The mission of the Daughters of Charity included physical care as well as ministering spiritually to those in need (Daughters of Charity Health System, 2015). As such, the nuns left the cloisters to serve the poor and disenfranchised, initially, treating people in their own

homes and local villages. Over time, hospitals were established to better meet the needs of the poor, ill, and other marginalized people (Daughters of Charity of Saint Vincent de Paul, n.d.-a, n.d.-b). In their care of others, the nuns focused on gentleness, cordiality, compassion, to help people adapt and find their own inner power to heal (Daughters of Charity, n.d.). The mission of the Daughters of Charity spread throughout France and into other countries.

By the early 1800s, the majority of nursing care was provided by a variety of different religious orders. The nuns provided care by ministering to the physical, emotional, spiritual and social needs of society, well-known, examples of include the Sisters of Charity in the US and the Daughters of Mercy in Ireland.

In the 1809, Elizabeth Ann Seton founded the Sisters of Charity of St. Joseph in the United States. Adopting the rules and constitution of the Daughters of Charity established earlier in France. Like their predecessors, the Sisters of Charity focused on caring for the poor through the development of schools, orphanages and hospitals (Emmitsburg Area Historica Society, n.d.). They were also well known for the nursing care provided to both the Union and Confederate armies during the civil war. The mission to care for the spiritual and medical needs of the soldiers and respect for the human dignity trumped all politics of the time (The National Shrine of Staint Elizabeth Ann Seton, 2015) .

In Ireland, Catherine McAuley founded the Sisters of Mercy in 1831 to minister to the sick and the poor and for the charitable instruction of the poor (Congregation of the Sisters of Mercy, 2015; Daughters of Charity Health System, 2015). This mission was quickly challenged with an outbreak of cholera in 1832 and other widespread illnesses like typhus (Congregation of the Sisters of Mercy, 2015; Sisters of Mercy, 2015). Known for their excellence in nursing care, like the Sisters of Charity, the Sisters of Mercy were asked by the Army to assist with the care of

soldiers fighting in the Crimea (Sisters of Mercy, 2015). Though less known than their British counterpart, Florence Nightingale, the Sisters of Mercy accepted the request and played an integral part in the nursing care of the soldiers in Balacava, Crimea. The Irish Sisters under the Supervision of Mother Bridgeman, utilized all of their skills in caring for the ill and wounded soldiers. They provided a clean space, comforted the ill and ministered to the spiritual needs of the catholic soldiers (Curran, 2008; Lynch & Lyons, 2014).

Florence Nightingale. The concept of holistic nursing was further promulgated by Florence Nightingale as a notable pioneer and founder of modern nursing. She contended nursing care should include unity, wellness, and the interrelationship of human beings, events, and the environment (Nightingale, 1860). Holistic care is evidenced throughout her career, in both the direct care of patients, in her writings on what nursing is and what nursing is not, as well as in the development of the public health care system for the United Kingdom during her era of leadership. The most notable example of the use of holistic care was evidenced in her early work caring for soldiers during the Crimean War (Nightingale, 1860).

Upon her arrival to Crimea, Nightingale found wounded soldiers in inhumane conditions, lacking medical care, appropriate staffing and situated in extremely unsanitary conditions. Devoted to the welfare of those in her care, Nightingale not only attended to the medical needs of the soldiers but also attended to the totality of their needs. This had a profound positive impact on their health outcomes. Nightingale sanitized the environment, provided proper nutrition and fresh air to advance healing, and comforted the men with compassion and spiritual care (Nightingale, 1860). With the dramatic shift that addressed the holistic care of the soldiers, Nightingale was credited for reducing the hospital death rate by two-thirds (Bloy, 2012).

Returning from the war, Nightingale continued to espouse the virtues of holistic care. A discussion with Queen Victoria that outlined the horrid conditions within the battlefield hospitals led to the establishment of The Royal Commission on the Health of the British Military. In a recent study of letters from Nightingale to Dr. Thomas Gillham Hewlett, a British physician and health officer in Bombay, India, recurring themes central to her leadership on nursing and global health were revealed, consistent with the concept of holism (Bloy, 2012). The themes included health and sanitation reforms; collaborative partnerships with citizens, medicine, policy makers, and governments; data-driven policy development; and health education (Harper, Davey, & Fordham, 2014). Nightingale, like the Daughters of Charity, the Sisters of Charity, the Sisters of Mercy and others, personified holism in caring for the whole of the individual, society, and the environment.

Holistic nursing: modern science. In considering holistic nursing, one cannot overlook Jean Watson's "Theory of Human Caring/Caring Science." Caring Science is the essence of holistic nursing; the core theoretical concepts include a transpersonal relationship that transcends the physical needs of the patient to include harmony of body and spirit, authenticity, inner harmony and the deep tenets of connection as human beings. Watson's theory elucidates caring within nursing based on the moral, ethical and philosophical foundation of love (Watson, 2008).

Since its inception, nursing has sought to provide integrative and holistic patient care with all attention towards the patient's achievement of his/her sense of spiritual, physical and emotional wellness. In recent decades; however, the implementation of high tech lifesaving technologies has challenged nursing's focus on holistic caring. Finnish nursing theorist Dr. Katie Eriksson is a pioneer in defining the science of caring in Scandinavia; her work focuses on "formulating caring's message in a new tone" that can survive the current pressured high tech

clinical environment (Eriksson, 2007, p. 201). She proposes a Theory of Caritative Caring whose foundation includes fundamental beliefs that caring is a communion between the nurse and the patient as human being, body/soul/spirit experiencing health/suffering where “dignity comprises the fundamental worth” (Eriksson, 2007, p. 201).

In the US, the concept of holism is the foundation for nursing practice and holistic nursing has been designated as a specialty field in nursing. There are many American nursing leaders who have influenced both the language and the practice of holistic nursing. Dr. Peggy Burkhardt, the current President of the American Holistic Nursing Association, leads a shift in the terminology used to describe holistic care to include the term integrative so that it encompasses the importance of a comprehensive interdisciplinary approach to treatment prevention and health promotion of the whole patient (Burkhardt, 2015).

An example of another contributor to the promotion of integrative and holistic nursing is Dr. Mary Jo Kreitzer; she started her quest to describe caring for the whole patient as a nurse practitioner in the 1970s; she observed that patients benefitted from and sought care that included focus on their emotional and spiritual health. She dedicated her career to the educating of clinicians and promoting integrative care. In the mid-1990s her vision took hold at the University of Minnesota and it is now the Center for Spirituality and Healing. In an interview with Dr. Kreitzer, she recalled a mentor telling her that she would "restore the soul into heath care" (Mittelman & Synder, 2009, p.68) through her efforts to promote holistic care.

The development and application of holistic and integrative healing techniques such as Therapeutic Touch provides nurses with tools to improve health and restore well-being. Therapeutic Touch was developed in the 1970s by Dr. Dolores Krieger and her colleague Dora Kunz. Building on the Rogerian model of Human Energy, they developed a technique where the

practitioner affects a patient's energy flow by bringing his/her own energy to the bedside to restore the balance and energy flow of the patient. Scientific literature reports that therapeutic touch positively influences the autonomic nervous system in times of physical and emotional stress (Center for Health and Healing, 2012). The continued development, testing and promotion of healing techniques such as Therapeutic Touch should remain an essential component of Caring Science in the future to adequately support the complex needs of the population.

Holism and the American Holistic Nurses Association. The AHNA was developed in 1981 in response to changes occurring in healthcare that included a nursing shortage, an increased patient acuity and the use of complex technology. In keeping with the underpinnings established by Nightingale and others, the AHNA's mission was to advance holistic nursing through community building, advocacy, research and education (American Holistic Nurses Association, 2015). Holism is defined as a healthcare philosophy that focuses on unity, wellness and the interrelationship of human beings, events and the environment. Holistic nursing "protects, promotes, optimizes health and wellness, prevents illness, injury, alleviates suffering, and supports people's quest for peace, comfort, harmony and balance" (American Holistic Nurses Association, 2015). It is a specialty practice that draws on nursing knowledge, theories, expertise and intuition to guide nurses in becoming therapeutic partners with people in their care. This practice recognizes the totality of the human being: the interconnectedness of body, mind, emotion, spirit, social/cultural, relationship, context, and environment" (American Holistic Nurses Association, 2015).

AHNA and scholars position holistic nursing as more than a profession; it is a way of being (American Holistic Nurses Association, 2015; Sharoff, 2011, p. 206) The practice of holistic nursing is not solely patient focused. AHNA states, "

> holistic nursing requires the nurse to be self-reflective, practice self-care, self - responsibility and include spirituality in their lives. The practice of reflection, self-care, self-responsibility and spirituality, it is thought, will lead nurses to a greater awareness of the interconnectedness with self, others, nature, and spirit. This awareness, in turn, may further enhance the nurses understanding of all individuals and their relationships to the human and global community, and facilitates the healing process" (American Holistic Nurses Association, 2015, para. 4).

The integration of holism into the nurse's personal and professional life allows the holistic nurse to become what Sharoff (2011) describes as a, "reflective co-participant in the healing-caring process" (p.207).

Holistic nursing addresses the needs of the patient through all bio-medical and technological methods available, however, it does not limit the focus to a disease state or affected organ system. The holistic nurse acknowledges the totality of the individual is greater than the sum of his or her parts (Erickson, 2007, p. 146). Similarly, the philosophy of holism was also embraced by the Greek philosopher and father of allopathic medicine, Hippocrates, who espoused the whole human being should be considered when diagnosing and treating patients. Aspects of holism such as the hygiene and nutrition contribute to the well-being of the individual (F. M. Sharoff, 2011). Although not all allopathic practitioners maintain a holistic view in the diagnosis and treatment of individuals there is an increasing trend of practitioners who have adopted holism in their practice (L. Sharoff, 2008).

Holism and medicine. The American Holistic Medical Association (AHMA) was founded in 1978, committed to fellowship and collaboration regarding holistic care of patients. Initially, membership was limited to physicians but in 2008 membership was opened to other

licensed healthcare professionals with the hope to better understand how the mind, body and spirit relate to healing (Academy of Integrative Health and Medicine, 2015). Over the years, two additional medical associations were created and have now merged to form the Academy of Integrative Health and Medicine (AIHM). While the central focus of the biomedical model is to cure disease, the AIHM that promotes education and certification in the use of holistic practices through the use of the art and science of healing to address the needs of the whole person: body, mind, and spirit (Academy of Integrative Health and Medicine, 2015).

The healing professions of nursing and medicine have strong historical ties to holistic care that remain constant in the diagnosis and treatment of individuals today. It is consistent with the iterative process of assessment, diagnosis, treatment, and evaluation that is part of every patient interaction within the nursing process. The paradigm of holism can be used to bridge the gap between the totality of patient needs and the principles of contemporary health care (Mason, 2014). In addition, holism is more patient centric than western medicine, shifting from a unidirectional perspective of care, to a collaborative multidirectional framework. It is a form of care that allows the patient to more fully participate in healing both with the healthcare team of providers and within themselves.

The philosophy of holism, the notion of unity, allows an individual to simultaneously hold onto disparate concepts and feelings of disease in conjunction with those of well-being. This can provide peace and comfort to those with chronic or even terminal illnesses. To promote a sense of well-being individuals are self-selecting their healthcare providers and those providers are referring them to a wide variety of complementary alternative approaches within healthcare. This has been occurred in combination with, or instead of, conventional allopathic medical treatments.

Complementary Health Approaches

Conventional allopathic medicine in conjunction with scientific research and the advancement of treatment modalities have contributed greatly to the health and well-being of society. Despite this enormous progress, science and medicine are not able to address the myriad conditions present in society today. Insufficient and inadequate healthcare, lack of access to conventional medicine, cultural norms, and a desire to experience alternative healthcare or as an augmentation to conventional treatments (Harris, Cooper, Relton, & Thomas, 2012; Helms, 2006; Okoro, Zhao, Li, & Balluz, 2013) has led to a surge in interest, use, and research related to treatment modalities based on paradigms different than the conventional biomedical model. These different paradigms are often referred to as complementary, alternative, or integrative therapies. This section will: 1) provide a brief history of the development of the National Center for Complementary and Integrative Health at the National Institutes of Health, 2) define the terms complementary, alternative, integrative therapies, and complementary health approaches according to NCCIH, and 3) give examples regarding the acceptance and advancement of CHAs based on results from the National Health Interview Study.

National Center for Complementary and Integrative Health. The use of complementary, alternative and integrative therapies among Americans has increased significantly since 1990 (Tindle, Davis, Phillips, & Eisenberg, 2005). In 1991 the U.S. Congress passed legislation and established the Office of Alternative Medicine (OAM) within NIH to investigate and evaluate non-conventional medical practices. The OAM evolved over time to become the National Center for Complementary Alternative Medicine (NCCAM) in 1999 and the National Center for Complementary and Integrative Health (NCCIH) in January 2015. The mission of the NCCIH is to "define through rigorous scientific investigation, the usefulness and

safety of complementary and integrative interventions and to provide the public with research-based information to guide health decision making" (NIH, 2015, para 1).

The research goals of NCCIH include; "the advancement of the science and practice of symptom management, the development of effective, and practical personalized strategies for promoting health and well-being and enhance evidence-based decision making regarding the use and integration of complementary alternative medicine (CAM) into healthcare and health promotion" (NIH, 2015b, para. 1). This is accomplished through grants and funding, educational training and the dissemination of information.

Definitions of complementary, alternative, and integrative healing. According to NCCIH, the terms complementary, alternative and integrative medicine or healthcare are used widely and interchangeably to indicate methods of treatment that are outside western conventional medicine. NCCIH identifies the differences between these terms in their definition of each: "complementary, is a non-mainstream approach together with conventional medicine; alternative, is a non-mainstream approaches used instead of conventional medicine; and integrative medicine or healthcare is the use of both non-mainstream approaches and traditional medicine by health care providers or within their practices" (National Center for Complementary and Integrative Health, 2015).NCCIH adopted and currently uses the terms "complementary health approaches" (CHA) to describe non-conventional therapeutics and practices and "integrative health" to describe the use of CHA with conventional health care (National Center for Complementary and Integrative Health, 2015).

Complementary health approaches are divided into two categories, natural products and mind and body practices. Natural products are non-vitamin, non-mineral substances that include botanical, herbs and dietary supplements utilized to advance wellness. Mind and body practices

incorporate a wide variety of procedures or techniques to facilitate health, examples include, acupuncture, massage, yoga, a multitude of meditation techniques, breathing exercises, guided imagery, muscle relaxation methods, tai chi, qi gong, healing touch and hypnotherapy. (NIH, 2015). Traditional healers, shamanic healers, Ayurvedic medicine, traditional Chinese medicine, homeopathy and naturopathy are recognized under the umbrella of complementary health approaches by NCCIH and their practices are fall under both categories (NIH, 2015).

National Health Interview Survey. NCCIH participates in the National Health Interview Survey (NHIS) to better understand the use and cost of CHA throughout the country. The NHIS is a national survey conducted to monitor the health of the nation and to track, health status, access to care and progress toward achieving national health objectives (CDC, 2014). The NHIS began in 1957 and is conducted every five years. Data are collected via personal household interviews throughout the year. The survey is conducted by the U.S. Census Bureau., for the Centers for Disease Control and Prevention (CDC) (CDC, 2014; Peregoy, Clarke, Jones, Sussman, & Nahim, 2014). The NHIS includes a selection of questions related to the use complementary health approaches.

Based on the 2007 NHIS, of the 2.2 trillion dollars spent on healthcare, 33.9 billion out-of-pocket expenditures were for CHA, 14.8 billion for non-vitamin, non-mineral natural products, 11.9 billion for practitioner visits, and 7.2 billion for the use of yoga, tai chi, qi gong, homeopathic medicine and relaxation techniques (Nahin, Barnes, Stussman, & Bloom, 2009). The results of the survey indicated the use of complementary health approaches increased from 36% in 2002 to 38.3% in 2007. Approximately 38% of adults and 12% of children had used some form of complementary health approaches. The use of CHA is influenced by economic and socio-cultural factors.

Preliminary results from the 2012 NHIS indicate 33.2% of U.S adults used some form of CHA. Natural products remain the most widely used CHA, which was consistent with the 2002 and 2007 surveys. Chiropractic or osteopathic manipulation, and massage maintained their position in the top 5 CHA. They were joined by yoga, which showed the greatest increase in usage from 6.1% to 8.4% (Peregoy et al., 2014). These results are preliminary and more findings will be revealed with continued data analysis.

The interest and use of CHA traverses across socio-economic strata. It is used by the disadvantaged where access to care may be limited and by the affluent who want to augment their healthcare towards disease prevention and healing (Harris et al., 2012). Cultural traditions like Ayurvedic, Chinese medicine and traditional healers such as indigenous shaman continue their practices, healing, and providing comfort to those unfamiliar with, distrusting of, and/or unable to access conventional medicine (Harris et al., 2012; Nahin et al., 2009; Peregoy et al., 2014).

Shamanism

The final section of the literature review describes shamanism as an ancient healing tradition, details specifics about soul loss, shamanic soul journeying and soul retrieval, Andean shamanism, and current trends. Shamanism itself includes a variety of concepts and cultural ideas. The conclusion of this section will discuss how shamanic healing can be understood in the context of the current scientific literature that describes methodologies and treatment modalities used to facilitate healing of adult CSA survivors.

Shamanism "represents the most widespread and ancient methodological system of mind-body healing known to humanity" (Harner, 1990 p. 40). It engages multimodal healing methods to restore the health of the individual, community, nature, and the universe. Examples of these

methods include: soul journeying, spirituality, energy therapy, and herbal therapies. According to Michael Harner (1990, p. xvii) a shaman is "a keeper of a remarkable body of ancient healing techniques that they use to achieve and maintain the well-being and healing for themselves and members of their community" (Harner, 1990 p. 40). The term shaman comes from the language of the Tungus people of Siberia. Shamanism is one of the earliest traditions of humankind and can be traced back twenty to thirty thousand years by archeological and ethnological evidence. Shamanistic practices are prevalent amongst indigenous cultures around the globe-- in North and South America, Central Asia, Siberia, Europe, Africa, and Australia. According to Harner (1990), shamanic assumptions and methods are remarkably similar throughout the world despite vast geographic distance between specific societies and tribes.

Historically, within tribal cultures that were nomadic, shamans were thought of as general practitioners responsible for the overall health of their community. Shamans utilized herbs, energy therapy, spirituality, and soul journeying. They were responsible for healing their community and the earth, determining when to plant and harvest crops and deciding the direction of travel on behalf of the tribe. As populations began to settle in geographic locations, the shaman's role began to change. Although shamans maintained knowledge of all healing modalities, they began to transform from the role of a general practitioner to that of a specialist in the areas of spirituality, herbals, energy therapy, and soul journeying. An individual shaman focused on the essential energy or the spirit/soul of a person and often sought to restore missing soul parts to re-establish the person's health and sense of well-being.

Soul loss. According to shamanic beliefs, an individual can experience the loss of a part of their soul as a result of any trauma. This is seen as a protective mechanism that enables the soul (an individual's vital energy) to separate from the person during times of trauma in order to

survive the full impact of the pain (Ingerman, 1991). Soul loss can be described as a sense of disconnectedness, emptiness, dissociation, and experiencing gaps in one's memory. The level of trauma one experiences or perceives can have a direct impact on the individual's dispirited sensation. As the soul part leaves the body it takes with it all of its gifts and vital energy, leaving the individual fatigued, depressed, or fragmented (Ingerman, 1991 p. 11). Once the soul part has left the body it enters a non-ordinary reality referred to by shamans as the upper, middle and lower worlds. The upper world is thought to be the invisible domain of our destiny and spirit. The middle world is our material world, and the lower world is where all of human history is held (Villoldo, 2015 p. xvi). To restore the individual to a state of health and well-being, the shaman must travel to these non-ordinary realities to retrieve the soul part.

Shamanic journeying and soul retrieval. Shamanic journeying is one of the most significant methods used by shaman for healing. According to Walsh (2007),"shamanism is a family of traditions whose practitioners focus on voluntarily entering altered states of consciousness in which they experience themselves or their spirit(s) interacting with other entities, often by traveling to other realms, in order to serve their community (p.15-16). Harner describes the journey to a non-ordinary reality as a shamanic state of consciousness (SSC), which is in direct contrast with our traditionally perceived reality, an ordinary state of consciousness (OSC) (1990 p. 20). This journey to a SSC begins with guided meditation and breathing exercises. Rattles, drums, and singing are often used to help the shaman enter the SSC and non-ordinary realities.

During the Shamanic journey, the soul is purported to leave the body and becomes a cosmic traveler to the upper, middle, and/or lower worlds as previously described. Travel in time is vastly different than the linear time experienced in OSC. Shamanic journeying begins with and

is guided by the shaman's intention and involves three phases: preparation, the induction of a SSC, and the journey itself (Walsh, 2007).Nature is used as a vehicle to enter non-ordinary states of reality. For example, trees are frequently used to access both the upper and lower worlds. The shaman's soul may use the tree's branches to reach the sky to connect with portals that complete the journey or travel through the root system to underground streams that can carry them to the lower world. Travel to these non-ordinary states of consciousness is not done in isolation, the shaman is accompanied by his or her guardians – the shaman labels these guardians 'spirit guides' or 'power animals' (Harner, 1990).

Guardians protect, empower, and guide the shaman in both OSC and SSC. Guardians can take on a variety of forms from fairies and leprechauns to animals. Among the shaman, animal guardians are referred to as the shaman's power animal and each animal has its own area of mastery or specialty. The job of the power animal is to "keep its charge health physically, emotionally, mentally, and spiritually by providing guidance and support" (Ingerman, 1991 p. 32). As the shaman develops over time, he learns to call on specific power animals to aid with specific issues required to meet an individual's needs. Power animals almost always aid in soul retrieval.

Ingerman describes soul loss as an adaptive strategy to physical and emotional trauma (Ingerman, 1991). It is the "most intelligent way to escape the full impact of a particular horror….a way to minimize pain…a safe place for the soul where no one can hurt it" (Ingerman, 1991 p. 36). Through soul journeying, the shaman can locate the lost soul parts and request their permission to return. If the soul part(s) is not yet ready to return, the shaman practitioner, working with the patient, will inform the soul part that the trauma is over, it is safe to return and that the integration of the part(s) is desired. With time, an increased understanding that the

traumatic event is no longer exists, and a broader awareness that integration is desired, the soul part(s) will agree to reunite with the whole of the being. When ready to reunite, the shaman brings them back and restores them to the individual. Soul part(s) are reintegrated through the chakra system of the body.

Chakras are spinning energy centers that govern specific organ systems of the body. The heart and crown chakras are two of the seven chakras in the body aligned along the spinal column (Bruyere, 1994). The reintegration of the soul part occurs when the shaman uses his or her breath (a life force) to blow the soul parts into the heart. The heart governs complex emotions such as unconditional love for self and other, compassion, passion, and spiritual devotion. The shaman also blows the soul parts into the crown chakras, which involve consciousness, unity and the sense of being (Ingerman, 1991).

Once the soul parts have been restored, the individual must take some time to sense the reintegration. The reaction to the reintegration of the soul part can be as varied as the soul retrieval process. Individuals may experience joy, a sense of connectedness and integration while others may feel sadness or nothing at all. Though the response to the reintegration of the soul part may vary, its return, increases conscious awareness, facilitates integration and leads to healing.

Shamanic healing therapies have the potential to benefit adult CSA survivors through the perceived reintegration of lost soul parts and the restoration of the wholeness of the soul, the individual's vital energetic essence. A review of the nursing and health sciences literature reveals scant information on shamanism and its use in western healthcare contexts and no research related to shamanic healing, soul journeying, or soul retrieval as integrative health modalities for facilitating healing and integration for adult CSA survivors.

Shamanism and nursing. This researcher performed a thorough and detailed review of the nursing and CHA literature. No research or scholarship describing the use of shamanic healing practice with adult CSA survivors was found. While much has been written regarding CSA and its sequelae, the gap in the literature related to integrative treatment, specifically related to the use of shamanic healing, provides an opportunity for research and knowledge development.

Summary

Shamanic healing offers a unique opportunity to address the holistic needs of adult CSA survivors for integration and healing among survivors who perceive and experience fragmentation/soul loss. Current conventional biomedical treatment modalities do not address healing into integrated wholeness for the adult CSA survivor who suffers from sense of fragmentation/soul loss. A shift in perspectives on healing from the biomedical perspective to that of the shamanic holistic approach to healing merges well with both historical and contemporary nursing conceptions. The goals of the discipline are to promote health and alleviate suffering, and nursing's holistic care philosophy of facilitating humanization, meaning, choice, quality of life, and healing (Willis et al., 2008). There is currently no literature describing the shamanic practitioner's use of soul journeying and soul retrieval for facilitating healing and integration among adult CSA survivors experiencing sense of soul loss. This researcher aims to substantively address this knowledge gap through conducting qualitative descriptive research to uncover the shamanic practitioner's perspectives and experiences providing holistic care to adult CSA survivors experiencing sense of fragmentation/soul loss. This research has the opportunity to provide nursing with additional means to address the lingering aftereffects among adult CSA survivors.

Chapter 3: Methods

Introduction

The review of the literature indicated that adult survivors of childhood sexual abuse (CSA) lack a full spectrum of holistic health modalities to facilitate healing and integration, specifically in regard to sense of fragmentation/soul loss. The ancient healing techniques of the Peruvian shaman called soul journeying and soul retrieval may provide an opportunity for healing through integration of the fragmented self or the perceived lost soul parts. The review of the literature identified a significant gap related to the role of complementary health approaches (CHA) of traditional healers/shamans in facilitating healing of adult CSA survivors; yet, many CSA survivors engage in health seeking behaviors whereby they solicit the services of shamanic healers. Thus, the purpose of this study was to conduct qualitative descriptive research, from the perspective of practicing shamanic healers, on shamanic healing, as a CHA to facilitate healing and integration for the adult CSA survivor. As stated earlier, this proposed research helped to explicate certain concepts described by Willis, Grace, & Roy (2008) as the central unifying focus for the discipline of nursing, namely "facilitating humanization, meaning, choice, quality of life, and healing …" (p. E.33) and will contribute to the development of knowledge in the discipline of nursing.

Chapter three outlines: (1) proposed research design (qualitative descriptive), (2) setting, (3) sampling approach, (4) inclusion/exclusion criteria, (5) proposed sample size, (6) procedures, (7) human subjects research protection, (8) data collection, (9) data analysis, and (10) qualitative research rigor.

Study Design: Qualitative Description.

This qualitative descriptive research addressed the gap in the literature related to shamanic healing as a complementary health approach to facilitate healing and integration among adult survivors of CSA. Qualitative description is underpinned by the tenets of naturalistic inquiry, whereby researchers examine and understand complex experiences, events and/or behaviors in their natural settings without manipulation of variables as would occur in positivist-oriented experimental conditions or control of certain pre-determined variables (Sandelowski, 2000). It attempts to answer the "who, what, and where of events, experiences, or their basic nature or shape" (Sandelowski, 2000, p. 338). Qualitative descriptive research is commonly used when the goal is to obtain rich detailed description, from the perspective of the participant of an event, phenomenon, or behavior in which little is known, with minimal interpretation (Sandelowski, 2000, 2010; Sullivan-Bolyai et al., 2010). Thus, qualitative description was a logical fit for the design of this proposed research as the purpose was to investigate shamanic healing from the first-person perspective of the shamanic practitioner.

Study Subjects, Sampling and Site.

The target population for this research was adult shamanic practitioners who have completed the Four Winds Society's Light Body School of Energy Medicine certification program and who are practicing shamanic healing, specifically shamanic healing related to fragmentation/soul loss with adult CSA survivors. The Four Winds Society's, Light Body Energy Medicine School founded by Alberto Villoldo, is based on the cultural lineage and traditions of Peruvian and Incan shamanism. The program consists of a seven week-long course curriculum that include didactic content, therapeutic practice and initiation to the rites and traditions of the Peruvian shaman. The four initial classes consist of the directions of the

medicine wheel, South, West, North and East, which is followed by three Masters level classes, Reading the Signs of Destiny, Working with the Sacred and Neuroscience of Enlightenment (The Four Winds Society, 2015a).

The Medicine Wheel begins with, the way of healer (South); and is followed by the way of the spiritual warrior (West), the way of wisdom (North), and the way of the dreamer (East). Each direction is associated with learning healing techniques, the creation of a Shaman's Mesa (a medicine bundle), an increase in self-awareness and consciousness, and the reception of the Munay-Ki rites of initiation to become a person of wisdom and power for the purpose of stewardship for all creation. The Munay-Ki rites include nine specific rites of initiation, these include the; 1) Healer's Rite, 2) Bands of Power, 3) Harmony rite, 4) Seer's Rite, 5) Daykeeper's Rite, 6) Wisdomkeeper's Rite, 7) Earthkeeper's Rite, 8) Starkeeper's Rite, and 9) Creator Rite. All of the initiation rites connect the shaman students to the lineage of shaman healers and assist in awakening and attuning them in becoming shamanic healers (Villoldo, 2015a).

Training continues after the completion of each of the seven curriculum courses. Students are given instructions regarding continued practice at home and are required to submit summaries from a minimum of ten healing sessions to the faculty. This allows for further supervision and training of students as they transition from the classroom to clinical practice. The continued work also helps to increase, awareness, consciousness and integrate the lessons and rites received.

While there are a variety of notable shaman practitioners e.g., Sandra Ingerman, Hank Wesselman, Tom Cowan, and Steven Farmer, who teach and have authored books on shamanism, there are only two noted schools dedicated to training individuals in shamanic healing. The Foundation for Shamanic Studies, founded by Michael Harner, is based on Core

Shamanism, which Harner considers the universal features that underlie all shamanic systems. As such the teachings are not based on a specific cultural framework, philosophy or tradition but are common shamanic practices throughout many shamanic traditions (Harner, 1990). In contrast, Villodo, brings the cultural traditions of the Peruvian and Incan Shaman through the Four Winds Society's Light Body Energy Medicine School. The school has programs in the United States, Europe, South America and Australia. Upon completion of the curriculum participants receive a certification from the school, indicating they have successfully completed the training. Continuing education credit hours are available to nurses, social workers, behavioral scientists and massage and body work therapists (The Four Winds Society, 2015a).

Shamanic practitioners who have completed their training through the Four Winds Society's Light Body Energy Medicine School were selected to participate in this research in an attempt to; reduce the variability, have access to potential participants, and due to the dissertation researcher's familiarity with the School and Peruvian shamanic healing. As with all healing professions, healing techniques vary from one practitioner to another, however selecting shamanic practitioners who have had consistent training, received the same rites of initiation and share a common philosophy of healing, provided a common framework in hopes to decrease variability in the research. The practitioner directory listed on the Four Winds Society's website, was an excellent resource and it allowed the researcher to invite shamanic practitioners from across the country and in different areas of the world to participate in the research. Finally, the dissertation researcher has participated in the Light Body Energy Medicine School program, experienced and practiced shamanic healing with other shamanic practitioners who have completed the program, and has spent time in Peru, traveling with Peruvian shaman and participating in shamanic healing rituals.

Sampling. According to Sandelowski (1995, 2000) sampling in qualitative research focuses on the "quality of information obtained per sampling unit, as opposed to their number per se" (1995, p.179) Morse, Barrett, Mayan, Olson, & Spiers (2002) suggests the method of sampling needs to be both appropriate and adequate. These authors proposed that appropriateness refers to the degree to which the choice of informants and method of selection fits the purpose of the study as determined by the research question. Whereas, adequacy related to the sufficiency and quality of the data collected.

As a result of these criteria, a variety of sampling methods including purposeful, maximum variation, and snowball sampling were used for this research. Purposeful sampling, frequently used in qualitative descriptive research, allowed the researcher to select participants according to the study needs. That is, the participants were specifically selected based on their knowledge of the research topic (shamanic practitioners' experiences providing shamanic healing for adult CSA survivors with a sense of fragmentation/soul loss). Maximum variation sampling targeted diversity among participants in this study related to practitioner demographics and geography. Finally, snowball sampling was used, where individual shamanic practitioners already enrolled in the study helped to identify others who were knowledgeable and suitable to participate in the research (Creswell, 2007). Practitioners enrolled in the study apprised other practitioners of the study and provide them with the researcher's contact information should they be interested in further information or participation in the research.

Sample inclusion criteria. Inclusion criteria for participation in the study consisted of shamanic practitioners who:

1) Are $\geq$ 21 years of age

2) Speak English

3) Have completed the full Four Winds Light Body School Energy Medicine curriculum (seven week-long courses and individual training sessions) as evidenced by being listed in the practitioner directory of the Four Winds program

4) Self-report an active practice of shamanic energy medicine for a minimum of one year

5) Have participated in the shamanic healing practice of soul journeying and soul retrieval or other shamanic modalities to facilitate healing of fragmentation/soul loss for adult CSA survivors

6) Have access to a computer allowing for audio video conferencing, and

7) Agree to audio and video recording of the interview

Sample exclusion criteria. Exclusion criteria for participation in the study consisted of shamanic practitioners who:

1) Were unable to speak and understand English and

2) Self-reported a shamanic healing practice of less than one year

Sample size. Unlike quantitative research studies, sample size in qualitative description research is not predetermined using statistical equations. The sample is determined by data saturation. Saturation of the data is achieved when the data ceases to reveal new information or themes from participant interviews (Creswell, 2007; Sandelowski, 1995b) In this study, when the data collection reached a point of diminishing return, meaning the new data did not elucidate or offer additional information or themes beyond what was captured in prior interview data, the point of data saturation/sampling end-point was mutually determined by the dissertation committee chair and the dissertation researcher. It was estimated that the sample required to achieve saturation of rich descriptive data for this research is 15-25 participants based on data

saturation sample sizes for other qualitative descriptive research studies published in the literature (Creswell, 2007; Sandelowski, 1995, 1995a).

Procedures

Participant recruitment. Following Institutional Review Board (IRB) approval at Boston College, potential participants were recruited from the Four Winds Practitioner Directory. Specifically, shamanic healers who are listed in this directory have all completed the Four Winds Light Body School Certificate Program and are actively practicing shamanic energy medicine. The Four Winds Society Practitioner Directory depicts a cross section of men and women practitioners representing different races, ethnicities, socioeconomic status, education, and geographic locations. Practitioners have a variety of professional licensures including registered nurses, psychologists, medical doctors, and social workers. This supported maximum variability sampling and targeted purposive recruitment of registered nurses who are shamanic healers. In addition, snowball sampling methods as discussed earlier were used whereby participants were asked to identify other knowledgeable shamanic practitioners who would meet the study inclusion criteria.

Measures and instruments. After receiving IRB approval for the study and obtaining written informed consent, demographic information of the participants in the study was collected using a researcher-developed demographic questionnaire. The demographic questionnaire was used to gain a better understanding of the sample including age, sex, education, race/ethnicity, and questions regarding shamanic healing practice (how long practicing, frequency of shamanic healing appointments/month, client case load/size). Participants were sent an email invitation to complete the demographic survey using Qualtrics, an Internet based survey software program. The use of Qualtrics allowed for: an electronic confirmation of consent, easy access to the

survey, which could be completed at a convenient time for the participant, and secure data collection.

Human Subjects Research

Enrollment and informed consent. All shamanic practitioners listed in the Four Winds Society Provider Directory were sent an introductory email from the dissertation researcher outlining the purpose of the proposed research including inclusion and exclusion criteria. The introductory email asked for potential interest and willingness to participate in the research. If a practitioner did not respond to the email within two weeks of the introductory email, a second email reminder was sent to the practitioner. If there was no response within the subsequent two weeks by the shamanic practitioner, recruitment of the practitioner ceased. Shamanic practitioners who responded to the introductory email or subsequent email expressing an interest in learning more about the study were scheduled for an introductory phone conversation/appointment.

The doctoral student researcher coordinated the phone conversation/appointment via email. The focus of the phone conversation/appointment was to verify eligibility/inclusion criteria, and review the informed consent and answer questions from the potential participant. Following the review of the informed consent, and once all questions have been answered, eligible potential participants were given the opportunity to confirm, defer, or decline participation in the research. For those who chose to participate in the research, verbal consent was noted and confirmed as the initial question before start the demographic survey. All participants were provided instructions regarding access to the demographic survey. An appointment for the videoconference/data collection was scheduled at a date and time convenient for the participant.

Protection of human subjects (participants). Prior to the initiation of any research data collection, the research proposal was reviewed and approved by the university IRB at Boston College as noted above. During the review of the study with potential participants, the researcher informed the potential participants about the details of the research, its purpose, methods, potential risks and benefits, and the voluntary nature of participation. Potential participants were notified that they could choose not to answer any question and that they had the right to withdraw participation at any time. Every attempt was made to assure participant confidentiality. For example, pseudonyms chosen by the participant were assigned to each study participant, transcribed data was de-identified, and all study data, recordings and texts were stored in password protected computer files. Demographic data or any data linking participants to their pseudonyms was stored in a separate password protected file. Upon completion of the study, the recordings of the participants' interviews were destroyed. Five years after the completion of the study, all identifiable data, consent forms, names, and phone numbers will be destroyed.

Finally, in an attempt to reduce the risks for research participants, anyone participating in the conduct of this research (the dissertation researcher, dissertation committee, and transcriptionists) obtained the Collaborative Institutional Training Initiative (CITI) certification, a course regarding the ethical treatment of human subjects. CITI certification is the standard used to educate researchers about the ethical treatment of research participants and maintaining the dignity and safety of all human subjects, which is consistent with the philosophy of nursing.

Data collection methods. Each participant was encouraged to ask questions to clarify anything they did not fully understand about the study or informed consent prior to beginning the interview process. They were informed that participation in the study was voluntary and they could select either not to participate or to participate. Participants were informed that they may

choose to skip questions during the interview process that they were not comfortable answering. If, at this time, the individual stated that they would like to continue participation in the research, a brief demographic questionnaire (discussed above) was completed and the interview began.

In keeping with qualitative descriptive research method, qualitative interviews were conducted to collect descriptions from shamanic practitioners about their views on shamanic healing and their use of shamanic health modalities and methods for facilitating healing and integration among adult CSA survivors who experience a sense of fragmentation/soul loss. The interviews were based on a semi-structured interview guide developed by the dissertation researcher. The semi-structured interview guide contained open-ended questions and several prompts to elicit descriptions of salient topics relevant to the research aims and questions (See Appendix A).

Interviews were conducted via video conferencing over the Internet using VSee. VSee is a free downloadable application that is compatible with both iOS and Android operating systems allowing it to work with computer based and mobile systems. It is a HIPAA compliant video conferencing program widely used in telemedicine, enterprise, and for individual use (VSee, 2015). VSee allows for real time conversations and the ability for face-to-face interviews via peer to peer videoconferencing. Confidentiality is maintained using secure Federal Information Processing Standards (FIPS) 140-2 256 bit Advanced Encryption Standard (AES)-encrypted video transmission. VSee uses end-to-end encryption. No server, including VSee servers, has the decryption key, meaning that the decryption occurs only on the user's computer and is not available to the company server, government or other entities. VSee provides the researcher the option of recording of both video and audio data to facilitate transcription and the management of data (VSee, 2015).

The use of advanced technology is increasing in qualitative research. Internet video conferencing software programs have been documented in the literature as a qualitative interviewing research method that allows for a diverse geographic representation within a study sample. Teleconferencing provides the benefit of culturally and geographically diversifying a study sample with minimal associated costs, and face-to-face video conferencing allows researchers the opportunity to witness visual nuances such as facial expressions and body language and audio; furthermore, video recording of the interviews assist researchers with concerns related to validity and reliability (Cater, 2011; Moylan, Derr, & Lindhorst, 2015).

Interviews began with general questions regarding the participant's initial experience in Shamanism and its healing practice. As noted above, interview questions were detailed in the Interview Guide found in Appendix A. Interview questions were arranged by topic and each question was followed by a prompt as necessary to gather detailed description, such as "would you expand on that idea further" or a specific follow-up question might have asked for further clarification of the data provided or for specific examples to complement specific shamanic healing concepts.

Interviews were recorded using digital audio and visual recording through the VSee software. In addition, a backup audio recording was made using a digital audio recorder. Following each interview, the audio and video digital recording were uploaded to a password protected computer and transcribed verbatim by the dissertation researcher. The researcher verified the transcripts for accuracy by reading them while simultaneously listening to the digital recording. Corrections to the data transcripts were made as needed, the data was de-identified, labeled with pseudonyms and the transcripts were formatted for analysis.

Field notes were documented during each interview. These notes were brief in nature and

include thoughts and ideas that the researcher had during the interview. Field notes included comments about the posture, gestures or inflections of the participant that might not have been captured on the digital recordings. These field notes were transcribed and additional memos about the interview, thoughts, or follow-up questions were included. The digital audio and video recordings, transcribed field notes, and memos were also be stored in password protected computer files under the participant's pseudonym. Data management was facilitated by use of computer assisted qualitative data analysis software (CAQDAS) software like NVivo. This software helped manage, classify, sort, and arrange the qualitative data during the data preparation and analysis process.

Data Analysis Plan.

Data was analyzed using content analysis. According to (Hsieh & Shannon, 2005), content analysis is defined as "a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (p. 1278). This research study specifically used a method Hsieh and Shannon referred to as conventional content analysis, which was appropriate as a qualitative analytic approach when describing an unexplored phenomenon. The use of this analytic approach was in keeping with the proposed research; it seeks to describe a novel phenomenon, the use of a complementary health approach, shamanic health modalities, for facilitating healing and integration of adult CSA survivors who experience sense of fragmentation/soul loss, through the lens and perspectives of experienced shamanic practitioners providing shamanic intervention for such survivors.

Hsieh & Shannon (2005) outlined the method of conventional content analysis in a step-by-step process. The process they outlined will be followed for this study: 1) immersion in the data by reading and rereading the transcripts, 2) development of codes by reading the transcripts

word for word and highlighting words that capture key concepts, 3) documentation of thoughts and impressions in the form of researcher notes, 4) development of labels for data codes, followed by the development of categories, groups, and clusters, which help to categorize the data, 5) development of definitions for categories, groups and clusters, and 6) preparation for reporting the findings though the use of exemplars related to the codes, categories and clusters. This method of conventional content analysis assisted the dissertation researcher in processing a vast amount of data, identifying codes, developing clusters of codes into categories/themes, and generating rich descriptions of the topic of study.

Data management. Data management was facilitated using NVivo, a computer assisted qualitative data management and analysis software (CAQDAS). This software was used to manage, classify, sort, and arrange the qualitative data so that the dissertation researcher could develop meaningful descriptions of the topic of study. In addition, NVivo served as an audit trail to facilitate reviews from peers and the dissertation committee members in order to bolster rigor and validity.

Rigor and validity. In order to advance knowledge in a particular field of inquiry, researchers demonstrate rigor and validity in data collection, management and analysis. Rigor relates to the procedures and methodologies used for both data collection and analysis and typically include the concepts of validity, credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Munhall, 2007). Validity is the extent to which the results can be considered authentic, trustworthy and reliable (Guba & Lincoln, 2005). Credibility refers to the accuracy or confidence in the truth of the findings. Transferability indicates the findings are applicable in other contexts. Dependability and confirmability attest to the fact that

the findings are consistent, could be repeated, and are shaped by the participant's responses and not the researcher's bias (Guba & Lincoln, 2005).

Several techniques were used in this dissertation research to achieve these qualitative rigor criteria. Member checking with a sub-sample of the participants who agree to be engaged in a member-check interview was used to enhance credibility (Miles & Huberman, 1994). In member-checking, these participants reviewed the findings with the dissertation researcher to assure that the findings reflected their experiences. The use of a culturally and geographically diverse sample and a detailed description of the data was used to address the issue of transferability. Techniques used to verify dependability and confirmability included the use of an audit trail and reflexivity. The audit trail is a description of the research from the beginning of the project to the reporting of the findings. Reflexivity relates to the prevention of researcher bias – thus, throughout this research study the dissertation researcher recorded methodological decisions, study logistics, and personal reflections with careful attention to content in order to prevent the influence of personal bias on data collection, data analysis, and the presentation of findings (Lincoln & Guba, 1985; Munhall, 2007).

Chapter 4: Results

Introduction

The purpose of this qualitative descriptive research was to investigate shamanic healing, from the perspective of shamanic healers, as a complementary health approach to facilitate healing and integration among adult childhood sexual abuse (CSA) survivors. In this chapter the researcher will present the findings of the qualitative analysis. The results are organized and presented as they correspond with each of the five research questions.

The following research questions were posed: 1) What are the shamanic practitioners' perspectives on the nature of healing and the role of shamanism in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/soul loss? 2) What assessment methods are used by the shamanic practitioners to determine the aftereffects from CSA, specifically related to a sense of fragmentation known as soul loss in the shamanic tradition? 3) What are the perspectives of shamanic practitioners regarding the use of specific shamanic healing techniques including soul journeying and soul retrieval for issues related to sense fragmentation/soul loss, to facilitate healing and integration? 4) What are the evaluation methods shamanic practitioners use to evaluate healing in relation to sense of fragmentation/soul loss and improvement in sense of healing and integration for adult CSA survivors? 5) What are the effects of shamanic healing on sense of fragmentation/soul loss as perceived by shamanic practitioners based on their evaluations of adult CSA survivors healing from fragmentation/soul loss in their practices?

Data Preparation

All interviews were transcribed and the transcriptions were verified against the original interview recording by the researcher to ensure accuracy. No personal identifiers were used

during the interviews therefore all transcripts were de-identified. In addition to the semi-structured interviews, all participants completed a demographic survey using Qualtrics™, a secure web-based analytics software program.

Data collection. In keeping with the research proposal, data was collected via semi-structured interviews using an interview guide with questions and prompts related to the research questions. Initially, all interviews were conducted using Vsee, a secure videoconferencing web-based software program. Due to computer service limitations for some participants, a protocol amendment was submitted to Boston College's Institutional Review Board. Approval was granted to conduct the interviews by phone, in addition to the on-line video conference using Vsee. Interviews varied in length from 1-3 hours, with the majority lasting 2 hours.

Data management. All interviews were recorded using two digital voice recorders and researcher jottings and field notes documenting the researcher's thoughts about the interview process and particular comments that participants made that needed follow-up with other participants. Following each interview, the digital recordings were uploaded to an encrypted flash drive and stored in a locked cabinet with the researcher's notes. A copy of each interview was placed on an additional flash drive, which was delivered by hand to the study's transcriptionist. All interviews were transcribed and the transcriptions were verified against the original interview recording by the researcher to ensure accuracy. Once the transcripts were verified, the original recordings that were on the two digital recorders and the transcriptionist's flash drive were deleted. This process left one copy of the digital recording and corresponding transcription on the encrypted flash drive.

Data analysis. Conventional content analysis as described by Hsieh and Shannon (2005) was the foundation for the data analysis for this research study. This included 1) immersion in

the data by reading and rereading the transcripts, 2) development of codes by reading the transcripts word for word and highlighting segments of words that could be coded, 3) documentation of thoughts and impressions in the form of researcher notes, 4) development of labels for data codes, followed by the development of categories, groups, and clusters, which help to organize the emerging findings, 5) development of definitions for categories, groups and clusters, and 6) preparation for reporting the findings though the use of exemplars related to the categories and their subcategories.

Data analysis began once the first transcription was received and continued throughout the data collection process. The analysis included listening to the interviews and reading through the transcriptions multiple times. The data from each interview was organized in categories by research question, and codes (Saldana, 2016) related to each specific research question were identified in the data transcriptions. Similar supporting quotes by participants were clustered together. The categories and codes were verified for trustworthiness by the researcher and the research committee chair. Once the categories and codes were identified and verified for each individual interview, data across all interviews were aggregated into a table by category and the associated codes. This process allowed the researcher to discover common codes and patterns across all of the data. Demographic data with compiled using Qualtrics™ analytics.

Characteristics of the Study Sample

A total of 15 participants completed the research study. Forty invitation emails were sent to potential participants. Nineteen individuals responded with an interest to participate in the study. Another five declined to participate. Sixteen did not respond to the original or follow up invitations to participate. Of the 19 potential participants who expressed an interest to participate, 15 consented and completed participation in the research. Three of the 19 potential participants

were unable to participate due to scheduling difficulties and one was ineligible because his/her shamanic practice was less than one-year-old.

Table 1. Demographic Characteristics of the Study Subjects (N = 15)

Demographic Variables	n	(%)
Gender		
Male	3	(20.0)
Female	12	(80.0)
Age		
45-54	5	(33.3)
55-64	8	(53.3)
65-74	2	(13.3)
Race		
American Indian / Alaskan Native	-	
Asian	-	
Native Hawaiian or Other Pacific Islander	-	
Black/African American	-	
White	14	(93.3)
More the one race	1	(6.6)
Unknown/Not Reported	-	
Ethnicity		
Hispanic/Latino	-	
Not Hispanic/Latino	14	(93.3)
Unknown	1	(6.6)
Education Level		
Some College	3	(20.0)
Associate Degree	1	(6.6)
Bachelor Degree	4	(26.6)
Graduate Degree	3	(20.0)
Professional Degree	2	(13.3)
Doctoral Degree	2	(13.3)

Introduction to participants. The following section provides a brief introduction to the participants including a synopsis of the participants' work or choices of professions prior to becoming shamanic healers, how they were introduced to shamanic healing, the education and training they undertook to become a shamanic healer, and how they established a shamanic healing practice.

Participants' work prior to becoming shamanic healers. The work or professional background of study participants varied. Some participants had several occupations before their entry into shamanism. Several participants were in the healing professions prior to shamanic healing: a pediatric flight nurse, a trauma nurse who was also a naturopath, a health-oriented entrepreneur who established a multidisciplinary healing center, a psychologist, a mental health counselor with her own private practice who also ran a non-profit focused on violence prevention for youth, and two were certified addiction counselors. The remainder of the participants represented both labor and business professions: a restaurateur, a financial advisor, a lawyer, manufacturing, and one was the first female welder in her area of the country. Two participants represented the arts: one was involved in fashion and advertising, the other was a designer and art director in the music and movie industry. Finally, one participant was a minister in the Congregational Church, which represented the spiritual profession.

Table 2. Professional Licensure and Certifications of the Study Subjects (N=15)

Biofeedback	(N=1)	Addiction Counselor	(N=2)
EMDR	(N=3)	Mental Health Counselor	(N=2)
Massage	(N=3)	Naturopathic Doctor	(N=1)
Hypnosis	(N=3)	Psychologist	(N=1)
Reiki	(N=8)	Registered Nurse	(N=1)
Neuro-Linguistic Programming	(N=1)	MBA	(N=2)
		Lawyer	(N=1)

Participants' introduction to shamanic healing. Participants described their introductions or discovery of shamanism as occurring in three ways: happenstance, desire, and curiosity. Each of these will be briefly reviewed.

Several participants were introduced to shamanism by happenstance. One participant was at a workshop that presented a video presentation. Another was asked by her brother to pick up a video to watch while visiting with her over the holiday. In both of these cases, the videos focused on shamanism by a leading teacher in the field of shamanic healing, medical anthropologist and founder of the Four Winds Society, Alberto Villoldo, PhD. Another participant was introduced to shamanic healing through her family of origin. She described that her father was culturally Native American (Cree Tribe), and that both her mother and sister had strong intuition and experienced visions of things to come. While growing up, her connection to the Native American tradition and her intuitive way of knowing were supported by her family, which resulted in an environment of personal inquiry that took her to Peru. While hiking on the Inka trail, she described meeting a shaman who invited her to share his heritage and lineage and to teach her the medicine of the shaman.

Happenstance or coincidence was one way participants described discovering shamanism, but the discovery was also described as emerging from a felt desire or need. For example, difficult family issues and health crises introduced participants to shamanism. One participant described going through a difficult time with her spouse. This resulted in her seeking counseling; the therapist practiced shamanic healing. The same participant also described that when she received shamanic healing, it sparked her desire for further education and training to become a shamanic healer. While emotional upheaval was the impetus for this participant, a physical health crisis led another to seek alternatives to the conventional western medicine. Her

positive outcome from shamanic healing provided her incentive to explore training in shamanic healing. Finally, one participant, a psychologist, became dissatisfied with her clients' outcomes, especially those of trauma survivors. In her desire for improved outcomes with her clients, she discovered the value that shamanism could play in facilitating healing from trauma.

For others, curiosity about shamanism proved to be their path. While in her early 30s, one participant described her interest being spurred while studying with a Native American and participating in a workshop on shamanism. Some participants shared that they started reading books on spirituality and shamanism early in their teens and 20s. Two participants had personal experiences that motivated their pursuit of training; one of these experiences occurred while traveling at Machu Picchu in Peru. The other experience happened while on a vision quest; as background, among Native American cultures a vision quest is a purposeful undertaking that involves isolated time in nature fasting and praying to find a spiritual center and guidance for one's life purpose from a guardian or the Great Creator (Cohen, 2006). **A**nother study participant was motivated by was Mercea Eliade's (2004) ground breaking novel, *Shamanism: Archaic Techniques of Ecstasy*; it captured the attention of the participant which led to the journey into shamanic healing. Finally, an existential conversation with a friend led one participant to study her Celtic heritage where she discovered Celtic shamanism as her first entrée into shamanic healing. Whether by happenstance, desire, or curiosity, each introduction to shamanism was a catalyst for further study and training.

Participants' shamanic education and training. After the initial exposure to shamanic healing, the participants continued reading about shamanism, watched videos, and attended a variety of workshops. Some participants explored other shamanic healing traditions with Native

Americans, Shamans in Peru, Celtic shamanic practitioners and noted instructors in America such as: Michael Harner, Sandra Ingerman, and Hank Wesselman.

All participants completed the Light Body School of Shamanic Energy Medicine at the Four Winds Society, which, as referenced earlier, was established by Alberto Villoldo, PhD. The length of time to complete the training varied among participants. Some approached it as an intensive study and completed all courses within twelve to eighteen months, while others took two or more years to complete. For each course, didactic information was presented, rites and ceremonies were conducted and healing methods were practiced. Following each course, participants were required to practice a minimum of 15 healing sessions at home for each healing method and complete a case summary for each of these practice sessions. This was only a foundational element of their training. For most of the participants, at-home practice was a natural transition to starting a shamanic healing practice.

Establishing a shamanic healing practice. All participants had established shamanic healing practices. Commonalities on establishing a practice were revealed in both the choice of setting and in the development of a clientele base. The majority of participants began working with clients in their own homes or in the client's home. With time, participants moved to practice in independent offices or within a group of complementary health practitioners, and some practiced in nature. Most described that they conduct distant healing via the phone or Skype-like services. Several participants were guided by intuition, visions, and a sense of knowing what to do. For example, one participant explained he had a vision directing him to establish a behavioral health facility with a focus on shamanic healing and a holistic approach using a variety of western and complementary treatment methods.

With the setting established, participants turned their attention toward developing their practices. To begin the process of growing a client base, many participants provided healing sessions without a fee. This provided an opportunity for the shamanic healer to become more skilled in the healing methods and to get the word out to others about shamanic healing. Other approaches participants used to develop practices included: workshops, establishment of websites, social media, and fliers and brochures. Two of the participants began teaching with the Four Winds Society. Teaching with the Four Winds Society provided these participants with continued expert mentoring, experiential learning, and interested individuals seeking personal healing while participating in shamanic training.

While each practitioner was unique, their descriptions of the aesthetics of the healing space and equipment were similar. Most participants discussed the importance of a creating "sacred space" when conducting shamanic healing. They described one way of creating sacred space as cleansing the environment with incense such as sage to clear the space of any heavy or negative energy. Many participants drew on spiritual methods, taking time to meditate, praying to quiet their minds, and requesting assistance from angels and spiritual guides and all who might assist with the healing process for the client. Participants described home and work offices that included objects from nature, and textiles from Peruvian, Native American or other indigenous peoples. The healing space often incorporated nature. Nature was incorporated through being in nature, being able to see nature, or through nature-inspired art work in the healing space.

In referencing the assessment and subsequent healing methods used with clients, shamanic healers described using a variety of different tools such as a pendulum, cleansing water, some form of relaxing rhythmic sound waves such as a rattle, drum recorded music, Tibetan singing bowls, and a mesa. The mesa includes thirteen healing stones and artifacts

representing elements of the shaman's own healing journey that are used during healing ceremonies, prayer and divination with the client (The Four Winds Society, 2016). The thirteen stones are earned as shamanic healing students experience their training through rites and initiations. Each stone, also called a khuya, represents a challenge or trauma, that became a source of wisdom and courage through the instruction. Once the education is complete, the new shamans use these khuyas during healings with their own clients (Villoldo, 2016). Demographic information about the practice characteristics of the 15 participants who completed the study is provided in the tables below.

Table 3. Numbers of Years and Hours Participants Practiced Shamanic Healing

	Mean	**Range**
Number of years practicing	11	7-20
Number of Hours practicing per week	21.6 hrs/wk	6-50 hrs/wk

Table 4. Healing Practice Characteristics of Study Subjects N = 15

	N (%)		**N (%)**
Compensation		**Other Practices**	
Private Pay %	10 (100)	Spiritual Healing	3 (20.0)
Third Party Payer %	NA	Hypnosis	3 (20.0)
Private/Pro Bono %		Biofeedback	1 (6.6)
85% private/15% 3rd party payer	1 (6.6)	Essential Oils	1 (6.6)
90% private/10% pro bono	1 (6.6)	NLP	1 (6.6)
No Answer	2 (13.3)	Crystal Consciousness	1 (6.6)
		Internal Family Systems Therapy	1 (6.6)
Other Complementary Practices			
Massage	3 (20.0)		
Acupuncture	1 (6.6)		
Reiki	8 (53.3)		
Healing Touch	1 (6.6)		
Sound Healing	2 (13.3)		
Eye Movement Desensitization & Reprocessing (EMDR)	3 (20.0)		
Guided Imagery	11 (73.3)		
Herbals	1 (6.6)		
Meditation	11 (73.3)		

Research Question 1: What are the shamanic practitioners' perspectives on the nature of healing and the role of shamanism in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/soul loss?

The aim of this first research question was to better understand the shamanic perspectives on the nature of healing from CSA from both the conventional western and shamanic viewpoints. Although the research question focused on the nature of healing, the participants' perspectives of trauma from both the conventional western and shamanic viewpoints were discussed in the interviews and are included here to provide a context for understanding the nature of healing. Given that the study participants were all shamanic healers, their descriptions of the shamanic viewpoint of trauma and healing were much more detailed than their ones of the Western perspective.

Western perspectives of trauma: Trauma initiates fight, flight or freeze stress response and creates a narrative. When analyzing participants' discussions of trauma healing through the lens of a conventional western perspective, the main categories that were discovered was the sense that trauma initiates the fight, flight or freeze stress response and trauma creates a narrative of the event.

Stress response to trauma. Participants described that the unprocessed stress response can lead to illness, hypervigilance, powerlessness, and fragmentation of the personality. Participants described that in response to trauma, the fight or flight response is activated and cascade of potential long-term stress responses due to the trauma is initiated. For example:

> When we click into fight or flight, our cortisol levels go up. Our whole body chemistry gets stuck in a fight or flight place which is very unhealthy, very stressful. It sets the basis for inappropriate reaction to minor life events, reactions that are out of context in

> the present tense. As the fight or flight chemistry increases in the body so does heart disease and all sorts of stress related illnesses. So, yes, stress may cause cancer for all we know. (N3)

Another example from another participant was further illustrative of this view of the fight or flight stress response held by the participants when they described the Western perspective of trauma:

> I think a Western model of trauma basically throws the brain and body into a fight flight response or freeze response. Because the events are too overwhelming to process, they get kind of stuck and the mind/body stays in fight flight freeze, which can have health effects because of things like increased cortisol in the system. It can have the kind of repetitive re-experiencing effects of the trauma because it hasn't been wholly processed… They can also lead to beliefs of powerlessness, helplessness and not being able to master the traumatic experience or stop it from happening. It can also lead to various forms of dissociation or disconnection because the nature of trauma is overwhelming, that there's a need to kind of distance and disown traumatic material and that happens really in all post-traumatic stress disorder but it can become even more extreme in repeated or complex post-traumatic stress disorder, which is often the case with child sexual abuse. It can even lead to fragmentation of the personality. (N8)

Trauma creates a narrative about the event. Another participant indicated that trauma in the Western paradigm is to manifest a story about an event. The story can become a trap for trauma survivors. They get stuck in the story of the traumatic event and are less able to move forward and heal. The story is also used to rationalize one's situation in life, rather than to teach the lessons that can come from trauma. A participant reflected, "I think trauma in the Western

viewpoint is used as an excuse. I think a lot of people gravitate to that story and they use it as a way to justify things" (N12).

Although the shaman's view of trauma from a Western perspective was briefly discussed by participants, it did identify the stress response which was also shared by the shamanic perspective of trauma, as presented below. The following section will provide evidence of the shamanic perspective of trauma held by the participants.

Shamanic perspectives of trauma: The origin of trauma is important for healing; trauma is an event that teaches you - meaning matters; the impact of trauma is multifactorial; and trauma results in energetic disturbances. When analyzing the data, four separate categories were discovered to describe the shamanic perspectives on trauma. The four categories included 1. the origins of trauma, 2. trauma is an event that teaches you (meaning matters), 3. the impact of trauma is multifactorial, and 4. energetic disturbances. The following section describes the four identified categories and includes several subcategories that reflect the shamanic view of trauma and its impact on survivors.

Origins of trauma. Participants described the *origin of the trauma* may occur in the temporal life of an individual or it may find its origin in a family lineage, epigenetics, or in a cultural/archetypical form. Trauma that occurs in the temporal life of an individual is the type of trauma most often thought of in society. It is the physical, the emotional or the sexual trauma, which occurs in the 'present' moment, or in linear time of one's daily life. While some trauma may originate in the present moment, the origin of other traumas may span generations in the family.

As one participant said, "in some cases the trauma goes on for generations in families and there's been a long-term pattern. This may be the first time that someone in this family, after

generations, is actually saying 'no, this can't continue'" (N8). The generational influence of trauma was referred to by another participant by using the metaphor 'traveling down a timeline':

> I'm trying to think about traveling down a timeline. You travel down a timeline and you're going back and you're looking at someone's blood lineage and you realize that maybe along the blood lineage, at some point, they were given to someone as a barter for something. Right? So they were sacrificed because maybe the family needed food. So if I give my youngest daughter, we will have food on the table. Fast forward five hundred years later, and there's another incident of a girl being given as a trade for drugs or something like that and it's tied into that old contract that someone had made. (N12)

Epigenetics was also described by some of the participants as the origin for traumatic experience. Several participants stated that trauma could be acquired via trans-generational epigenetic inheritance. Epigenetics is the study of the mechanism of temporal and spatial control of gene activity during the development of complex organisms; it can be used to describe anything, other than the DNA sequence, which influences the development of complex organisms (Hall, 2013). One participant explained that traumas endured in prior generations influences the development of subsequent generations. As an example, she cited the experiences and fears endured by holocaust survivors that have continued to impact the survivors' children and grandchildren. "The trauma experienced by holocaust survivors is capable of being passed onto their children is the clearest sign yet, that one person's life experience can affect subsequent generations" (N3).

Cultural or archetypical patterns were also described as the foundation of trauma by some of the participants. This was described as a type of traumatic experience that is known and understood by society as unjust, but it continues to exist. The role of the individual seeking

healing for this type of trauma is to attempt to heal not only themselves but to also heal the cultural or archetypical injustice. One of the participants discussed the concept of healing cultural and archetypical trauma by recounting an experience with a client who was confused about the actions of her two sons:

> She had two sons. Her second son was very dramatic, very loud, always having to make a big deal out of nothing. Her blood lineage is from [a part of the world outside the United States] where the second son (is from) doesn't even exist. So the archetypical energy that was running through the family here in the United States in 2016 continues to manifest that cultural archetypical energy in which the second son does not exist. As a result of the cultural impact, the second son was acting out in an attempt to be seen. (N12)

Trauma is an event that teaches you - meaning matters. A common shamanic perception of trauma among participants is that trauma is an event that teaches you – meaning matters. According to the shamans, trauma should not define you. It is one of many events that occur in one's life. Participants described trauma as a 'great teacher' whereby the impact of trauma was defined based on an individual's meaning of a trauma. A traumatic event in the shamanic tradition was referenced as a life lesson, as one participant stated, "trauma becomes the best teacher" (N7). The focus was to widen one's perspective to understand life's gifts and life's lessons in order to evolve. Another participant described past trauma as "an invitation to explore where parts of you have left in the present moment" (N4). Other participants similarly described trauma as an invitation to learn:

> Shamanic practices have a bigger context. So it's not only person A did something to person B. It's how does this event impact you? What can you learn from it… how do you understand it in relationship to your life? Why are you here on this planet? What

have you come to learn? How did this unfold for you in a way that enlightens you and is a revelation to you of your purpose and why you're here? So it's a much broader context for understanding. So traumatic events, it's not just 'you are the victim'. (N2)

According to the participants' reflections, it is shamanic healing from trauma that provides one with an opportunity for expanded consciousness and opportunity for meaning making of the trauma to gain mastery. Many of the participants discussed the impact of trauma and the relationship with an individual's perception and meanings of the trauma, his or her ability to engage in healing, and the support of others. For example, given the unique perception of each person affected by a traumatic event, one participant reflected on the meaning that a trauma survivor gives to the event. The impact of what appears to be the same type of traumatic event (i.e. life-threatening) can vary from person to person based on the person's perceptions:

> When a trauma, which is a situation that is somehow life-threatening, happens to a person, it might not be [perceived] life-threatening to another person, it is the perceived threat that renders a person frightened for his or her survival, powerless, helpless and entrapped. (N6)

While trauma may provide the prospect for evolution and transformation, the impact of trauma is based on the individual's perceptions and meaning making of that traumatic event. "Trauma, in my book, is not qualified by what action happened. It is how it is perceived and stored" (N3).

The impact of trauma is multifactorial. In general, the participants described the trauma experienced by the CSA survivors as exerting a multifactorial impact on the energetic, psychological, and relational life of the trauma survivor. As one participant stated referencing the multifactorial impact, "It can affect your health on a great many levels. It can also affect your social life. It affects your business life. Your whole world can be affected by some stored event

such as this" (N3). Another participant said, "with trauma, you have this experience and your view of the world changes. You see the world through this experience. It is all encompassing and you are reliving it as though there are elements of this traumatic event in every aspect of your life" (N15).

According to participants the consequences of trauma have a progressive domino effect, beginning in the energetics (energy within and surrounding the body, such as the chakra system and the bodies aura), then spreading to psychological wellbeing and on to physical health of the individual. One participant described this progression, "It starts as an energetic trauma. It becomes psychological if it's not attended to. And it progresses, because the psychological thing hasn't even been addressed, and it starts manifesting in physical things" (N14). The following three sections, highlight the impact of trauma related to the subcategories identified in the data – energetics, psychological, and the relational aspects of the individual.

Trauma's impact on energetics. Energetic disruptions: Soul loss (loss of one's vital energy), energetic disconnection, and toxic energy imprinting. Soul loss was described by study participants as the loss of one's vital energy resulting from a traumatic experience (CSA). Soul loss was considered a protective mechanism during traumatic CSA experiences. During the moment of trauma, the individual's spirit or vital life energy removes itself from the traumatic situation and travels to non-ordinary reality. In shamanic tradition, this non-ordinary reality is a different dimension of time and space, a place away from one's conscious awareness. This situation, framed as 'soul loss' in the shamanic tradition, leaves the sexual trauma survivor feeling fragmented, empty, and not whole, as if something vital for one's wholeness is missing. When asked to define the shamanic perspective on the energetics of soul loss, a participant compared it to the psychological model of conventional medicine. He said:

> In a western model, we would call that disassociation. So a person's dissociated. Part of them is not there and they might sense that as there's something missing. They can't engage. They're lost. They don't feel whole. They're empty. It's like… their psyche can't handle it. So it [psyche] just disassociates from the event… What happens is there is part of us that can't reconcile that. So that part of us just shuts down. That would be kind of a Western perspective. Shamans call that soul loss and we can bring that soul part back. (N11)

Another participant spoke of soul loss as loss of vital energy that carries gifts of the soul, "Soul loss is the loss of a quanta of energy that used to be available carrying gifts, passions, contracts, perspectives or perceptions, and ways of looking at yourself and your experience in the world" (N1). One participant talked about soul loss, referring to a tendency among survivors to 'bounce out of their body'. She said, "It's been my experience working with many people…they bounce out of their body because they don't feel safe in their body" (N2). Another participant helped to describe the value of the shamanic conception of the energetics of soul loss when discussing the ability to facilitate healing through the shamanic retrieval of the soul part:

> In shamanic terms, when there is soul loss, the shamanic practitioner, with the help of helping spirits, would actually go in search of the lost soul piece, life force, or life energy in order to bring it back to the person so that they have that life energy again within their energy system. (N8)

Several participants tried to further clarify the concept of soul loss when they indicated that the soul never really leaves the energy field of the individual, rather is it unavailable to the conscious mind:

> The soul is very expansive but when we're frightened that fear contract us. When we contract around that fear, it's not that the soul is not there or available, it's that we're not available to it. We're looking in another direction. I want to say we sort of get pulled into our navel. That's exactly where that adrenal gets released and the fight or flight gets activated. We just become small. We become what we fear we are, which is that finite being and it makes us contract, whereas the soul is always an invitation to expand and to breathe and to allow one's self that connection to the divine, which is ultimate spaciousness. (N2)

Another participant reflected on her sense of soul loss. She explained her perspective, which views the soul part as remaining connected, yet unavailable, to the individual as compared to the view that the soul part is separated or lost. She described soul loss using an analogy of a kite that is far up in the sky but remains tethered by a string to the self:

> One of the things that my spirits taught me, which is as a metaphor, when there's soul loss going on, we don't ever really fully lose our soul part. I liken it to imagining that you're holding a kite on a string and that kite may be very, very far away. That kite is like that soul part. But that string, that filament of energy that's connected to you, can never be severed because it's part of you. That part, that's part of you, cannot be separated. (N14)

Soul loss was not the only energetic disruption in the aftermath of trauma that participants discussed. Participants described the blockage of energy flow through the human seven-chakra energy system, as well as imprints in the luminous energy field, and possessive energies – all of which are presented below.

Disruption of the chakra energy system was described as energetic disconnection from the first, the second and the third chakras. The lower three chakras provide grounding and are connected to one's senses of: 1) safety and survival (Root); 2) well-being, pleasure, sexuality, self-worth (Sacral); 3) courage, confidence to be in control of one's life (Solar). These chakras are the most disrupted by childhood sexual abuse. The upper chakras are connected to one's sense of: 4) love, hope, and intimacy (Heart); 5) communication, creativity, and faith (Throat); 6) reason and logic (Third eye); and 7) intellect, selflessness, integrity and wisdom (Crown). (Villoldo, 2000).

Several participants stated that disruptions in the chakra system resulting from sexual trauma prevented an individual from making fully informed decisions. This is because the sexual trauma survivor is not connected to natural instincts and feelings from the lower chakras that help guide decision making. One participant aptly described the relationship between lower chakra disconnection and decision-making with adult CSA survivors:

> They come up into their upper chakras. They don't feel safe particularly in their procreative organs...So it leads to a very twisted view of themselves because they're not comfortable in their body, they're not comfortable getting information from that root chakra, that second chakra, that third chakra. They really are at a great disadvantage to make choices in life. (N2)

Inhibition of energy movement through the light body, described in the shamanic tradition as the 'luminous energy field' or the energetic field surrounding the body, was also discussed. This was seen as blocked energy flow. One participant described it as an "imprint - a little area of your light field where the light is not flowing freely" (N15).

Another participant talked about the 'off-loading' of toxic energy when discussing the healing faced by victims of sexual trauma, stating: "the perpetrator, if you like, for want of a better word, offloads all of their guilt and all of their shame energetically onto the victim" (N9) This off-loading was further described as ridding the perpetrator of "those feelings and imprinting them onto the energy field of the trauma survivor. The survivor is unable to differentiate the toxic energy as the perpetrator, and interprets those feelings as his or her own" (N9).

According to the participants, if the energetics are not cleared and healed, the impact will extend and affect the psychological well-being of the adult CSA survivor. Thus, the next section addresses the shamanic perspective of the psychological impact of CSA on the adult survivor.

Trauma's impact on the psychological domain. Participants described multiple psychological consequences that included depression, anxiety, post-traumatic stress disorder (PTSD), hypervigilance, trust and safety issues. Of the psychological consequences discussed, participants focused primarily on hypervigilance, and trust issues.

In these descriptions, the shamanic perspective shared the Western view of an activated stress response among adult CSA survivors. For example, "when someone is confronted with trauma, a part of them is not able to experience it. It's just too much … the freeze happens and the trauma gets stuck in their unconsciousness or in their energy body" (N15). The activation of the stress response often leads to hypervigilance in which the survivor is always on alert for something to happen or not feeling safe: "It's just the message in general - the world is not safe. It's easier to be by yourself or limit yourself" (N4). Another participant described 'waiting for the other shoe to drop':

> I would say one characteristic might be that they're waiting for the other shoe to drop. They're always on edge. Their antenna is always up to say where is the danger? … They can't feel at home in their body, feel at home with other people, feel at home with other peoples' bodies…. (N2)

The psychological expressions of trauma were also influenced by challenges with trust. Trust was described as almost always being obliterated with CSA, because the majority of perpetrators of CSA is known to the child and is innately trusted by the child to provide love and safety. This breach of trust can have long-term influences on decision-making and relationships. Survivors were described as being left with thoughts of fearfulness of being harmed again, not knowing who to trust, and even having difficulty trusting themselves. One participant noted:

> There's a hesitation to trust. They tend to really view things from their head rather than from what they are sensing from their feelings and their gut. This puts them in a vulnerable state, they're not in their bodies. So they're not getting the signals that our bodies give us that this is a trustworthy person. This is an untrustworthy person. This is a trustworthy situation. They're not receiving them because they're not fully incarnate. That traumatic event makes them approach the world with their hands held out like don't get too close because I don't know who or what to trust and I don't even trust myself … They really are at a great disadvantage to make choices in life that are based on their needs and their wants and their purpose. (N2)

In addition to fearfulness and mistrust, the psychological dynamic of shame was also described. One of the participants explained:

> I have clients that were abused at three or four and they are now forty-five saying I'm so ashamed, I couldn't get him off me or couldn't get him out of the room, I'm useless. I

don't deserve anything. I'm guilty. Because this happened to me, I am bad. It must be my fault. (N9)

Given these psychological issues, challenges with relationships were highlighted.

Trauma's impact on relationships. Relational difficulties were discussed as a facet of the multifactorial impact of the traumatic experience. According to the participants in this study, many trauma survivors experience relational difficulties. They described the survivor's tendency to separate oneself from family, work, and community life, contributing to the survivor's potential isolation. As an example of this isolation, one participant shared:

> I see people isolating themselves. I think that's probably one of the biggest things. I see people isolating themselves from family, from work situations, and so that's a premier piece...It is almost like they are swimming in mysterious waters and they are not sure… these people say, 'I'm scared, I'm scared to leave the house'. And there's this effort to have a lot of control over things because a violation has occurred … it creates a lot of barriers and walls. So I see people isolating themselves, almost shutting down from life in the community. (N4)

On healing: Western perspectives of healing. With both the Western and shamanic perspectives on trauma presented above, the backdrop is set for understanding participants' perspectives on healing. Analysis of participants' perspectives on the conventional Western treatment model to assist adult CSA survivors revealed two major categories. First, Western treatment focuses on the trauma event and the trauma story, which can lead to perpetuating a sense of victimization and a false sense of power. Second, participants' descriptions painted a view of Western treatment as limited in addressing the totality of the impact of sexual trauma through a 'fix it' mentality and attempting to adequately manage symptoms. Particularly, the

energetic and spiritual aspects of holistic healing were not seen as being adequately addressed in the Western perspective of healing.

Western perspectives on healing: Focus is on the traumatic event, perpetuating a sense of victimization. According to the participants in this study**,** Western providers**,** in a well-intentioned attempt to understand and help individuals heal from CSA, regularly ask survivors to relive the event by providing a detailed account of what occurred. This painstaking retelling of the traumatic event was seen as having the potential to reinforce the impact of the trauma and trigger the stress response of fight, flight, and freeze as part of the treatment approach. According to the participants, the western behavioral approach of reiterating the traumatic event often stimulates feelings of shame and guilt. The retelling has the potential of leading the survivor into identifying with the trauma story, 'wearing it like a nametag' as one participant suggested, thus; perpetuating or maintaining a victimization stance. This participant's particularly poignant depiction of how survivors can be led within the Western mental health perspective to wrap themselves into the trauma story (not really moving beyond the trauma into a sense of true empowerment) is shared to reflect similar views from other participants.

> From a mental health standpoint, there is this desire to uncover a source point of the trauma and this is a difficult way to start to empower people. The Western model has you wrap yourself in your story…there comes a point in which you identify with your story, you start to wear it like a nametag and it becomes who you are. So it's like a nametag..... It's almost like you traded the trauma for a 'locked in feature of your life' or it continues to affect everything and then you traded that in for a 'story about your trauma', which gives you a false sense of power. This is a false sense of power, it is like they walked one

> step away from the shadow of what was going on inside…so they were no longer in the haunted house; but, they still heard the screams. (N4)

Limited scope of the Western medicine perspective: Fix the problem and manage the symptoms. While the greatest issue with the western model described by all the participants was that the Western model focuses too much on the traumatic event (noted above), another finding gleaned from participants' descriptions of Western treatment was that the western treatment approach was limited in its focus on trying to fix the problem. The participants believed that the Western perspective and approach frequently relied on pharmacology, primarily addressing the physical aspects of the trauma. Treatment for the psychological manifestations were discussed as symptom management and returning the adult CSA survivor to a functional state. Limitations on treating the wholeness of the individual were commonly discussed among participants when describing the Western perspective. One participant reported:

> My viewpoint of the Western medicine, and I think it's changing a little bit, but my viewpoint is they tend to want to give a drug or do a treatment. They want to do something…They want it to go away. So in the Western model, I they… give you a pill, they give you electrotherapy, whatever is available. That way, they can try to fix it… They don't want to see anything out of order in Western medicine, nothing should be out of order. (N10)

Other participants discussed that the complex nature of the impact of CSA can befuddle medical providers. In turn, they focus on treating the symptoms without a focus on healing the insidious experience and cosmic horror of the aftereffects of CSA:

> Western conventional method, speaking only from my experience, and it's been a long experience, but the fact is that the medical community is uncomfortable in my opinion

> with everything they cannot directly do something about. And it makes sense, it's not an insult, it's just trauma… it's like if it's physical, 'great because we can do something about that'… Sexual and emotional trauma are the most deadly and insidious experiences that anyone of any age can have and it affects every aspect of being… it affects perception, it affects biochemistry, it informs choice and so a person who has been sexually abused develops a wall of silence and that cosmic horror is being kept in. It makes them a puzzle for physicians to figure out, including psychiatrists. It is like okay we just want to deal with their symptoms, we don't want to deal with the insidious experience and cosmic horror. (N1)

The descriptions offered by participants revealed that they did not view Western treatment as holistic healing, particularly the Western perspective was not seen as adequately addressing all aspects impacted by the trauma such as the energetics and spiritual needs.

Shamanic perspectives of healing. Participants shared in-depth descriptions of their perspectives on shamanic healing for the adult CSA survivor. Four broad categories were discovered that captured their descriptions, as presented below: Shamanic healing defined, shamanic healing addresses the root cause of trauma, shamanic healing involves holistically addressing the human energy field, and shamanic healing involves transforming meaning.

Shamanic healing defined. *Shamanic healing from CSA was described by the participants as a multilayered process or journey that addresses the nature of the soul, integrating the energy field and consciousness, restoring vital energy to be fully conscious, peaceful, and empowered to live one's destiny***.** All of the participants contributed to defining shamanic healing. Participants discussed shamanic healing as, "a journey or a process without a beginning, no end point, no arrival point. It is a sense of awakening as a person steps into his/her

life at home and comfortable with oneself, a shedding of the victim mode" (N4). "Healing is stepping out of the triangle of disempowerment and into an empowered whole self" (N2). It is "understanding all aspects of the trauma and finding gifts to enrich one's life" (N10). "Healing creates a new journey map, leaving the trauma in the past and destiny in the present and future" (N8). "Healing is an ongoing process that restores energy, empowers and moves people forward" (N3) "Healing is the non-disturbed sense of being fully conscious of one's entire being" (N1). Shamanic healing "addresses the nature of the soul" (N11). It is "knowing the imbalance and welcoming it with love and light" (N6). Capturing many of these aspects of shamanic healing, one participant described:

> Healing in the shamanic tradition is the integration of the energy field and of consciousness so that in the physical, the symbolic, the mythic, and the energetic levels are all aligned. Shamanic healing provides a sense of peace such that even if the body dies that peace is not disturbed. It empowers individuals to be fully conscious… to make choices that help them become who they are meant to be... It's multi-layered, the first layer is it allows the survivor to connect to a source of nurturing and comfort that was not available to them before. It can reestablish the person's perception that they have as much right to be on this planet as anyone else, they have a right to dignity. Their dignity is not lost and they are not defined by a traumatic experience…on the physical level it can free them from the cycle of stress hormones, continuous stress hormones. It empowers people to differentiate between messages coming from the aftermath of abuse and from those coming from who I want to be. It provides a biofeedback mechanism that allows them to connect with their own healing and learn a language of communicating their experience so that it can be understood by others who can provide further support.

> Shamanic healing opens the doors to choices…it frees them from defining himself or herself as a victim. It liberates them from the traumatic event, It's like, 'this is not who I am, this is an experience that I had'. And that is enormously liberating. It frees them from limiting factors and allows them to say 'I can choose'. It frees them from the cycle of suffering…it reconciles them to the sacred and it restores innocence and beauty. (N1)

Shamanic healing addresses the root cause of trauma: Identifying the origin. As indicated in the prior discussion of shamanic perspectives on trauma that set the context for understanding shamanic healing, trauma from the shamanic view may occur in the temporal life of an individual or it may find its origin in a family lineage, epigenetics, or in a cultural/archetypical form. When assisting clients in healing from sexual trauma, participants discussed the importance of finding and addressing the trauma from the point of origin as conceptualized within the shamanic tradition. Through a process referred to as a 'shamanic journey', shamanic healers were described as addressing the root cause of trauma by traveling outside of ordinary time, traveling into the past to discover the origin of the trauma, heal it at the origin, and bring the healing forward back to present current day to facilitate the client's healing.

> I have to take care of this little wounded part and I have to determine when he did that, in that lifetime, or that moment, or when you were born. When was it that you were traumatized... You work with a timeline and you say where's the trauma and then you go back before the trauma occurred meaning five years, ten years, twenty years, two hundred years, heal it and bring that healing to today. (N7)

Others described 'soul contracts' in their references to addressing the root cause of trauma. These soul contracts were seen as instrumental in healing at the origin of the trauma. Participants referred to these contracts as being made before the client was born. Participants described the

soul contracts in shamanic healing as serving a purpose – putting a mirror up to the self, investigating one's purpose for coming into earthly existence from the soul realm, and teaching the survivor lessons from the bigger perspective of the soul.

> You have to get to the root cause, and with shamanism, what we'll do is find out what's going on, where did this come from and it's always going back to self. So put a mirror on. It's not about somebody doing something to you. It's look in the mirror, what is this situation trying to show you? What lesson has it to teach us? Because before we're born, we're all these little souls up in heaven. We're coming for an assignment here on earth and we sign up for lessons. The ailments, injuries, situation, and disease comes to us for an opportunity to learn and grow. So any situation that comes, any trauma that comes to us, changes us, we're not the same person as we go through it. When we embrace and say 'okay what did we learn here, what is this lesson trying to show me and why did I put it in my life'. So we always bring it back to self. Once you make peace with this situation and you look at it from the bigger perspective (being the soul), imagine being the soul up in heaven looking down and saying 'oh I know why I solved that problem'. Maybe I was the general in the army who murdered that man in a previous life and this is a balancing of karma. It could be anything. (N13)

Shamanic healing involves holistically addressing the human energy field: Finding and clearing energetic imprints. Shamanic healing was described as seeking to holistically work at the level of the human energy field – a 'blueprint' for one's embodied pattern – addressing energetic conditions that need to be healed.

> Shamanism has been more holistic the whole time. We look at the energy system. Energy is the organization of all matter. Even Einstein said that. The wave, the field is the

> governing body of the particle, meaning if I take some metal filings and sprinkle them out on a table and they'll just be all rampant like pepper. If I put a magnet underneath there, that magnet, the field is going to organize those metal filings. So if I want to understand the pattern, I have to look at the field. If I want to understand what's going on in the body, I have to look at the field and the shamans have known that forever. And that's where energy medicine comes from. And that's why the healing from trauma happens so much more completely, when we're looking at the human energy field, because it organizes … it's like a blueprint. (N11)

As alluded to earlier when describing participants' views on trauma in the shamanic tradition, participants specifically described imprints in the luminous energy field that can inhibit the flow of energy and disruptions in the human energy chakra system. Thus, shamanic healing was described as addressing energetic imprints; for example, such as the tethered offloaded energy from perpetrators. The quote that follows provides information about the search that shamans conduct in order to find the energetic imprints and also highlights the relationship in shamanic healing between addressing the origin of trauma (described above) and addressing energetic imprints.

> In the shamanic paradigm, we're trying to find that energetic imprint, that dark spot that's in your field and clear it. This type of healing is really working at the soul level. Like I might have to travel back down your timeline and find out what past ancestor had this contract that allows us to have it now. What part of you when this trauma happens left your body and that we need to bring back so you can be whole? What piece during the trauma do you need to reclaim, to empower yourself with now? (N12)

Clearing the energetics of past trauma was viewed as providing healing for the client, allowing for deeper understanding. Clearing the energetics of the trauma could also bring sexual trauma survivors toward balance. As participants noted, clearing the trauma energetically "resets the physical, emotional mythical and spiritual realms allowing for a deeper understanding of the trauma" (N14). Or, as another participant described in relation to healing clients energetically, 'we get a person coming back into balance':

> We needed to disconnect that button, cut the wires, heal the situation, bring the traumatic event into the present, into adult realization and clear it energetically and that resets the chemistry in the body, it resets the whole thing. It disconnects the process and some of the things that the reset can fix are alcoholism and drug abuse, compulsive eating, different types of behaviors that are affecting people's lives on many levels as well as some triggers for what might be called mental illness or brain disorders. There are all sorts of responses that get automatically triggered and when we remove those triggers and we disconnect all of those responses then we get a person coming back into balance. (N3)

Shamanic healing involves transforming meaning: Widening the frame beyond victimhood and restoring the right to dignity and connection. Participants described that CSA, a sexually traumatic event, can result in soul loss to the survivor. This loss of one's vital energy through CSA was described as leaving survivors feeling fragmented or in a less than whole state, which impacts their thoughts, perspectives, feelings and behaviors. As described earlier, this perceived less than whole state has a significant negative trajectory, including hypervigilance, disempowering victim thoughts, feelings of shame such as 'I deserved this', and relational trust issues and isolation in which the individual can disappear to oneself or to others. This negative

spiral established a pattern or cycle of traumatic experiencing within a narrowed framework that influences decision making and limits choice. Given this point of view on the trauma of CSA, shamanic healing was described as seeking to widen the scope of understanding the trauma, finding the gifts for one's life embedded in the event, and altering the story to allow for an enriched life.

> I think one of the most challenging and courageous things for a client to do is actually process the trauma with the help of a shamanic practitioner. They come to see that it is more than the story they have been telling themselves. It is so much bigger than that. When they break it all open, all of the information, the lessons and the energy loss to their consciousness, returns. They shine as who they really are, in their totality. (N6)

One participant used the expressive idea of creating 'a new map away from the trauma' when describing freeing up space around the trauma story for survivors' views of themselves to be transformed away from victimhood:

> I feel like the core of what the shamanic practitioner offers a client in healing the ability to afford them a new map away from the situation. It is treating them with of all the wisdom and all of the energy that got merged or buried when the situation happened or the period of time that things were happening and even their reaction afterwards. If you can free enough space around that story, where they can say 'I'm not the victim anymore' and they are able to create a new role for themselves, then they are making huge steps away from the patterns resulting from the trauma. (N4)

Participants described that when survivors live in the victim mode this is a very limiting scenario, constricting their life and choices. Many participants specifically referred to transforming meaning as stepping out of the "triangle of disempowerment" and moving on in

life. One participant cleverly used an analogy to the different acts within a play, communicating the sense that in healing from CSA it is critical for the survivor not to get stuck in Act I, which is like being stuck in the victim or disempowered mode:

> It's stepping out of the triangle of disempowerment and saying okay I really didn't like what happened to me, let's see how I might understand it and understand the soul loss… So the possibilities for forgiveness become wide and open in the shamanic way. If you are a victim, that is a very limited scenario without choices. That's like being in act I of a play, the play of your life, where bad things happen and you never get to act II where you are in charge. Shamanic healing, I think, recognizes that there is some meaning and purpose in all of the events that happen to us and that we're never a victim. We are really the choice maker who has chosen maybe a hard path to bring us to greater wisdom and understanding, to bring us to a kind of enlightened state where we can be deeply compassionate to ourselves and to other people. (N2)

Furthermore, transforming meaning in the shamanic healing tradition involves restoring the survivors' right to dignity and connection with humanity, nature, and the sacred. Participants described shamanic healing as empowering CSA survivors to live their destinies of dignity and connection, beyond living in the victim mode. While discussing the transformative nature of shamanic healing one participant said:

> Shamanic healing allows the survivor to connect to a source of nurturing and comfort that was not available to them before. It reestablishes the person's perception that they have as much right to be on this planet as anyone else, they have a right to dignity. Their dignity is not lost and they are not defined by the experiences that they have. They are empowered to have the life that they want for themselves, empowered in every aspect of

> their lives to go and seek their own happiness. They are able to connect to mother earth and the sacred to free themselves of that sense of being alone and isolated. Shamanic healing gives them access to energy that can support their highest good instead of forcing them to conform, to be okay when they're not, and go forward bravely without any self-satisfaction or self-realization. (N1)

In summary, the participants' descriptions in this research study indicated that shamanic healing aims to impact the wholeness/totality of the individual along the continuum of time through repairing and clearing the luminous energy field, restoring energy flow, transforming the meaning of the traumatic event, and liberating individuals from the constriction and shackles of a life outlook of victimhood.

Research Question 2: **What assessment methods are used by the shamanic practitioners to determine the aftereffects from CSA, specifically related to a sense of fragmentation known as soul loss in the shamanic tradition?**

The intent of the second research question was to obtain an understanding of the various methods used by shamanic practitioners to assess their adult clients for a history of CSA.

Client assessment methods: Multimodal approach – observing, interviewing and energy tracking. The participants in this research described using a multi-modal approach for the initial assessment process. Three major descriptive categories were identified that captured the initial shamanic assessment approach: 1) assessment entails observing (the client's body positioning, use of language and tone) 2) assessment incorporates some form of interviewing (questionnaires or western medical style intake forms, a pendulum, and symbolic tarot-type cards) and 3) energy tracking is essential to shamanic assessment (using soul journeying, meditation, prayer and the aid of spirit guides).

Assessment entails observing. While discussing the assessment process, participants described the importance of being aware and conscious of the information the client is providing though body position, and changes in both the language and tone of speaking as the information may indicate a history of sexual trauma. As an exemplar quote, one participant described deep listening and observing, noting the client's body positioning and nuances of language in detail. The quote provided below represents similar views from others' descriptions of observing during the assessment process.

> I do some very deep listening and looking … they start to mention something about a relationship and you see how they're holding their body. Stereotypically, I'm seeing them start hold themselves around the middle, like a chakra or something like that, around their belly. People will fold inward, holding themselves and sometimes they'll look around a little bit as if their spirit is listening…As they get comfortable enough to mention something that sits a little deeper, it comes almost like an aside … This is when I too notice they often have memory loss associated with this issue. Even their tone of voice will change. I look for areas where there may be a place, where because of soul loss, they are just a bit anchored into a certain mode, a certain maturity level or a certain expression level that has really not grown up with the rest of them. With some people, I notice a drop in their field, a drop in their voice tone, any change in the language they use and how they're sourcing for memories. I am assessing for the possibility that some aspect of their soul that's not present. (N4)

Observing the effect of a client's energetics provided practitioners with information about CSA and soul loss. One participant described observations related to affect assessment:

> A lot of it is the affect of the person, the level of control, anxiety, "shut-offness", there's just no ability for levity. It's not light. There's no lightness in things. It's just heavy, very heavy. There's a heavy, heavy feeling to it, that is what you feel, you can just feel all of that heavy energy. (N6)

Another participant described noting fragmented energy when she assessed the energy field of a CSA client before initiating any healing, "You'll see the energy, you'll feel the energy split, when you put them on the massage table and you're feeling the energy and the aura. It feels different. The top feels different than the bottom. You know that it's fragmented" (N13).

When assessing clients for soul loss, participants discussed some common attributes that they have observed in the assessment among some CSA clients: a sense of fragmentation, emptiness, and feeling alone/isolated. One participant's description addressed all three of these:

> I feel like with soul loss, you have a part of yourself that is really not there anymore, it is just not available. You sit there, it's almost like you've gone into the house of yourself and you say, funny I'm going in this house and there ought to be something here, but I don't see the room. It's like the room has no doors. It's like a secret house, a secret room in a house that has no doorways to get into. So there's something that's not accessible. It's like that feeling like that there should be more here. It is like I don't feel like I'm completely here. I can't seem to access something. They even talk about that it's like, suddenly it's like, their brain doesn't even want to work. There's something about it, they can't access something. It is not available. It's like I'm not there or there should be more, there should be more of something, there should be more of something inside. It is this lingering sense of emptiness. (N4)

Assessment incorporates some form of interviewing. The majority of participants described using some form of a questionnaire or interview guide to assess clients for the aftereffects of CSA during the process of assessment interviewing. Some utilized an on-line or email process to decrease the amount of time dedicated to information gathering during the actual healing session and to limit the potential for the survivor to get stuck in the trauma narrative. As one participant indicated, "the story helps with the introduction to the issue, it is not the focus" (N5). The interview process was described by participants as including direct questioning of the client.

Some participants also elaborated on alternative lines of inquiry like the use of symbolic inquiry such as using tarot cards and a pendulum to answer questions about the client's history and wellbeing. As described by one of the participants:

> I take a card reading before they come which just gives me a theme to pursue and it also tells me what needs to be addressed in order for the person to be healed. Then, I have a sheet of fifty different things that I will go through with a pendulum while they're there or while they're on the phone. That would tell me exactly what healing needs to be done and in what order. (N9)

Energy tracking is essential to shamanic assessment. Among all participants, an important and essential component of the shamanic assessment process was a technique practitioners conceive of as 'energy tracking', described by the participants as a method used to assess the client's energy.

> The final step is tracking; I will track their energy…I get kind of a theme if you like and then I look at it energetically as well and I can see what's going on, what needs to be done. I keep asking. I look at everything. I ask a lot of questions and I give them a long

time to talk and sometimes that's what they really need. They will often tell me a lot of things they have never told anyone. (N9)

The clarity of the following expression of 'tracking' in its comparisons to a 'hunter or a trapper' reading the signs, provided an exemplar to highlight its importance in the shamanic assessment process.

Tracking from the ordinary reality perspective; it is tracking as if you're a person who is a hunter or a trapper. You learn to follow animal tracks. Shamans track at an energetic level. So tracking is following the energy thread of the emotion, and with tracking, the client may give you a cue in how they choose to language things. A client may be possessed by a spirit and they will say 'I feel like when my uncle died, he never left me,' or they'll use language like that, sort of indicating 'well if he never left you, then, where is he?' Or, they will start using language, 'well, We think this' and they're like, 'well who's We'? So, there are lots of signs and signals in ordinary reality and in non-ordinary reality that give us the trail…If we're trying to follow the quarry, going back to the animal tracking, we're trying to follow and understand the state of mind of the quarry and what the quarry is doing. We need to be able to read the signs and the symbols and what's going on and determine what trail they're leaving – be it a physical trail, their body motion, their tics, their emotional reactions and their energy trail. If you've learned to read energy, you get a certain hit from things. You feel certain things as the client is talking. Sometimes I'll get this flush going through my body of big emotional charge and I know it's not me. I know I'm feeling something that they're feeling, and I'll pause a moment and I'll say, 'tell me what such and such feels like to you'. I actually use my body as a sounding board to read what is going on with the client and all of these are

mechanisms of tracking. You're tracking on a physical level, you're tracking on an energetic level, you're tracking on an intuitive level and all these things help… You need to be able to follow the energy of what the client is telling you because in following that and listening to that with your heart and with your body and with the helping spirits… you start narrowing down to what is really going on and what energetic imbalance is happening…. (N14)

'Soul journeying' with the client was also described as a shamanic assessment technique in the realm of tracking to discover information about what the client is sensing:

I think there's more value in taking them on the journey with me. Having them with me, as I guide them in the journey, allows them to tell me what they are sensing. This can be very revealing because the brain does know the difference between consciousness and unconsciousness. So you can discover things in the unconsciousness in a soul journey that you might never uncover with conscious awareness. (N9)

Soul journeying was described as being used by the practitioner to assess for changes in the client's energy. One participant provided an example of how soul journeying aided her in further assessing her client for CSA and soul loss:

In doing a journey, I look at the wounded part, it is like seeing a picture, Sometimes the child will be totally in the dark and hiding. I had one client, she presented as a little teeny tiny doll in a little teeny tiny dollhouse, like she was trying to disappear. I'll have kids that are all tied up. I'll have kids that just feel crushed. I'll have kids just in a state of shock. (N15)

Furthermore, spirit guides were referenced by some of the participants as important in the assessment process as revealed in representative statements like: "Spirit guides provide

information" (N6); or "Spirit reveals the issue, what is needed and the intervention to use for healing" (N5), and "I'm going to ask the question that opens the door to where I want to go. It's just about being open in the space and listening for spirit to tell you where you need to go" (N12).

In summary, the assessment method was described as multi-modal in nature, including a blend of intake forms, interviewing, the use of tarot type cards, pendulums, intuition and energy tracking. Providing a safe space for people to be vulnerable, through active listening and observations in ordinary and non-ordinary reality was described as essential to the assessment process.

Research Question 3: What are the perspectives of shamanic practitioners regarding the use of specific shamanic healing techniques including soul journeying and soul retrieval for issues related to sense of fragmentation/soul loss, to facilitate healing and integration?

The aim of the third research question was to obtain descriptions of the various shamanic healing methods used by shamanic practitioners to facilitate healing and integration among adult CSA survivors.

Participants discussed numerous healing rites, methods and ceremonies used to facilitate healing and a sense of wholeness. As a result of the specific focus of this research, all participants described their use of soul journeying/retrieval. While a variety of other techniques can be used in the shamanic tradition of healing, this research will report only on those methods discussed by a minimum of a third (N=5) of the participants. These shamanic healing methods are described below: illumination; soul journeying and soul retrieval; extractions (compassionate depossession, cord cutting, and decoupling); and shamanic homework to aid integration of healing into the client's life beyond the shamanic healing sessions with the practitioner.

Participants described that the use of these different healing methods was based on information from the shamanic assessment and the identified healing needs of the client.

One participant described an "arc of the healing journey, which includes an illumination, extraction, soul retrieval and destiny retrieval" (N7). There are times when that type of arc is the perfect map to follow, but sometimes the client's needs may require a different pathway. For example, this participant further revealed, "sometimes people need extractions first because an entity may be causing the trauma, when you extract that entity, people immediately shift their perspectives of the trauma. The trauma almost goes away and the healing commences" (N7).

The following sections pinpoint the types of shamanic healing techniques or modalities described by the participants as being used to facilitate the healing of adult CSA survivors.

Illumination: Clears the energy field of toxic energy, revitalizes with healing light and love. All of the participants described use of illuminations as a shamanic healing method. Describing the illumination method, one participant referred to removing imprints and illuminating the chakra with light:

> An illumination is essentially removal of heavy energetic imprints in the chakra system. The imprints are impressions of past experiences and traumas. Once the negative energy is removed, the chakra is illuminated with light and compatible energy. (N8)

A shamanic illumination was described by participants as a healing that clears the luminous energy field that surrounds the physical body and the chakra energy centers of the body. In the shamanic paradigm, trauma, regardless of its origin (temporal, epigenetic, or cultural/archetypical), can deposit heavy energy in the luminous energy field and chakras leading to physical, and emotional difficulties and maladaptive and repetitive behaviors. An illumination is focused on clearing that heavy sluggish energy of past hurts and suffering and replacing it with

a higher vibrational energy that heals. Another participant provided a detailed description of an illumination noting that the illumination involved slowing down the brainwave patterns of the client and sensing into where energy is blocked or stuck, opening that block up, and letting light or loving healing energy flow in to cleanse the energetic imbalance.

> My understanding of illumination is it's a piece of energy work. The shaman is… helping the person they're with to start to breathe more deeply, to start to relax … slows down the brainwaves …from the ego thinking, quick beta [brainwaves] to the slower … alpha brainwaves. With this slowing, there's an opening of consciousness. The illumination process is really learning how to sense into the chakras and also into the aura, which is the energy surrounding the person, which actually is the energy holding the physical space of the person. It's not a surrounding the person really, it is part of the person. So it's a matter of sensing into that energetic emotional, physical and mental body of the person and then determining, through your explorations with the person and your own intuitive process, where the stuckness is, where the block is, what's out of balance. Typically, it's held in a chakra, not always, but typically it is. You next open the chakra and then that energy can start to be explored and experienced. That is a main part of the illumination process is identifying and opening the story of the chakra so that it can start to come into consciousness in some way and then the final part is sort of blessing, letting in the universal love, this is the love. You can call it light, the sacred spirit, whatever it is. I just think of it as love. Just pure love energy and I'll often see it as coming in and helping to balance. So there's an energetic component to that energetic imbalance that kind of cleanses it and shifts it in some way. (N6)

Some participants described illuminations that included using a pendulum to explore the energies of the chakras and a healing stone from their mesa of the shaman's healing energies.

> I'll have them lie down and, using my pendulum, I will see which chakra swings counterclockwise the most. Sometimes I have people that will have chakras with no movement. Sometimes all the chakras will have backwards movement. I determine which chakra to work with based on the movement of the pendulum. I open it [the chakra] up and put the stone on it. I then hold their head and ask them to breathe any issues that come up into the stone. I will do a series of their holding the head and then go to the stone and clear it. I continue to rotate between holding the head and clearing the stone until no more issues come up. It usually takes three or four times to clear it. I have a crystal I use that helps to clear up the energy and will use sage and a feather to help remove energies. With each clearing, I will have visions. I will get different information visually or I will hear it. I see colors a lot of times or I see different spirits that come into help with the clearing. After each clearing, when I'm just holding the head, the visions will change. Sometimes I'll get a lot of voices talking or a lot of commotion and then I will clear it until it's peaceful and calm and a color comes through. Once it is quiet and calm, I illuminate the chakra. It is the part of the energy healing that I do through my hands. I channel light from above and energy from below until it's in my hands and then I place my hands over the chakra filling it with healing light and energy. I kind of do a quick scan of the chakras and energy field and then close the chakra. (N15)

Soul journey and soul retrieval. Participants defined both soul journeying and soul retrievals as shamanic energetic healing methods used to facilitate healing. Soul journeying and retrieval were described by the participants as a shamanic journey to non-ordinary reality to

locate a client's soul parts and negotiate their safe return and integration. The process they described, involves the shamanic practitioner entering an altered state of consciousness through the use of the breath, meditation, or the rhythmic beat of a drum or a rattle. In this trance or shamanic state of consciousness, shamanic healers are able to travel outside of time to non-ordinary reality and access different realms where there are spirits and guides to assist with the healing ofindividuals, communities and nature. Several participants provided long in-depth descriptions of these different realms, referring to them as the lower, middle and upper worlds. The lower world is often referred to as the 'collective unconscious' and holds the history of all humankind; it is the realm of the soul. The middle world is the world of our senses, the world we live in and experience daily; it is the world of linear time. The upper world is the world of our potential and our destiny. Journeying to the lower world or the collective unconscious allows for the discovery of soul parts, from childhood and prior lifetimes.

> The shamans talk about three different worlds, the upper world, the middle world, the lower world. The lower world is our subconscious and our unconscious. It's the big file cabinet and the big story room where all that stuff is kept…The middle world is the world we live in and most of us are so busy earning a living and taking care of somebody else's needs and desires, children, elders, boss whatever it is that we often neglect the things that we really need for ourselves. We need a place without intrusions from anybody or anything, so we create a segment of the middle world that is private and safe. The upper world, that's our spiritual world. That is where our celestial parents are. This is where the spirit resides. There's a lot of information there that we can access once we clean house in the middle world using the lower world as our tools. (N3)

Shamanic soul journeying to non-ordinary reality. Participants described soul journeying as the first step in the soul retrieval process. It allows the shaman and the client, if they choose to journey with the shaman, to travel to the lower world to locate the original origin of a trauma, to understand the wounds, the contracts or meaning made from those wounds, lost soul parts and gifts such as power animals and spirit guides to protect and help on the healing journey. While discussing soul journeying and soul retrievals the participants talked about the efforts of Alberto Villoldo, PhD to gather the information he had acquired while working with the shamans in Peru and developed a map of sorts to aid others to journey to the lower world for a soul retrieval.

Participants described the map as four different chambers: the chamber of wounds, the chamber of contracts, the chamber of grace, and the chamber of treasures. The chamber of wounds holds the original wound, the trauma that lead to soul loss. The chamber of contracts, contains promises or contracts that you have made, based on the trauma. The trauma maybe ones that have occurred in this lifetime, epigenetic, karmic, or from a prior lifetime.

According to the participants, the contracts are the meaning, understanding or stories created based on the trauma. The chamber of grace contains the lost soul part with all of its vital energy ready to return. The chamber of treasures holds resources or gifts that support healing and living to one's potential. The map created by Villoldo for journeying was described by a participant when she discussed the path that she travels for a soul journey and soul retrieval:

> I have a number of Native American guides who work with me and sometimes the client's spirit guides will come and they'll be with me in the journey. Then I go into the four different rooms, the locations are different for every person. So it's always interesting to do that. I go in the first room and I see the wounded part. I see the traumatic event. I'll see

an image and then the next room is the contract or sometimes it's the belief that the person formed as a result of the trauma and then that third room is the soul part and the fourth room is the gift. Something to help remind them that their soul part has returned. (N15)

Another participant described her shamanic healing journey through the lower world as mythical and symbolic:

> It's not always the actual story of the trauma. Everything in the non-ordinary reality will be very symbolic and metaphorical. Sometimes what practitioners or the client might experience or perceive in the chamber of wounds, might be the person in a dungeon being tortured. A big mistake that people make is thinking, oh you must have had a past life, you were in a dungeon and you were tortured and that's not necessarily true. It's symbolic. It's on a mythic level. I mean I don't know, maybe the person was in a past life in the dungeon and tortured, but that's not necessarily what it means. It can be very symbolic; not necessarily oh this must have happened to you in a past life. Journeying though the chambers is a map or a structure that Alberto developed and it is very helpful in the beginning but with time you develop your own practice. You can continue traveling through the chambers but what I have found over time is bringing back that life force, that life energy, which is the most important piece of the healing. (N8)

The beginning of the reintegration of the lost soul part occurs in journeying to the lower worlds. This work is facilitated by the shaman, with the assistance of spirit, healing guides, and with the permission of their client and the client's soul part. Some shaman participants discussed journeying using the map developed by Villoldo to traverse the four chambers. Others

modified the process of journeying from Villoldo's map to one they developed over time and with experience.

Soul journey and soul retrieval: negotiating the return and integration of the soul part. The process of journeying through the chambers of the lower world and negotiating the return of a soul part was described as integral to the healing methods used by shamans. The full impact of the healing for the client occurs with the reintegration of the soul part with all of its vital energy and knowledge that had not been available to the client's consciousness since the time of the traumatic event. The negotiation process for the return of the soul part was described by participants as asking the soul part what it needs to return. Then, the negotiation is advanced by asking the clients if they want the soul part back, followed by asking clients if they are ready to do the work required for the integration. In order for the integration to occur, the client needs to agree to meet the needs of the soul part and actively participate in the healing process, otherwise the part will bounce out again.

> You cannot just go and get a soul part and bring it back. It won't stay unless the client is at that place of saying I'm ready for it to come back and is willing to do the steps that help that soul part stay back and really integrate it. Usually the soul part is not going to just come back because the client wants them back, but that's a very powerful invitation. It's also about: you acknowledge yourself. It is: I need me. It's a weird thing because the soul part is having a conversation with itself. I need you to not give your power away. I need you to love yourself. I need you to go ahead and say the truth. I need you to do this, that and the other. I need you to make me feel safe. We need to play more. The soul parts have very strong requirements defining what they need for their aspect to be completely present back within the individual…

> Sometimes it can be quite a challenge for them to find the resources to do what is needed and a huge part of the session work is to actually help the person find the resources to do the work so that the soul part can stay…The soul part alone knows what is needed to return, they're the ones that were involved when the trauma happened, when the situation wasn't safe, when there was threat of telling the family secret or whatever happened. (N4)

Another participant described soul retrieval as a critical shamanic healing method. Through soul retrieval, one of her CSA clients was facilitated to understand triggers originating in her childhood sexual trauma and process the trauma using psychodrama.

> A client came to me puzzled about a very bizarre behavior that she would exhibit spontaneously when something upset her, when her energetic buttons were pushed. It was pretty strange and doing these things upset her and it was interfering with her life. Since it was a repetitive thing and it had a trigger that we could identify at least on the surface, we did soul retrieval and I discovered that this woman was going into protective mode because she'd been molested as a very small child. We had a discussion with the soul part and it was really obvious that this was protective mechanism behavior, physically getting away from the places and situations where this had happened in her childhood. It fit together perfectly. She had absolutely no memory of the molestation at all and so we got together as a group and we portrayed different items in the scenario so that she could ask questions. using psychodrama… A mesa proxy works that way too, where you take a number of objects and you give them the labels of the different items in the soul retrieval picture, and the client is able to have a conversation with them in a safe manner. (N3)

Addressing the needs of the soul part to return allows for the reintegration of that vital energy and all the gifts associated with it. One participant describes reintegration as a wedding:

> It's very interesting how the whole ecology of their lives that starts to re-grow and collateral issues may come up for them to work with in a subsequent session. It is fascinating work to see the soul recovering and with additional work fusing with itself again. To me that's like the wedding… that's their soul part, re-fallen back in love, wedded as one. (N4)

Extraction: removal of toxic energy. Extraction was another healing method described by the shamans. Extraction was described as the process of removing toxic energy. As one participant explained, there are two types of energy, "energy that is vital for us, and energy that is toxic for us…energy that is toxic for us impacts our energy field by depleting our energy" (N11). In the shamanic tradition, a depleted energy field can lead to a sense of general malaise to maladaptive behaviors and illness. Thus, with shamanic healing, the extraction process was described as helping clear the energy field to restore wellbeing. As described above, repairing the flow of energy through the chakras and clearing imprints are part of the illumination process. Yet, treating an attached or tethered energy such as that of a discarnate being calls for other shamanic healing methods known as compassionate depossession and cord cutting.

Compassionate depossession: clearing of discarnate beings. According to the participants, discarnate beings, also known as spirits or entities in shamanic traditions, have the ability to attach to another's energy field. This attachment can occur when the spirit of someone who dies does not "cross-over," for example. It could be a relative who chooses to stay close as a protective spirit, or it may be the energy of someone who wants to influence another's life decisions and choices. Regardless of how or why the spirit or entity attached, the attached energy

makes it difficult to manage one's feelings. In the shamanic tradition of healing, often the spirit needs help to move on, allowing for a lighter energy field and easing the management of the client's emotions. As the name implies, a 'compassionate depossession' seeks to free the attached entity without judgment or as one participant stated, "without a charge" (N4). The release of the energy is the catalyst for healing of both the client and the attached energy. The attachment of discarnate beings, the tethering of energy, and the release were discussed by the participants.

> In some cases, and I know this is getting a little weird, but there are some abusers who actually have ways to stay connected to the person they hurt, It's almost like beings or entities that can get attached to a person and they suck their energy. That is treated with an entity removal or entity extraction or sometimes called compassionate depossession, which is removal of those beings. (N8)

Another participant shared a similar perspective in discussing the extractions or compassionate depossessions. She indicated that the trauma and disequilibrium manifesting in her clients may have nothing to do with the client. It was described as a manifestation of the entity that is attached and once it is released the client feels much better. The extraction healing method is illustrated in the following quote from her interview:

> Sometimes people need extractions before they have any other form of shamanic healing because sometimes what actually causes the trauma was an entity in them. So when an entity, with all its needs, all the trauma and stuff, when that energetic signature and the vibration in the client's field is gone, those people feel like it is a miracle healing. They'll say, I don't know what just happened there, but I am a totally different person … So,

> when you take the energy out, the people immediately shift their perspectives of the trauma. The trauma almost goes away. (N7)

Cord cutting: *untethering energy bodies*. Participants discussed shamanic healing methods that focused on cutting energetic cords that tether the energy of one spirit to another's energy field, referred to as cord cutting, a form of energy extraction. This cord connection can result in repetitively experiencing the trauma on an energetic level. It may inhibit relationships with one's self and others, and can deplete one's energy. One participant described cord cutting as "the removal of energy ties with a perpetrator or an abuser" (N8). In an exemplar quote of cord cutting, the following participant discussed the energetic attachments CSA survivors can have with their perpetrators and the healing that can occur through symbolic cord cutting.

> In the shamanic world, there's what we refer to as cords or attachments. It's like a connection point that occurs between the person who has experienced the sexual trauma and the person who was the perpetrator of that sexual trauma… The way I look at it, everybody is experiencing it, the trauma …With the cord, there's an energetic connection between the perpetrator and the person who experienced the sexual trauma. This can result in an energetic re-experiencing of the traumatic event, you can say they're actually experiencing the event again and again through that attachment … There is a connection to somebody who could be very, very unhealthy, and a drain of the vital energy from the person who experienced the sexual trauma. One of the things I do is actually cut those cords. Using conscious intention, I cut those cords, I have a stone knife for this process and it goes through the cord. I then scrape on the person's skin where it was connected and somewhere, usually one of the primary chakras it may be connecting somewhere along the spine. I actually cut that cord completely off to sever that connection. Then I

> seal the area using some scented burning wood… I refer to it as energetically cauterizing the area so there's no way that there can be an activated reattachment to that space. I'm sealing it off and healing it. So I'm actually extracting from that person that connection to that cord … It's just simply letting it all go back to where it came from, which is also freeing to them as well. (N4)

Decoupling: resetting the stress response, synchronizing the second and fourth chakra centers. Decoupling was another shamanic healing method discussed by participants. Decoupling is the process of disengaging the fight, flight, or freeze stress response experienced in the aftermath of childhood sexual abuse. Participants described physically using their hands during the decoupling treatment to reset the client's adrenals, shutting down the exaggerated stress response, and grounding the client to allow them to feel safe again. For example, it was described as "decoupling the heart and the adrenals so the central nervous system isn't constantly firing your adrenals…that's what you're doing with your hands" (N1). Another participant described the process she uses in decoupling her clients' stress response and clearing any lingering toxic energy. The decoupling was described as a sequential process of the practitioner aiding the client to drop heavy energy from her body/energy system including specific techniques by which the practitioner was involved in putting her hands under the client's heart and sacral area (second chakra) and guiding the client to let go of pain, heartache, sense of loss, etc.

> Decoupling…addresses symptoms of PTSD, the anxiety attacks, the panic and it also helps to remove any remaining strands of heavy energy. When I do a decoupling with a client, I put both hands under the heart and I'll ask them to drop the energy from their heart, any pain, any heartache, any grief, any sense of loss, drop it down into my hands.

> And think of it, then, flowing down into the table, then to the floor and through the floors of the building, through the foundation to the ground, deep down into the ground. Then I'll take one hand and put it under the second chakra and I'll ask them to drop the energy from their second chakra – any feelings of fear, anxiety, panic – and drop that into my hand all the way down; and, I'll do it one last time into both hands, all the way down deep into the ground. I have them imagine that they're lying on the earth and that the earth is slowly supporting them, the earth is comforting them, and the earth is nourishing them; and, then, I'll take my hands out and then I'll tell them to take a moment to lie on the earth and soak up the earth's energy. When they get up, we talk about it. (N15)

Synchronizing the energy of the second and fourth chakras was described as a critical component of disengaging the stress response. Participants described it as the process of resetting the rhythm of the second chakra (sacral chakra), which in turn rests the adrenal glands and inhibits the continued release of stress hormones like adrenaline.

> You scan the energy field to see what it feels like and you get the sense that the top half is different than the bottom half. To synchronize the energy, you put one hand under the heart like it would be in the center of the back and the other hand would be the second chakra. Next you run the energy around in a circle so it's going up the body, across the heart, from the heart up, your left hand across your heart, out your right hand to his sacrum and you're running this energy with pure love out of your heart as you're doing it and what you're looking for is a synchronization because when you put your hand under his heart and your hand under his sacrum, you're going to feel a heartbeat and if he's uncoupled, you'll feel two different heartbeats. So what you want to accomplish is a

synchronized one heartbeat between yours and his and that's how you know it's coupled. (N13)

Homework to aid integration of healing beyond healing sessions with the shamanic practitioner. Many of the participants described giving homework to their clients at the end of a healing session and the importance of integration by keeping healing in the conscious mind. Homework was used to facilitate the integration of soul parts, to keep the energy flowing and balanced, to reinforce new patterns, and to expand the meaning made by the client regarding an event. One participant said, "Everybody always get homework…You have to participate in your own healing process" (N12). Practitioners described asking some of their clients who had undergone a soul retrieval to "take their soul piece out on a little date" (N6) to help solidify the connection, bring it into the conscious mind, and allow it to feel welcome and safe. As another example of shamanic homework, participants could ask their clients to create a sand painting, a symbolic process used to clarify the healing journey and remap the path to wholeness.

> The client goes outside, gathers some stones and makes a circle with the stones. Using items from nature, they decorate the inside of the circle to reflect the issues they are working on and whatever they are trying to release or manifest is put into the circle. They go there every day to reflect on the issues and pray over it. They can move items in the circle or remove them if they feel that's what is needed. After a week they dismantle it. (N15)

The participants often described the use multiple forms of homework that could be instrumental in solidifying the integration of healing the soul part.

> Whether or not somebody comes on the journey with me, we will work ceremony afterwards, we'll bring back allies, and we'll bring gifts and treasures; that's homework.

> We take it to ceremony. We'll do mesa proxies, sacred dramas, writing the three card story with the archetype and taking it to a sand painting, to an altar, to working with fire ceremony or with burying something symbolic in the earth, I want the soul part to stay too. I'm doing all of that with them so they leave the office empowered but they still have their homework. I mean to me it is their encounter so I will have people work with the soul part through some sort of spiritual exercise, journaling, creating a sand painting of some sort, creating an altar or two to the soul part, an altar to themselves to really be able to acknowledge and witness and put grace and appreciation into what's happening to them so that they can really infuse that. It is saying 'welcome home to themselves and embracing themselves and holding themselves'. It infuses them with a powerful feeling. (N4)

Shamanic practitioners also asked their clients to create sacred healing memories such as through the use of an altar or some sacred place where they could place objects that represented the returned soul part, ancestors, power animals, and other people, places or events of healing importance to the client. The participants described that the client would then spend time in the sacred space reflecting on the items to maintain what they represented in their consciousness.

One participant said, "I try to make the homework go along with whatever the healing was about" (N1). Another participant described sacred gardening homework she recommended for a particular client to aid her with integration of healing into her life, leveraging the client's passion for gardening:

> I had one client who is an avid gardener. I had her go out and actually physically weed her garden because that was a really, really great metaphor for her. She was already gardening but she wasn't thinking about it as being a sacred act. So my clients really look

> at their life and where it can be sacred. We have really great intention, but there's always an act of ceremony. It's the next step of continuing to remove this out of your body, to honor it out of your body. (N12)

Another participant added:

> The homework is to really try and avoid certain patterns of behavior that they've been doing. I said nobody's perfect but if you want to start new you don't want to fall back into the old patterns… I recommend they take Epsom salt baths for a day or so, drink lots of water, eat food that feels healthy, avoid being in situations that are really stressful. Take some time for themselves. Take a walk I nature. I recommend if they have a spiritual practice or to do something they feel is good for themselves…To search for what feed their soul and what nurtures them. (N14)

As depicted above, there were many different types of homework shamanic practitioners used, and they felt it was important to select a homework task or process that reflected and reinforced the healings from the shamanic practitioner healing sessions. In summary, the primary healing methods they described were: illumination, soul journeying and soul retrieval, extractions (compassionate depossession, cord cutting, and decoupling), and homework to facilitate integration of healing.

Research Question 4. What are the methods shamanic practitioners use to evaluate healing in relation to sense of fragmentation/soul loss and improvement in sense of healing and integration for adult CSA survivors?

The fourth research question was designed to identify the different methods used by the shamanic practitioners to evaluate the adult CSA survivor's healing response. The evaluation process following shamanic healing sessions was described by the participants as similar to the

assessment phase before the intervention. The evaluation included re-assessment of the energetics and attributes associated with the soul retrieval. In addition, the participants discussed the timeframe for the integration of the soul part and the number of sessions needed for the healing as integral with evaluation. In the following paragraphs, evaluation will be described: evaluation of the chakras and the luminous energy field, recognition of healing attributes associated with soul retrieval, and a variable timeframe for healing.

Evaluation of the chakras and the luminous energy field: flowing, balanced, higher vibrational energy. Participants discussed how they reassessed their clients for any continued energetic disequilibrium, following the energy healing methods, by evaluating the flow of energy through the chakra centers, the luminous energy field, and by noting the changes in the client's vibrational energy. One participant described her reassessment evaluation process using the same list of assessment questions and pendulum that she had referred to in describing assessment. Although she reassessed each of the 50 questions during her evaluation, she focused on the areas where an issue was discovered during the initial assessment. She reported:

> I do the diagnosis sheet going into each question and I have the pendulum over the question to make sure it is going in the right direction. If you're taking them on guided journeys, you can hear it. It's the client that is doing the work freeing themselves. They see themselves chained and undoing the chains or whatever it is they're doing are doing it in the journey. Then, normally afterwards, they can see differently, the colors will be brighter and they'll go 'oh my God, it feels so different'. They're smiling and happy. It's about getting their soul parts back and all of a sudden, they've got their potential back. (N9)

Another participant described evaluating the healing response to the shamanic sessions by assessing the client's vibrational energy:

> Energy changes. The more energy work that you do, the lighter you become. You're vibrating at a higher lighter level. It's like you look at a computer… I have a MacBook; my MacBook has a new operating system. When I look at my MacBook on the outside it doesn't look any different, but when I open it up, it's operating different. It's the same thing when you're doing energy work with clients, they just operate differently. (N12)

One participant added another method of evaluation based on feedback from her clients. She started to evaluate changes in the client's energy based on the way others responded to them following the energetic healing.

> I tell my clients to pay attention to how people respond to you… A lot of people say that they notice people act differently towards them. It is like you've always acted like this doormat and you're treated like a doormat. Then … all this power's brought back to you, it's amazing how many people unconsciously read that energetic change and respond to you like you're more powerful and start treating you differently. There's a guy that I worked with who really didn't like kids at all and always kind of stayed away from children because of this childhood trauma. After the healing work, one of the things he said to me is that kids started coming up to him. He would be in the store and some mother would come in and would have a couple of toddlers or younger children and they would come right up to him and want to show him their toys and stuff and he said kids never used to do that to me before. So I say pay attention to how people treat you differently and how you react differently to people. If somebody really, really bothered you at work, noticing are they still getting under your skin the same way. Or, do you feel

more chill about them? I tell them, the feedback you're going to start getting will show you that you've changed… and that is very affirming for people because they feel different. But part of what affirms it is, they start being treated differently. (N14)

Participants also noted a change in attributes or characteristics represented in their clients as described below.

Recognition of healing attributes associated with soul retrieval: self-aware, confident, more fully present in one's body, and empowered. The participant's evaluation following a soul retrieval involved recognizing several common attributes among their CSA clients. The attributes included a greater sense of self, feeling confident and empowered, feeling more fully present in their body, and less isolated. Changes in their clients' energy were important in evaluating healing responses. As one participant commented, "Most people will say 'I feel lighter. I feel more in my body. I feel more confident. I feel stronger, more confident. I feel less anxious. I'm less depressed. I found my own voice. I can stand up for myself more'" (N8). Other participants described a similar evaluation.

You do have some sense of people reporting that they feel more fully present in their body, that their dreams are returning, that they have an ease that they haven't experienced before. Their friends and family say they notice a change and it's for the better. (N2)

The client's sense of wholeness or completeness (in opposition to fragmented or scattered pieces) was described as an evaluation consideration.

They feel complete. They feel empowered. They feel confident and all of one piece instead of scattered pieces. All the pieces are in the same box and ready to go to work instead of having to go over and try and retrieve things. Yes. Definitely, it's bringing into

> the open that which is hidden and that taboo and walled off and protected, something in the body that's been isolated. (N3)

Other participants discussed body posture as an evaluation focus. In the following quote, a participant emphasized paying attention to the manner in which shamanic clients manifested body shifts after healing sessions, such as leaving with a bounce or pep in one's step.

> When they have addressed their light body, addressed soul contracts and attachments and anything that is at this whole level, everything shifts. The way they hold their body shifts. The way that they present themselves out in the world shifts. Their posture, they're standing, they're sitting up. They're arms are not folded across the chest. They're looking you straight in the eye, all of that changes right away. You can see that and literally they leave with a pep in their step. I mean you can see the change, people come in and they're all hunched over and shuffling their feet and they leave and they have their bounce back in them. (N12)

A variable timeframe for healing: immediate and over time. In discussing the evaluation of healing responses, participants were asked to describe their perspectives on the time it takes for their CSA clients to experience a noticeable healing difference. Healing changes that shamanic practitioners distinguished as part of the evaluation process were described as occurring immediately after a healing session as well as over time. Some healing was described as occurring in the moment, however, integration of healing into full conscious awareness was thought to take extended time. When discussing the impact of clearing toxic energy, for example, one participant referenced a more immediate sense of healing for clients.

> I've witnessed vast relief. The clients they just sparkle. They go 'oh, is that what that was? Oh, yes, well, I'm a big girl now, I can understand this and we talk about the

> significance of projection and owning projections. When you're whole, you realize, these things that you're experiencing as being real, are not about you. They're about the other person – the perpetrator projecting something.' So, we're able to appreciate it from that standpoint. Any traces of guilt or any traces of responsibility are removed and for the client, that is a big thing. It's a huge relief to know that none of this was about them, that they were innocent bystanders who happened to be there at the time, and guilt can destroy you. So immediately get rid of that. Yes, their life changed completely in a moment. (N3)

However, another participant described the nature of shamanic soul retrieval noting how the integration may begin slowly, but as the unconscious part comes into the consciousness and there is a sense of safety, the healing process can accelerate. For example, the shaman may first look for an expansion of a client's perception from limitation to one of possibility, and find that the whole process gains a momentum of its own as it unfolds.

> The first thing that I look for is an expansion of the perception of limitation to a perception of possibility. Then there is a palpable opening and enlarging of the energy, even if it's really painful material, it shows up in a different kind of hopefulness, a sense of authenticity, a sense of being with what is, being able to be with what is…That sense of an expansiveness feels good to the person. A sense of whatever showed up that they're glad it showed up even if it hurt them, even if they're filled with sadness, they feel like it's good because it's true, some truth has occurred…So they come into that actual present moment of interface with the conscious moment and the unconscious material and just let it be. The way energy work functions with imagery and sort of holistic 'hologramistic' manner, there so many things are happening at once, but the biggest thing

> is that our unconscious material is coming into consciousness. As the unconscious material, the soul part, starts to come into the consciousness and sees that it can be present in the consciousness while feeling safe and the part receiving it feels safe, the integration of the soul part into the whole it starts to pick up some speed and then suddenly it's just vroom, done. (N6)

Given the examples above, it was discovered that participants viewed the time required for healing and integration as variable. The evaluation of healing responses was described as dependent on the client's issues and the type of shamanic healing work required and conducted. Thus, participants were further questioned about how many healing sessions they believed were needed in order for CSA clients to achieve a sense of integration and wellbeing.

The number of treatments is client dependent. Tied to the shaman's evaluation of when a client was no longer in need of shamanic healing sessions, the number of treatments required was described as varying from person to person based on how the person responds to the healing work. Some participants encouraged clients to determine the number of sessions they felt they needed, as one participant elaborated:

> It varies from one person to person for me... I leave it up to that person to be the one who says 'well, I think I'd like another one next week or I think I'd like another session next month or I'll call you when I need another one'. I will follow up with an e-mail because the energy work I think puts people in a very different space energetically and they're often very tired but also very deeply relaxed and I don't want to pop them out of that state… I follow up with an e-mail with some suggestions about how they might take their next steps and I'll say let's keep in touch through e-mail. (N2)

Others described recommending a certain number of sessions depending on the type of issue being addressed. For example, one participant usually recommended three or four sessions.

> I'm usually looking at three sessions for sure, and perhaps even a fourth session because I notice the forays made in creating a new map for their life are powerful. What happens in that third or fourth session takes it to such a higher level, it's like the fullest. In fact, some of the parameters or key points that they include on the map were baby steps out of a situation where they felt stuck… I'm only referring to them as baby steps compared to what they can create for themselves in the third or fourth session. It's beautiful steps. Those are huge courageous steps. I mean they're amazing steps to be able to step away from habitual patterns or processes or a lack of self, based on sexual trauma, and how it courses through their system or their whole identity, their whole emotional sense of self. (N4)

Tied to evaluation, others described that a healing response can take CSA survivors months of shamanic work.

> There may be some readying. I will take a couple of sessions to impress upon the person that this is a big piece of work, and it has to be the right time, it has to be a time when you can focus and you can commit to yourself … I always say three months. I never know how long it's going to take, but typically for somebody who has had childhood sexual abuse it takes that long to get to a place where you start to feel better, where you legitimately start to feel okay, like this can be healed. (N6)

Most of the participants suggested reflective time in between sessions for clients to honor the healing work that has occurred, to do the homework, and to bring the healing fully into conscious awareness. For example, as one issue is peeled away and cleared, it makes space for

other issues to come to the surface to be cleared and healed. Therefore, the passage of time between sessions was seen as giving clients space to identify additional healing needs. Some participants noted that the number of sessions needed and the degree to which the client wants to participate in the healing process could be different.

> How many sessions someone needs and how many sessions they're willing to do are two separate things. Lots of people just get addicted to feeling good after a session, and they don't want to do the work. So then they end up having to come in for more sessions because they're not doing their work…What you're teaching people to do in this type of work is to learn how to find their internal compass, how to deal with stuff differently, not come at it the same way. Part of that is doing their homework and owning their own healing process. (N12)

Research Question 5: What are the effects of shamanic healing on the sense of fragmentation/soul loss as perceived by the shamanic practitioner based on their evaluations of adult CSA survivors healing from fragmentation/soul loss in their practices?

The aim of this research question was to discover the effects of shamanic healing, based on the evaluation of the shamanic practitioner, on the adult CSA survivor and to understand if the healing effect extended beyond the individual client.

Shamanic healing facilitates integration and a sense of wholeness for the client. Shamanic healing was described as having the effect of facilitating integration and a sense of wholeness for the client. As effects of shamanic healing, CSA clients were seen as getting well, experiencing a sense of wholeness associated with unguarded joyfulness, the renewal of trust, and transforming the meaning related to the trauma from victim to an empowered self, able to access their internal compass and live their destiny.

The effects on the adult survivor of CSA following shamanic healing, according to one participant is that: "they get well. That's what happens. Their problems no longer dictate their behavior to the same degree. They're no longer trapped in the past. They're no longer referencing their life through the lens of being a victim" (N11). The sense of being well again was described by many participants, as a result of the soul retrieval.

The return and integration of the soul part into the consciousness facilitated a sense of wholeness through the return of the energy, characteristics, and attributes that were not available with the soul loss. One participant described the transformation to a greater sense of wholeness following soul retrieval:

> I mean right from the start there will be glimmers of what's coming but then as it starts to consolidate, it is just so much more positive energy. There is a joyfulness that comes in, that is an ability to be in the present moment. There is more unguarded joyfulness as hypervigilance starts to drop. With soul loss, when we lose a chunk of our energy, we're losing those abilities that go with it. There is a loss of confidence in the ability to perceive what's actually happening, to know and to discern. With soul retrieval, there is much deeper sense of trust in oneself, one's original perceptions and one's ability to perceive, because often the part that comes back is the part that really perceives things. (N6)

As an example of a healing effect, the process of going through the four chambers described in relation to shamanic soul journeying allowed clients to shift the meaning or understanding of the traumatic event that was used to create the self-limiting story. Traveling through the four chambers encouraged clients in need of "breaking contracts, healing wounded aspects, bringing gifts to support the healing, and bringing them back towards fullness" (N9).

The return of the soul part through shamanic healing was viewed as bringing a greater understanding of what occurred during the time of the trauma because the part was present at the time of the event. This increased understanding once returned to the client was described as leading to a greater sense of confidence and empowerment. The effect of shamanic healing was described as "understanding yourself now, and why you do things", which helps clients to "have the lives that they should have had – the lives that they deserve" (N9). Soul retrieval facilitates healing in the moment and for the future. As an effect of shamanic healing, one participant claimed that clients "stand in their strength, and other toxic energies cannot influence them anymore; they are empowered, they are standing in their strength" (N12). This participant further discussed the effects of shamanic healing in terms of the client being able to access an internal compass for direction in life:

> You're accessing your internal compass. You have direct access to who you really are, not with a bunch of other people's stuff on you. Now, this gives you a clear more direct connection to yourself, which empowers you, which allows you to walk into the world with more confidence without looking bad. You're not living in the past because you've let all that go. You're not holding onto your [past] stories because you don't need them anymore. They're not triggering you the same way because you've cleared it and it gives you this sense of trust in who you are. That's the goal…Love, trust, honor, that's where we all want to be. (N12)

Participants also described the effects of shamanic healing as having an influence that was more far reaching than the client alone. They referenced healing effects that could span time, extend to others, nature, and the universe as described below.

Shamanic healing has effects extending beyond the client. Participants described the effects of shamanic healing for the survivor of CSA extend beyond linear time, to others, to nature, and to the collective consciousness/universal energy through a sense of interconnectedness. While describing trauma, one participant used the analogy of the ripple effect to discuss the far reaching impact of trauma. Although, it was an individual child who suffered the sexual abuse the ripple of that abuse extended to others. Building on this idea, of a ripple effect associated with trauma, so too participants described that there is a ripple effect associated with shamanic healing.

According to participants, the healing was able to affect change beyond the individual through a sense of interconnectedness of all beings and through the universal biosphere or oneness of everything. Participants shared that when clients heal and clear the toxic energy from their own family lineage, the whole family is healed, both those extending into the past and those for years to come. One participant described the ripple effect through the energy body and its interrelationships.

> We have an energy body. We live in something called the biosphere and that's the shared energy of all the things on the planet. So your heart field for example goes out and radiates around you and again your consciousness effects things around you. So the answer to that question is you better believe it does. It effects everything primarily the stuff that resonates up and down the family line. It can affect people that have gone before us including those that are no longer on the planet. That might be a little bit out there in trying to get the thing looked at by somebody that doesn't understand that, but I can just tell you, due to the quantum effect of this, yes it does. (N11)

Another participant reflected on this sense of healing the family and extending to the greater community. She said:

> I would say that the shamanic work is always more than just the personal. It heals the person and ancestral lines. It heals the past, your own past and your family's past. It provides a different trajectory for your future and your family. It also heals in a wider sense the community. We are part of a community and any healing that we experience is healing for her, it's healing for all. In the case of abused women, it's healing for the feminine. So it's both personal and evolutionary. It's for us all. (N2)

Yet another participant similarly shared descriptions of the ripple effects of shamanic healing.

> I always tell my clients that you're doing your healing. You're doing the healing for your family and you're doing the healing for the world. Some people really understand that. They understand that we're so interconnected that it is that direct. Some people don't understand that and that's okay, but yes it shifts everything because the more people that you have walking around that are clearing and balancing and at a higher vibration, that is service to the world. Doing soul work does service to yourself, but it's service to the world because you're clearing your line. You're healing for your family, for your friends, all your relationships. Everyone you come in contact with is now going to be dealing with you and you're lighter. (N12)

In terms of the ripple effects of shamanic healing for survivors of CSA, participants discussed an awakening to something greater than ourselves, which is described eloquently by one participant.

> It starts with the individual becoming whole and becoming empowered and then it extends through the tools and gifts that we accumulate during the process. It does extend to a greater sense of being, an expression of the creativity of the universe because that's

> what we are and also that in the quantum sense that we are all one. So a person gets not only the gift of their personal wholeness, but they get the gift of their being part of a unified field. There's a spiritual alignment and awakening and integration that comes along with this process. (N3)

A similar sentiment was shared by a participant who described healing in the larger world expanding outward from individual healing.

> I think healing always expands beyond the individual. We can't create healing in the world without having healing in ourselves. There's a spiritual truth that in every esoteric tradition that says 'as within so without, as above so below'. If we're not healed, if we're not into our own healing work, we don't know how to embody peace, embody a healed state, embody love if we're caught in our own trauma, anger, response, fight flight responses, no way we can create that in the world. Through the commitment to the healing, we can create, heal and embody peace and love. (N8)

The core of the effects of shamanic healing that extends beyond the CSA client was aptly described by a participant when she said, "there's obviously a brighter light shining in the world, a world that doesn't need any more darkness. So the way I think about it is, the I'm healing the world one person at a time" (N9).

Summary

The fifteen shamanic practitioners who participated in this study shared their embodied knowing about the myriad challenges associated with childhood sexual abuse that linger into adulthood, and the arduous process of holistic healing. The described holistic healing that goes beyond physical and psychological symptom management including healing in the energetic and spiritual realms which they believed could be facilitated by integrative shamanic methods,

particularly related to energetic soul healing. The descriptions gleaned from the participants' responses to qualitative interviewing are highlighted in this chapter. The descriptions help illuminate some of the potential benefits that a holistic shamanic approach to healing can produce for adult survivors of CSA who are open to this type of complementary health paradigm.

Chapter Five: Discussion

Introduction

In this chapter the researcher provides an overview of the purpose of the study and reviews the findings of the research, current literature and nursing theory as they relate to the research questions. Implications for policy, research, education, and nursing practice are presented as well as study limitations.

Overview of the Purpose of the Study

The purpose of this research study was to investigate the use of shamanic healing practices as an integrative healing modality for adult CSA survivors. Specifically, this research investigated how shamanic healing methods address the sense of fragmentation/soul loss experienced by the adult childhood sexual abuse (CSA) survivor and facilitate a sense of integration and wellbeing.

Review of Research Questions

The research questions employed in this study included:

1) What are the shamanic practitioners' perspectives on the nature of healing and the role of shamanism in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/soul loss?

2) What assessment methods are used by the shamanic practitioners to determine the aftereffects from CSA trauma, specifically related to sense of fragmentation/soul loss in the shamanic tradition?

3) What are the perspectives of shamanic practitioners regarding the use of specific shamanic healing techniques including soul journeying and soul retrieval for issues related to sense fragmentation/soul loss, to facilitate healing and integration?

4) What are the evaluation methods shamanic practitioners use to evaluate healing in relation to sense of fragmentation/soul loss and improvement in sense of healing and integration for adult CSA survivors?

5) What are the effects of shamanic healing on sense of fragmentation/soul loss as perceived by shamanic practitioners based on their evaluations of adult CSA survivors healing from fragmentation/soul loss in their practices?

Introduction to Discussion of the Research Findings

The findings of this research study will be discussed in the following sections in relation to relevant literature. Each research question will be addressed in sequential fashion with the exception of combining the discussion for research questions 2 and 4 given the overlap in the findings for these two questions. The findings of the study revealed that assessment and evaluation were similar in their methods, thus the rationale for discussing them together. The major difference between the assessment methods and evaluation methods was one of timing of pre and post shamanic healing.

This qualitative descriptive study revealed differences in the shamanic practitioners' perspectives of trauma and healing from Western and shamanic viewpoints as discussed below. Shamanic assessment and evaluation were described by the participants and will be discussed together as noted above. In addition, varied descriptions of multiple shamanic healing modalities and the outcomes of shamanic healing will be discussed.

Research Question 1: What are the shamanic practitioners' perspectives on the nature of healing and the role of shamanism in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/soul loss? Shamanic Practitioners'

Perspectives on Trauma

Shamanic practitioners' perspectives on trauma from a Western viewpoint. It was important to understand the Western and shamanic perspectives on trauma as the backdrop for healing. Regarding the Western perspective on trauma, the findings indicate that shamanic practitioners view the impact of CSA and treatment methods among Western providers as limited in scope. Attention provided from the Western perspective to adult survivors with complaints of mental health issues was generally described by the participants as focused on the stress response activation of fight or flight, freeze, and the persistent state of hypervigilance, as well as the Western focus on creating a narrative of the trauma. The participants noted that the Western paradigm focus was on symptoms and symptom management such as depression, anxiety, dissociation, etc. These findings are consistent with the literature on trauma treatment from the Western perspective documenting numerous multifactorial effects and long term sequelae associated with CSA, Among the most prevalent effects were, anxiety, depression, PTSD, dissociation and suicidal ideation and attempt (Briere & Elliott, 2003) and other complications of guilt, shame and vulnerability (Ginzburg et al., 2009). As these myriad aftereffects reveal, adult survivors are significantly influenced from CSA in all aspects of their wellness and from the Western perspective on trauma, they clearly require treatment to function in society.

Shamanic practitioners' perspectives on trauma from a shamanic viewpoint. The shamanic viewpoint on trauma, unlike those of their Western counterparts discussed above, was described as oriented toward an expanded perception of the traumatic effects associated with CSA among adult survivors. This included discussions on the origin of the trauma, multigenerational bearing of trauma, and trauma as an event that serves to teach life lessons.

These findings related to shamanic practitioners' perspectives on trauma are new and have not been reported in the nursing and health sciences literature; in fact, these findings are not reflected in the Western paradigm. Trauma viewed from the shamanic tradition was described by the participants as having a multifactorial impact on the survivor; these impacts include: physical, psychological, spiritual, energetics, and inter-relational. As noted above, within the Western paradigm, trauma is viewed as influencing the physical, psychological, and relational aspects of the survivor's life. What is new regarding this finding is that the spiritual and energetics aftereffects are highlighted and these problems are not reflected or prioritized in the Western paradigm.

According to the results of this study, it is paramount for the shamanic healer to address the origin of the trauma. This is important because trauma occurring in this lifetime for an individual may be a manifestation of a pattern established long ago in past generations, inside or outside the confines of the family lineage. It is essential for the shamanic practitioner to identify and address the originating insult to clear energetic patterns and allow for healing. Furthermore, because participants stressed that traumatic events do not define a person, it is important for the shamanic healer to frame trauma as an invitation to explore one's full potential and to understand life's gifts and lessons. These findings are novel and have not been reported elsewhere in the nursing, psychological, medical, and health sciences literature related to trauma.

This research finding related to understanding life's gifts and lessons stemming from the trauma is consistent nursing theory on the nature of health. For example, Newman's theory on Health as Expanding Consciousness is similar to the shamanic perspective as it allows for the growth and expansion of the individual as he/she moves from being bound from trauma, toward freedom as part of his or her evolving health pattern. (M. Newman, 1994).

Participants described common energetic disruptions for the adult CSA survivor. One of these disruptions was perceived as soul loss, or the loss of a quantum of vital energy. While it was discussed as a loss of a quantum of vital energy, the shamanic participants acknowledged the loss as a perceptual one, in which an aspect of the self is unavailable to the consciousness. While this is a new finding not reported in the nursing and health sciences literature, it can be likened to the Western notion of a dissociative state, which also results from a traumatic event (Briere & Scott, 2006; van der Kolk, Bessel, van der Hart, Onno, Marmar, 2007). In the Western literature, dissociative states usually result from trauma and are described as variations in normal consciousness with alterations in psychobiological integration. These disruptions result in altered access to memory, thoughts, feelings, identity, consciousness, perceptions and motor function. (Briere & Scott, 2006; Spiegel, Loewnstein, Vermetten, & Dell, 2011; van der Kolk, Bessel, van der Hart, Onno, Marmar, 2007)

Other manifestations of energetic disequilibrium offered by the participants included disruptions in the chakra energy system. Participants described both the blockage of individual energy centers with heavy or toxic energy and the disconnection of the lower three chakra centers from the upper four centers. Several participants stated that disruptions in the chakra system resulting from sexual trauma prevented an individual from making fully informed decisions. This is because the sexual trauma survivor is not connected to natural instincts and feelings from the chakras that help guide decision making.

The final energetic disruption described by the participants was the attachment to and imprints on the luminous energy field surrounding the body. Participants talked about attachments as discarnate beings tethered to the adult CSA survivor's energy field in an attempt to maintain power or influence over another or to draw energy from them. Further, offloaded

toxic energy onto the energy field of another such as feelings of guilt or shame were described as imprints. This reference to discarnate beings and their impact on the energy field is important in that energetic attachments and tethered energy have not been explicitly reported in the nursing, psychological, or health science literature. These attachments and imprints can have significant negative impacts on the adult survivor because he or she is unable to discern that the attached discarnate being or the offloaded toxic energy is separate from his or herself. This toxic energy can result in an eroded sense of self confidence and self-esteem; additionally, sometimes these imprints can lead to behaviors that are foreign to the individual's moral compass.

Participants also discussed the impact of trauma on the mental and relational wellbeing of the survivor. Specifically, they described that adult CSA survivors often contract into themselves; they experience relational difficulties due to a sense of mistrust and engage in maladaptive behavioral coping strategies. This finding is similar to published research from the Western perspective noting relational aftereffects and trust issues as central to the experience of adult survivors of CSA (Dube et al., 2005; Hornor, 2010; Kia-Keating, Sorsoli, & Grossman, 2010; Kim, Talbot, & Cicchetti, 2009; D. R. Wilson, 2010).

Shamanic Practitioners' Perspectives on Healing

Shamanic practitioners' perspectives on healing from the Western viewpoint. Within the Western perspective on healing, the findings revealed that shamanic practitioners in this study viewed Western healing modalities as primarily limited to medicine's approach of symptom management and development of coping skills. The participants also suggested that conventional Western medicine approaches are limited and do not adequately address the multigenerational aftereffects of CSA, energetic disequilibrium, and spiritual perspectives. In line with the shamanic practitioners' reflections on Western healing of trauma, the standard

treatment approaches in the Western paradigm that include evidence-based interventions such as cognitive behavioral therapy, dialectical behavioral therapy, and eye movement desensitization and reprocessing do not address these phenomena (Calvert, Kellett, & Hagan, 2015; Chard, 2005; Eye Movement Desensitization and Reprocessing Inc, 2016; McDonagh et al., 2005; Steil, Dyer, Priebe, Kleindienst, & Bohus, 2011; Wheeler, 2014). This can be interpreted as a shortcoming of Western medicine's approach to care of adult CSA survivors who are attempting to move toward a sense of integration, wholeness, and wellbeing.

In addition, healing from the conventional Western medicine and psychological perspective was viewed by the participants as potentially causing harm by keeping the adult CSA survivor in victim consciousness, focused on the trauma narrative and reliving it. Western medicine and psychological approaches to treatments focused on the traumatic event which have the potential to keep survivors attached to the trauma, re-exposed to traumatic triggers, and entangled in the triangle of disempowerment. Unintentionally, these therapies can encapsulate the adult CSA survivor in the triangle of disempowerment, which positions individuals in the roles of victim stuck in the perceptual story of trauma and never transcending to self-actualization. From the perspective of the participants, this treatment approach results in not only preventing a return to wholeness and wellbeing, but also is thought to potentiate further harm to the adult survivor. These findings about the difference in the approaches of shamanic healing in contrast to the conventional Western medicine and psychological perspectives for treating the adult CSA survivor have not previously been reported. Based on the experiences of shamanic practitioners in this study, many clients struggling to heal from CSA expressed dissatisfaction with their experiences with the conventional Western approaches because the clients' desires for wholeness, and healing were not comprehensively addressed.

While the participants described limitations in the conventional Western treatment paradigm, they also acknowledged that some Western medicine approaches may be beneficial for some adult CSA survivors. For example, Somatic Experiencing™, an evolving therapy in the Western paradigm, was viewed as being especially suited to address the survivor's energetic disequilibrium. Levine (Levine & Fredrick, 1997) developed Somatic Experiencing ™ as a psychobiological method of trauma therapy for addressing physical and emotional trauma, PTSD, and stress related conditions. Mirroring the views of shamanic healers on the importance of energetic phenomena in healing from trauma, Levine identified and acknowledged the need to discharge the encapsulated trauma energy within the survivor before discussing the psychological impact in order to avoid causing additional trauma leading to withdrawal and immobility (Yalom & Yalom, 2010).

Shamanic practitioners' perspectives on healing from the shamanic viewpoint. Healing from within the shamanic tradition, in contrast to the Western medicine perspective of cure, was viewed by the participants as having the capacity to address a more comprehensive range of aftereffects of childhood sexual trauma including energetics and spiritual phenomena. Shamanic healing was also seen as being well suited for the holistic care of adult CSA survivors. This type of healing could occur either in conjunction with Western treatment or independently according to the client's individual needs. This is the first study to describe shamanic healing for the adult CSA survivor from the shamanic practitioner's perspective. It is important because this study demonstrates that shamanic healing has the potential to provide adult CSA survivors with expanded options to achieve healing.

From the shamanic healing perspective, creating a safe and sacred environment along with ethical behavior and acting with integrity (e.g. acting impeccably) were considered essential

in establishing healing and trusting relationships with vulnerable clients. This finding is consistent with the focus on safety and trust in Western perspectives on trauma therapy such as cognitive behavioral and other therapies (Briere & Scott, 2006; Draucker et al., 2009; Finkelhor & Berliner, 1995; Herman, 1992b). Similarly, this finding is reflective of nursing's theoretical underpinnings, particularly Watson's Caritas Processes oriented toward caring and healing (Watson, 2008). Watson's theory prioritizes the need to create a safe and sacred healing environment, and to build a transpersonal caring-healing trusting relationship with the one being cared for that allows the client to be simultaneously vulnerable and safe (Watson, 2008, 2016). Watson's (2010) Caritas Processes call for "developing and sustaining a helping-trusting, authentic caring relationship" (p.2). Both Watson's theory and the shamanic tradition integrate an epistemology inclusive of sense data, science, art, personal, experiential, intuitive, and spiritual insights to assess and care for individuals within the context of an expanded moral ethical consciousness and cosmology.

According to the participants, once the trusting relationship was established with the adult CSA survivor, they utilized an assortment of healing modalities. This finding is consistent with nursing perspectives on healing and Watson's (2008, 2010) call for healers to engage in "creatively using self and all ways of knowing as part of the caring process; engaging in artistry of caring-healing practices" (2010, p.2). Healing modalities in the shamanic perspective provide opportunities for new learning, to address the original traumatic wound, to clear toxic energy, to retrieve the soul part, and to reframe the beliefs and meaning of the trauma to create a healed and whole individual. This research finding is new but aligns seamlessly with Watson's (2008, 2010) Caritas Processes of "engaging in genuine teaching-learning experience that attends to wholeness and meaning, attempting to stay within other's frame of reference" (2010, p.2). Additionally,

Watson's Caritas Process focused on "being authentically present and enabling, and sustaining the deep belief system and subjective life world of self and one-being cared for" (2010, p.2) is in line with the finding. Once an individual who has suffered for years with the aftereffects of CSA experiences the profound transformation associated with shamanic healing, the client is able to see the past trauma as an event rather than one that defines him/herself; and the past trauma can now provide gifts for the soul and personal evolution as the unknowns of his/her life process unfold. This research finding is not reported in the literature but mirrors Watson's proposal (2008, 2010) for caring-healing consciousness in her Caritas Process, "opening and attending to mysterious dimensions of one's life-death; soul care for self and the one-being-cared for; allowing and being open to miracles" (2010, p. 2).

Shamanic healing allows the adult CSA survivor to realize and experience his/her healing, empowerment, destiny, interconnectedness to the universe, and self-confidence from gained wisdom as opposed to living the limited life of a victim. This finding is consistent with Williams' (2005, p.174) discussion of the principles of Peruvian Shamanism in his book entitled *Andean Codex.* These principles include 'munay' or "to practice loving kindness and live and your life in beauty;" "yachaym" or "the need for correct knowledge guided by wisdom to live in beauty;" "llank'ay" or "right action, to do good work and leave a legacy because without making what you feel and think practical, nothing of lasting value is accomplished;" "kawsay" or "respect for life and all life sustaining processes;" and "ayni" or "reciprocity and the guiding principle of the Andean way … to give back, and to circulate energy, goods, knowledge, and labor for the benefit of family, society, and culture." These shamanic principles inform the shamanic healing process and provide the shamanic healer a guide for living a full and interconnected life with self, community and the universe.

Research Questions 2: What assessment methods are used by the shamanic practitioners to determine the aftereffects from CSA trauma, specifically related to sense of fragmentation/soul loss in the shamanic tradition? Combined with Research Question 4: What are the evaluation methods shamanic practitioners use to evaluate healing in relation to sense of fragmentation/soul loss and improvement in sense of healing and integration for adult CSA survivors?

Assessment methods used before shamanic healing and evaluation methods used following shamanic healing. Shamanic participants described a variety of methods used to assess for CSA aftereffects and needs of adult CSA survivors. These included methods similar to those described in the literature of Western paradigms such as active listening and conversation, observations for nonverbal body positioning and verbal tonal changes, the use of language unbefitting chronological age, and structured interviews using intake questionnaires (Briere & Spinnazzola, 2009; Chadha, Malhotra, & Srivastava, 2013; Herman, 1992a). In the Western paradigm, assessment to determine the effects of trauma and PTSD generally includes: observation for activation, avoidance responses, affect dysregulation, structured interviews and administration of standardized psychological instruments(Chadha et al., 2013). In addition to the Western style assessment and similar to approaches used by holistic nurses, shamanic practitioners utilized other assessment methods such as spiritual guidance through prayer, meditation, intuition, and spirit guides, as well as energy assessment.

Energy assessments were conducted with the use of a pendulum and a shamanic process known as soul journeying. Shamanic participants described using the assistance of spirit guides and energy assessments to aide in the discovery of CSA trauma-related aftereffects and in determining the best healing modalities to achieve an optimal healing outcome. These

assessment methods were used to assess for chakra center blockages, soul loss, and attachments and imprints in the luminous energy field. Assessment of the energy field provided the shamanic practitioner access to the client's affect/anxiety, sadness, fear, "shut-offness", distress as well as their vibrational energy indicating the degree to which they were grounded. Soul journeying was another shamanic assessment modality that all participants used in assessing both presenting and associated issues, specifically soul loss or the loss of a quantum of the survivor's vital energy as a result of CSA. These assessment approaches are similar to nurses who use a holistic framework and energy based healing modalities. It is less evident in in the psychological or medical literature. This is the first in-depth qualitative research exploring shamanic practitioners' perspectives on assessment of the adult CSA survivor to determine CSA aftereffects.

Related to shamanic methods of assessment for aftereffects of CSA, another finding was that most shamanic providers specifically chose not to focus on a client's trauma story. They described the trauma story as a perceptual account of an historic event that has the potential to keep the survivor stuck in the role of victim. Several shamanic practitioners described obtaining a history through an online survey or email that would form the basis for the shamanic healing appointment; they used this information as well as knowledge obtained through spiritual guidance and energy assessments to discover the underlying issues during their initial and subsequent client meetings. This form of assessment limited the client's exposure to the traumatic event and preserved time to conduct the shamanic healing. Regarding these findings, similarities exist with Western approaches of assessment of the aftereffects of CSA especially in the collection of client information and data using questionnaires (Chadha et al., 2013). Shamanic healers are clear in their perspective that their healing approach does not focus on the trauma story and instead utilizes spiritual guidance and energy assessments related to discovering

the aftereffects of CSA with their clients. Therapies grounded in nursing such as healing touch and therapeutic touch also focus on the whole human being and the energy field assessment rather than the traumatic event, but there is a lack of literature describing the use of these approaches in persons who have experienced CSA.

Following the initial assessments of the client, participants described several common assessment findings associated with the aftereffects of CSA. The attributes identified by participants that indicated a strong likelihood of CSA overlapped with those indicating soul loss in the shamanic tradition. Identifying soul loss during an assessment was often a cue to the shamanic practitioner that their client could have experienced CSA; it was common in their practices to find an association between soul loss and CSA.

Shamanic assessment findings that cued the shamanic practitioner to suspect a history of CSA were: 1) changes in the energetics, exhibited as a sense of fragmentation/soul loss or emptiness; 2) maladaptive behavioral practices/repetitive life patterns seen in addiction and serial toxic relationships; and 3) distorted, self-limiting, thinking and decision making brought upon the client due to guilt, shame, karma, and off loaded toxic energy from the perpetrator onto the client. The finding related to sense of fragmentation/soul loss is congruent with the conventional Western medicine and psychological literature addressing dissociation; described as the development of unintegrated fragmented dissociative memories stemming from fear (Howell, 2005). However, the novelty of the findings centers around the source of shame, guilt, and other toxic energies; in the shamanic tradition, these do not belong to the client. This finding contrasts with the Western psychological perspective in which the individual is the locus of negative emotions such as shame and guilt. Within the shamanic tradition, the practitioner asserts that the aftereffects of shame, guilt, and negative energy come from an external source that has to be

cleared in order for healing to occur. This is an important finding as the survivor cannot discern that the offloaded shame and guilt energy are not of their own making but projected onto them via the perpetrator. From a nursing perspective, the focus is on the whole person and it is not clear whether the onus of these feelings is external or internal.

Shamanic practitioners assessed energetic issues before and after healing sessions to determine energetic needs and if the client's energetic issues were resolved or had improved toward energy balance and flow after shamanic healing. This was logical given the nature of the problems being assessed from an energetic perspective. The evaluation methods used by the shamanic healers included: conversational interviewing; observations of body language, vocal tone and word use; re-assessment of energetics for flow and the clearing of attachments and imprints; connection and flow of energy through the client's chakra system; and finally, engaging with the adult survivor about his/her feelings about his/herself, the perception of others, and his/her interactions with others after the shamanic healing sessions.

The assessment methods used before healing sessions and the evaluation methods used following shamanic healing were important findings as they provided the shamanic practitioner the ability to identify underlying issues associated with CSA that might not have been identified due to fear, distrust, a sense of vulnerability and/or a lack of conscious awareness on behalf of the adult survivor. Evaluation of changes following the healing sessions helped the practitioner to further determine what additional interventions are required to support and maintain of a sense of wholeness, integration, and wellbeing. These healing changes that the shamanic practitioners evaluated will be discussed as outcomes in the upcoming section for the fifth research question.

Research Question 3: What are the perspectives of shamanic practitioners regarding the use of specific shamanic healing techniques including soul journeying and soul retrieval for issues related to sense fragmentation/soul loss, to facilitate healing and integration?

Specific shamanic healing techniques used to facilitate healing and integration. As described previously, once the shamanic assessment was completed, the shamanic practitioner began facilitating the client's healing by implementing a variety of shamanic healing modalities tailored to the client's assessed needs. Shamanic practitioners shared a number of different types of shamanic healing methods used to facilitate a sense of wholeness in relation to the adult CSA survivor's perceived sense of fragmentation/soul loss. These shamanic healing methods all addressed injuries held within the client's energetic field and consisted of: illumination; soul journeying and soul retrieval; extractions (compassionate depossession, cord cutting, and decoupling); and shamanic homework. These findings related to shamanic healing have not been reported in the literature in relation to healing methods for the adult survivor of CSA.

The shamanic participants described the energy healing technique of illumination used to clear toxic energy lodged in the chakras, restore energy flow, reconnect the lower chakras into balance with the whole system, and revitalize the chakras with healing light and love. This finding regarding the use of energetic healing known as illumination is congruent with nursing approaches such as healing touch and therapeutic touch as well as the work of Price (2005, 2007, 2012); but to date, there are no studies reported in conventional Western medical literature. Other energetic healing techniques described by Eastern medical traditions have been found to be beneficial healing modalities; examples of these therapies include acupuncture, a traditional Chinese healing modality and the Japanese healing tradition of reiki. Acupuncture is a healing technique used to balance the qi (life force/energy) through the body's energy pathways known

as meridians (Faircloth, 2015; National Center for Complementary and Integrative Health, 2016a). Reiki is a Japanese energy healing technique developed in the early 1900s. The name indicates both universal energy and the energy of all living creatures. Reiki therapy, healing touch, and therapeutic touch facilitate the flow of universal energy to areas of the body that need healing (Birocco et al., 2012; Price, 2005, 2007, 2012). Like shamanic healing, these energy healing modalities help to restore a sense of wellbeing.

The participants described the technique of soul journeying used to explore the client's trauma history, discover the origin of the traumatic event, and locate any soul parts that disengaged from consciousness during the time of the traumatic event/s. With these explorations complete, shamanic practitioners described the next phase in the healing journey as soul retrieval or negotiated reintegration of the soul part; this process requires the assistance of spirit guides and permission from the client and the client's soul part.

These findings related to soul journeying and soul retrieval for adult CSA survivors are new and have not been reported in the nursing or medical literature. The findings related to soul journeying and retrieval are important because the adult CSA survivor achieved a sense of integration and wellbeing when the perceived lost soul part/s integrated into his/her consciousness. Further, shamanic healing modalities of soul journeying and soul retrieval provide examples of health as expanding consciousness similar to Newman's work, through the process of transformation, finding greater meaning and connectedness to self and others (M. Newman, 2008; Petitrin, 2016a).

The only study published in the nursing and medical literature that addressed soul journeying and soul retrieval, in addition to extractions, was a pilot intervention and feasibility study of shamanic methods for temporomandibular joint disorders (TMD) (Vuckovic, Williams,

Schneider, Ramirez, & Gullion, 2012). This study is particularly notable as it was funded by the National Institutes of Health (NIH) Center for Complementary and Integrative Health as a phase 1 feasibility study of 20 women with TMD who were randomly assigned to one of two shamanic practitioners. As this was only a phase 1 feasibility study that examined shamanic healing for the first time in a clinical trial, there was no control group. Participants completed 5 healing sessions in which they experienced a variety of shamanic healing treatments, soul retrieval, extraction, and guided meditation to facilitate healing. The results indicate improvement in pain and functional impairment associated with TMD following shamanic healing (Vuckovic et al., 2012). This early study of shamanic healing is of great value because it shines the light of conventional research on shamanic healing practice; however, as demonstrated by this dissertation, the discipline of nursing and other practice professions have more work to do before shamanic healing becomes part of mainstream treatments for patients suffering from trauma sequelae. In the healthcare professions of nursing, psychology, medicine, and social work, practitioners want to help those who experience CSA have there healing needs met. Thus, these practitioners need to be open to a one size does not fit all approach. All healthcare providers should be more informed about holistic and integrative approaches as well as conventional Western ones that may be of help to the CSA survivor.

Another shamanic healing method described by the practitioners in this study was extraction. It is used as a healing method for the removal of toxic energy: either the attached or tethered energy from a discarnate being or energy such as guilt and shame offloaded from the "perpetrator" onto the luminous energy field of the adult survivor. This is a significant finding because as previously described, the removal of toxic energy is essential to restore the adult client's wellbeing following CSA.

The removal of toxic energy described by the shamanic participants brings the individual's energy into right relationship. It also facilitates the flow of energy throughout the body to free the luminous energy field of toxic imprints and release discarnate beings without judgement for its own healing. This finding is aligned with Rogers' (1992) Science of Unitary Human Beings and her four postulates of energy fields, openness, pan-dimensionality and pattern, which informed the therapeutic touch work of Kreiger (1993). The awareness of pattern of the human and environmental fields is integral to the client's healing and this patterning changes through the clearing of discarnate attachments (toxic energy and imprints).

The shamanic participants described other energy healing methods used to clear the client of toxic energy. Decoupling was explained as helping the client shift from his/her constant state of hypervigilance to a state of calm. Decoupling energetically resets the adrenal glands and promotes ease and relaxation. There is a paucity of research in the nursing or medical literature that describes energy healing with the exception of Levine's (1997) Somatic Experiencing™ therapy which focuses on the release of encapsulated traumatic energy. While shamanic energetic healing and Somatic Experiencing™ both address encapsulated traumatic energy as a method to facilitate wellbeing, Levine's technique to clear encapsulated energy differs. Somatic Experiencing™ is a body oriented therapy focused on grounding the client as they explore sensations, impulses and emotions held within the body following a traumatic event. Those sensations are then released through cycles of contracting and expanding the affected area of the body leading to increased well-being (Levine & Fredrick, 1997).

Many participants discussed the use of homework outside of healing sessions to focus the client's consciousness and to assist with the integration of healing into the client's awareness. Homework included a variety of exercises such as: psychodrama, the creation of sand paintings,

the establishment of an altar, the engagement of the soul part that had returned, the acknowledgement of a sense of calm and wholeness and the possibility of living to his/her destiny. In addition to supporting ongoing progress, homework helped the client recognize tools available outside of his/her relationship with the shamanic healer; this fosters independence and sustained health for the client. The study participants described the successful completion of homework as transformational for the adult CSA survivor.

Through the lessons learned from the previously described shamanic healing techniques, the adult survivor successfully stepped outside of the triangle of disempowerment to alter the meaning of his/her experience of childhood sexual abuse from one that defined him/her personally to one of many life events that now provides lessons and gifts. The restoration of the soul part afforded the adult survivor the opportunity to consciously experience a sense of wholeness once again. As compared to traditional Western healing techniques which can take years to achieve any success for the adult CSA survivor, shamanic healing is more immediate, taking place during a few healing sessions. More importantly, per the study participants, shamanic healing restores the client to a more complete sense of integration and wholeness.

All the previously described shamanic healing techniques are in sharp contrast to the Western treatment paradigm. Western derived cognitive healing techniques focus on teaching the trauma survivor to recognize distorted thoughts about his/herself, others, and the future. Once recognized, Western treatment assists the client to substitute the distorted cognitions with healthy perceptions of self (Chard, 2005; McDonagh et al., 2005). The behavioral healing strategies of the Western paradigm attempt to promote healing by exposing the adult survivor to adaptive behavioral responses, or coping skills, useful in the present moment but are not reflective of his/her past trauma (Ehring et al., 2014; Kleindienst et al., 2016; Steil et al., 2011). Instead of

focusing on the acquisition of skills only for the present, shamanic healing techniques provide the client a more profound healing experience.

The participants emphasized that shamanic healing modalities work in the mythic and the symbolic realms to facilitate spiritual and energetic healing to restore a sense of wholeness for the adult CSA survivor. This finding is important because the nursing literature acknowledged that there is little focus within the Western paradigm on spiritual phenomena associated with CSA and other sexual violence, including spiritual suffering and spiritual healing (Draucker et al., 2011; Willis, DeSanto-Madeya, Ross, Sheehan, & Fawcett, 2015). While the Western paradigm does not focus on spiritual or energetic phenomena, Roger's (1992) view of Unitary Human Beings and Watson's (2012) notion of caring-healing consciousness aligns easily with the shamanic perspective of transgenerational healing.

Shamanic healing methods described by the practitioners were not limited to the present moment, rather they could transcend our commonly held notion of linear time and space to heal transgenerational trauma, to heal past wounds, and to allow transgenerational healing to carry forward into the future. This finding indicates that healing extends beyond the present moment and beyond the individual. This is similar to Rogers' (1992) postulate of pan-dimensionality which transcends time and space (Petitrin, 2016b; "Society of Rogerian Scholars," 2016).

Research Question 5: What are the effects of shamanic healing on sense of fragmentation/soul loss as perceived by shamanic practitioners based on their evaluations of adult CSA survivors healing from fragmentation/soul loss in their practices?

Effects of shamanic healing on sense of fragmentation/soul loss as perceived by the shamanic practitioners based on their evaluations. Shamanic practitioners discussed significant changes among adult CSA survivors following shamanic healing sessions.

Specifically, the participants reported that the effects of shamanic healing experienced by adult CSA survivors were positive. There was generally overall holistic improvement in the client's sense of wellbeing, integration and wholeness; the client no longer described a sense of isolation and reported the ability to interact with others without fear. Additionally, the participants noted that their clients enjoyed a greater sense of self-worth, self-confidence, vitality, empowerment, and most importantly an increased awareness of the self as integrated and whole rather than fragmented. The participants noted that their clients experienced a sense of wholeness associated with unguarded joyfulness and a renewed sense of trust allowing access to their internal compass and the capacity to stand in their strength and live their destiny.

Given the goals of shamanic healing aimed at facilitating a sense of integration and wellbeing for adult CSA survivors, reliable and validated holistic measures offer an opportunity to capture outcomes reported for this study. However, evaluating the changes due to energetic healing such as the clearing of the charka system, the extraction of toxic energy, and the impact of the soul retrieval remains a variable that is perhaps only measurable at this time in terms of conscious awareness. The goals set forth by the shamanic healing approach and treatment methods should guide the selection of a full range of measures, including holistic measures of wellbeing. Thus, the outcomes related to shamanic healing as revealed in this study are best suited for what Wheeler (2014) described as holistic outcome measures in trauma healing. These holistic measures may include, "hope, resilience, connection to others, relationships with others, quality of life, overall health, and spiritual well-being" (p.703).

In contrast to the holistic measures used to gain a greater understanding of the global outcomes associated with shamanic healing, Western treatments currently focus on discrete symptom management, utilizing instrument measures and check-lists to assess symptoms to

capture the client's symptom specific treatment outcomes. For example, a study evaluating the outcomes of inpatient treatments for adult CSA survivors used four different reliable measures that assess symptomatology, including the Beck Depression Inventory (BDI) to evaluate symptoms of depression, the Symptoms Check List 90 (Derogatis, Lipman, & Covi, 1973) to evaluate general psychiatric symptoms, the Impact of Events Scale (M. Horowitz, Wilner, & Alvarez, 1979) to assess ongoing symptoms of trauma, and the Inventory of Interpersonal Problems (L. M. Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988) to measure perceived interpersonal problems (Jepsen, Svagaard, Thelle, McCullough, & Martinsen, 2009).

Another study evaluating the outcome of group cognitive analytic therapy for female CSA survivors utilized other measures such as the Brief Symptom Inventory to measure psychiatric symptoms, the Hospital Anxiety and Depression Scale to evaluate symptoms (Calvert et al., 2015). These studies represent the current trend in behavioral science to assess symptom outcomes of interventions. These measures can reliably demonstrate changes in symptoms and are useful in this regard. While there is a plethora of questionnaires, scales and inventories to assess specific symptoms such as anxiety, depression, interpersonal problems and other symptoms, the limited scope of these instruments fails to adequately address the holistic needs of the client. In sharp contrast, shamanic healing utilizes a more holistic and comprehensive process, which includes evaluation of symptoms, spiritual and energetic wellbeing.

The impact of a clients' healing from the aftereffects of CSA was thought to extend well beyond the client, into the consciousness and energy of the universe as the healing client sensed an interconnectedness to all beings and through the universal biosphere or the oneness of everything. The extension of healing beyond the individual was described as the reversal of the traumatic ripple effect of CSA; the healing of the client extended outward from the client beyond

the ego into the family lineage, time, culture, karma, and the universal oneness of all. This finding is in keeping with Watson's (2008) ideas about the universal field of unitary caring consciousness. She asserts the need for an "emerging, evolving wonder at and appreciation for viewing the human-universe as one. The holographic view of caring mirrors the holographic universe: that is, the whole is in each part, and each part affects the whole" (p. 10). In a similar way, within Newman's Health as Expanding Consciousness theory of health, human beings cannot be divided into parts, instead they are inseparable from the universe and from one another (M. Newman, 2010).

Implications

Implications for policy. The findings from this research support potential benefits of shamanic healing for the adult CSA, although further nursing and health science research is indicated in order to build the evidence base. In addition, the findings highlight several issues related to health policy, access and reimbursement, and education that warrant further discussion.

Dissatisfaction with outcomes related to Western Healing was the catalyst for both study participants and their clients to seek complementary and integrative healing practices. According to the participants, access to these types of interventions is inhibited for many from a fiscal standpoint. While some third party payers are beginning to recognize and support the use of several types of complementary and integrative practices, such as chiropractic, acupuncture, and massage, the majority of complementary and integrative services are not covered. The rates for all services have risen and were more pronounced for those without insurance (National Center for Complementary and Integrative Health, 2016b). The lack of reimbursement coverage is directly related to the paucity of research establishing efficacy for complementary and integrative practices (Wheeler, 2014). Additionally, those seeking to take advantage of tax exempt account,

such as flexible spending and health spending accounts, for many complementary and integrative services find the services are not covered under the program (National Center for Complementary and Integrative Health, 2016b). As a result, many of the health approaches are accessible only to those with a higher disposable income who can afford the out of pocket expense.

In addition to the fiscal challenges associated with access, education related to complementary and integrated therapies is woefully lacking to the general public and practitioners restricting access to those with higher education and the ability to investigate available options (Clarke et al., 2015). Public health policy should support the dissemination of information related to complementary and integrative approaches to facilitate wellbeing and health for those seeking alternatives to conventional Western treatments. Educators in the sciences and health professions need to address the information gap so that providers have the knowledge to properly advise clients regarding services available to help meet their health needs. This would require that educational standards promulgated by accrediting bodies require that complementary, alternative, and integrative modalities be incorporated into curricula.

The findings in both the review of the literature and this research indicate that childhood sexual abuse is a significant health problem. As devastating as CSA is to the individual, the aftereffects are extremely burdensome for society as a whole. From a fiscal perspective alone, the average lifetime cost per victim due to costs incurred from healthcare, criminal justice, child welfare, special education and productivity losses is $210,012 (Fang et al., 2012). The cost burden per victim reflects only the tip of the iceberg because it does not account for the vicarious trauma encountered by those associated with the victim, the impact of substance abuse (Simpson & Miller, 2002), increased risk for teen pregnancy (Noll, Shenk, & Putnam, 2009) and losses

associated with suicide associated with CSA. Childhood sexual abuse is a significant health policy issue that deserves greater attention. It society's moral obligation and responsibility to care for and protect the innocent and vulnerable, especially children who depend on us to do so. Society has an ethical responsibility to treat those who have been abused.

Implications for research. This landmark study opens a new area of research by exploring the facilitation of healing for the adult survivor of childhood sexual abuse through shamanic healing. Continued research on this topic will address a critical area of need, develop an evidence-base for humane knowledgeable care for adult CSA survivors who are often stuck in their trauma histories and remain bound to the physical, emotional, energetic, and spiritual trauma sequelae. According to Rhead (2014), integrative therapies are radically more innovative than conventional treatment modalities because they place great emphasis on the subjective reality. Rigorous research regarding shamanic healing affords the nurse researcher an opportunity to embrace, value, and integrate various ways of knowing and subjective knowledge associated with intuition, hunches, dreams and other profound experiences while advancing nursing science. It is imperative that future research address the efficacy of shamanic healing to achieve greater acceptance as an integrative therapy. In addition, evidence of efficacy is an essential component for reimbursement by third party payers.

As a result of this research, additional areas of inquiry for future exploration were identified. Areas of qualitative research may include, studies that examine the perspectives of shamanic healing from other cultures in order to compare healing methods and outcomes. Another area is research that engages the adult CSA survivor to answer questions related to their own experiences with conventional western interventions, rationale for seeking alternative traditional therapies such as shamanism and their perceptions of healing following shamanic

interventions. The dissemination of findings of this study provides valuable descriptive information from the perspective of shamanic healers, which can be leveraged to continue to support further research on the role, value, and efficacy of shamanic healing.

Mixed methods research is another avenue to explore not only the perspectives of the adult survivor but to evaluate outcomes using more standard measures (discussed above) to assess for anxiety, depression, PTSD and spiritual distress pre and post shamanic healing interventions when these are deemed relevant within the context of the proposed study. If researchers can demonstrate that shamanic healing is efficacious in reducing anxiety, depression, PTSD symptoms, and spiritual distress, as well as improving holistic outcomes such as hope, resilience, connection to others, relationships with others, quality of life, overall health, and spiritual well-being, bridging or integrating of the conventional Western approaches with shamanic perspective can be advanced. Biological markers such a salivary cortisol level may be used to further assess the findings stipulated by participants that the shamanic healing method known as decoupling resets the adrenals and disengaged the stress response and sense of hypervigilance.

The aftereffects of trauma are not specific to adult CSA survivors. Additional research may explore the use of shamanic healing in relieving the aftereffects of other forms of trauma, such as those suffered by our military veterans, or an individual exposed to domestic or urban violence. The shamanic healer participants described trauma as one of many life events. Therefore, as this research guides us, we must continue to research methods that liberate survivors from the myriad sequelae while facilitating integration and wholeness and assisting in the discovery of the lessons and gifts associated with the traumatic event. Further, the benefits and risks need to be addressed and explored through additional research.

Implications for education. As indicated at the outset, this research was initiated on the philosophical notion, central unifying focus, and moral-ethical ideal of facilitating humanization, meaning, choice, quality of life, and healing through living and dying (Willis et al., 2008). Holistic nursing of human beings in mutual process with the environment is viewed as the foundation of the profession from its origins in the mid seventeenth century with the Daughters of Charity and further developed with the writings and ministrations of Florence Nightingale (Bloy, 2012; Daughters of Charity Health System, 2015; Sullivan-Bolyai et al., 2010). As a profession that seeks to care for the whole human being, nursing's perspective and research on healing must be integrated within realms of interdisciplinary education for other professions such as medicine, social work, and psychology. All of these professions prepare practitioners who ethically should understand and strive to meet the physical and emotional needs of human beings as well as energetic, relational, and spiritual needs. It is critical that nursing education does not recoil from its grounding in holistic care as it attempts to keep pace with increased acuity, financial constraints, and ever changing sophisticated technology. In order to avoid being reduced to a task-oriented profession, symptom scales, and one size fits all protocols, nursing education needs to look to the future with an inquisitive nature to identify the needs and trends of society. One fruitful area for scholarly inquiry is aimed at developing knowledge to advance nursing science of complementary and integrative therapies.

Dissatisfied with conventional Western therapies due to poor outcomes or treatment related toxicities, individuals have sought alternative healing modalities such as acupuncture, reiki, meditation, yoga and shamanic healing. The use of alternative and integrative healing has grown substantially since the early 1990s in the United States particularly among health care workers (P. J. Johnson, Ward, Knutson, & Sendelbach, 2012). Complementary and integrative

health education, enhanced awareness and expanded consciousness of the various healing powers inherent within the life process, and robust programs of research into these types of topics and trends offers nursing education the opportunity to provide students with knowledge advancements and a wide array of potential treatment options to meet their patients' needs.

Educating nursing students about the theoretical foundations and interventions of holistic and integrative nursing provides the student nurse with increased awareness of the different type of healing methods patients may use. It also allows nurses to become facile with these interventions thereby disseminating pertinent knowledge in the process of caring for patients. This in turn informs questions grounded in nursing practice that inform nursing research including the development of measures that align with the conceptual basis of this work. As the evidence-base is established for different complementary and integrative health modalities, nursing students and nurses will have a better understanding, acceptance and ability to care for patients who choose to use complementary and integrative therapies. Holistic care is one of the American Association of Colleges of Nursing (AACN) baccalaureate and masters essentials for nursing education (AACN, 2008). If incorporated into such programs, nurses on each level can sit for holistic nursing certification rather than waiting for post-baccalaureate and post-masters education. The baccalaureate and masters prepared nurse is prepared to practice from a holistic, caring framework (American Association of Colleges of Nursing, 2008). Even though the baccalaureate and masters essentials (AACN, 2008) indicate that nursing education should prepare the nurse to practice within a holistic caring healing framework, not all nursing schools offer baccalaureate and masters coursework and experiential learning in holistic and integrative approaches. Some may also choose to pursue further education, training, and certifications within the context of nursing schools or other organizations in order to integrate specified

modalities into their own practices once they have entered into nursing practice. For example, the nurse who is interested in developing knowledge and skills in shamanic healing approaches and other holistic healing methods would need to pursue an intensive educational program in order to be proficient and would not likely find educational offerings and training within a school of nursing. One exception in terms of schools of nursing is the University of Minnesota School of Nursing (Edwardson, 2013)where they have fully embraced caring and integrative holistic healing and have the Center for Spirituality and Healing in the school of nursing, which draws an interdisciplinary cadres of professionals and students (Edwardson, 2013). With advanced training and certifications, the incorporation of complementary healing techniques can afford the nurse the chance to gain knowledge and skills to proficiently move their practice beyond the physical and emotional realms of care to competently address the energetic and spiritual dimensions. This is necessary in order for nurses to truly attend to the holistic needs of the patient who may request healing assistance beyond a focus on symptoms and the body physical.

Implications for nursing practice. The findings of this study revealed a significant distinction between the Western and shamanic healing methods for the adult CSA survivor. Both sought ways to alter the meaning associated with the CSA and its aftereffects. The participants described Western healing, such as emotional, cognitive, and behavioral/exposure therapies as treatments and coping strategies to manage symptoms. Coping with and managing the traumatic sequelae sustains the status quo in which the traumatic event subjugates healing, integration, and transformation for the adult survivor. According to the participants in this study, unknowingly and unintentionally, these therapies can encapsulate the adult CSA survivor in the triangle of disempowerment, which positions individuals in the roles of victim, perpetrator and rescuer

stuck in the perceptual story of trauma, never transcending beyond those roles to self-actualization.

In sharp contrast, the participants in this study repeated the purpose of shamanic healing for adult CSA survivors was to help them step outside of the triangle of disempowerment, to detach from the limited notion that they are defined for the rest of their lives by the CSA, and to disavow the perception that they have no choice and are unable to live out their fullest human potential. The transformational message coming out of the shamanic healing tradition for the adult survivor is that the CSA is one of many life events. The shaman participants in this study emphasized that CSA does not have the power to limit or define one's life's purpose and the power to transcend the trauma. Transformational healing is an achievable choice in this tradition that emanates from within an integrated, self-empowered human being.

The advancement of knowledge can be the catalyst needed for mental health providers as well as general practitioners to further investigate and engage in the advanced education and training to master the healing methods of the shaman in order to integrate them into their current practices. The issues of spiritual distress and energetic disequilibrium experienced by the adult CSA survivor are areas underserved in the current treatment models; practitioners can begin to explore these issues and open avenues towards a sense of wellbeing and wholeness for their clients. These findings may act as an incentive for nurses to more carefully consider complementary and integrative healing modalities as options to facilitate healing, not merely as an afterthought when Western healing methods have failed to achieve the outcome goals, but as choices for the adult survivor to contemplate at the onset of treatment. Nurses and other health care professionals need to be attuned to their patients' use of complementary, alternative, and

integrative healing modalities. Each nurse should incorporate specific questions during the initial assessment process to document and incorporate these modalities as appropriate.

Study Limitations

Several limitations of this study need to be considered. As far as this researcher and the dissertation committee are aware, this is the first in-depth qualitative descriptive study describing the perspectives of shamanic healers related to their use of shamanic techniques for facilitating experiences of healing among adult CSA survivors. While the participants provided rich perspectives on Western and shamanic healing traditions, the sample size was small (N=15). The participants who agreed to enroll in the study may not represent the perspectives of other existing populations of shamanic healers; therefore, the findings should be considered thoughtfully. The findings are not necessarily applicable to the general population of shamanic practitioners across the world but should have transferability at least within the context of the United States where this study was conducted.

Additionally, the method of using phone interviews, rather than in person interviews, may have left out some details or nuances found only during face-to-face interactions. Finally, all participants in this research study were trained in shamanic healing by the Four Winds Society, so it is not possible from this study to understand the perspectives of practitioners trained in another venue. Nevertheless, there was variability noted in the healing methods used by the participants in this study although they all trained with Four Winds. The variability will likely expand when conducting research that includes shamanic practitioners from other traditions and other parts of the world including indigenous cultures. As noted earlier, it is clear that further research is needed to explore similarities and differences in approaches to facilitating experiences of healing and sense of integration for adult CSA survivors in these other contexts.

Summary

The findings of this seminal research study contribute new knowledge to the discipline of nursing related to the use of shamanic healing to facilitate integration and wellbeing among adult CSA survivors. Based on the data of participant interviews, it is clear that adult CSA survivors yearn for expanded prospects for fulfilling their full potential and experiencing wellbeing and seek out shamanic practitioners for complementary and integrative healing. The findings of the study serve as a reminder to contemporary practitioners that the experience of healing from trauma did not begin at the inception of modern psychology. The ancient traditional healing practices of the shaman have successfully addressed community and individual needs for healing for thousands of years. Perhaps the time has come for the ancient to become novel once again.

References

Academy of Integrative Health and Medicine. (2015). Academy of Integrative Health and Medicine. Retrieved from https://aihm.org/about

Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology*, *60*(2), 185. JOUR.

Alexander, R., Aaron, L., Alberts, K., Martin, M., Stewart, K., Bradley, L. A., … Triana-Alexander, M. (1998). Sexual and physical abuse in women with fibromyalgia: association with outpatient health care utilization and pain medication usage. *Arthritis & Rheumatism*, *11*(2), 102–115. JOUR.

Allen, J. (2004). *Coping with trauma: Hope through understanding* (2nd ed.). Washington, DC: American Psychiatric Publishing.

American Association of Colleges of Nursing. (2008). *The Essentials of Baccalaureate Education for Professional Nursing Practice*. Washington, DC.

American Holistic Nurses Association. (2015). American Holistic Nurses Association. Retrieved from http://www.ahna.org/

American Nurses Association. (2015). Code of Ethics. Retrieved January 10, 2014, from http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf

American Psychological Association. (2013). *The diagnostic and statistical manual of mental disorders* (5th ed.). American Psychological Association.

Arias, I. (2004). Report from the CDC The legacy of child maltreatment: Long-term health consequences for women, *13*(5).

Bal, S., Crombez, G., Van Oost, P., & Debourdeaudhuij, I. (2003). The role of social support in

well-being and coping with self-reported stressful events in adolescents. *Child Abuse & Neglect*, *27*(12), 1377–1395. JOUR.

Bass, C., van Nevel, J., & Swart, J. (2014). A comparison between dialectical behavior therapy, mode deactivation therapy, cognitive behavioral therapy, and acceptance and commitment therapy in the treatment of adolescents. *International Journal of Behavioral Consultation and Therapy*, *9*(2), 4.

Birocco, N., Guillame, C., Storto, S., Catino, C., Gir, N., Balestra, L., … Ciuffreda, L. (2012). The effects of reiki therapy on pain and anxiety in patients attending a day oncology and infusion services unit. *American Journal of Hospital and Palliative Medicine*, *29*(4), 290–294.

Bloy, M. (2012). Florence Nightingale (1820-1910). Retrieved from http://www.victorianweb.org/history/crimea/florrie.html

Bogar, C. B., & Hulse-Killacky, D. (2006). Resiliency determinants and resiliency processes among female adult survivors of childhood sexual abuse. *Journal of Counseling & Development*, *84*(3), 318–327. JOUR.

Bonomi, A., Anderson, M., Rivara, F., Cannon, E., Fishman, P., Carrell, D., … Thompson, R. S. (2008). Health care utilization and costs associated with childhood abuse. *Journal of General Internal Medicine*, *23*(3), 294–299.

Brand, B. L., & Alexander, P. C. (2003). Coping with incest: The relationship between recollections of childhood coping and adult functioning in female survivors of incest. *Journal of Traumatic Stress*, *16*(3), 285–293. JOUR.

Brennan, D. J., Hellerstedt, W. L., Ross, M. W., & Welles, S. L. (2007). History of childhood sexual abuse and HIV risk behaviors in homosexual and bisexual men. *American Journal of*

Public Health, *97*(6), 1107–1112. JOUR.

Bridgeland, W. M., Duane, E. A., & Stewart, C. S. (2001). Victimization and attempted suicide among college students. *College Student Journal*, *35*(1), 63–76. JOUR.

Briere, J. (1996). A self-trauma model for treating adult survivors of severe child abuse. In T. Briere, John, Bulkley, J., Jenny, C., Reid (Ed.), *The APSAC Handbook of Childhood Maltreatment*. Newbury Park, CA: Sage.

Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse and Neglect*, *27*(10), 1205–1222.

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: prevalence, correlates, and functions. *American Journal of Orthopsychiatry*, *68*(4), 609. JOUR.

Briere, J., & Jordan, C. E. (2009). Childhood maltreatment, intervening variables, and adult psychological difficulties in women: an overview. *Trauma, Violence & Abuse*, *10*(4), 375–88. http://doi.org/10.1177/1524838009339757

Briere, J., & Scott, C. (2006). *Principles of Trauma Therapy: A Guide to Symptoms, Evaluatin and Treatment*. Thousand Oaks: Sage Publications.

Briere, J., & Spinnazzola, J. (2009). Assesment of the sequelaeof complex trauma:Evidence-based measures. In C. A. Courtois & J. D. Ford (Eds.), *Treating Complex Traumatic Stress Disorders* (pp. 104–123). New York: The Guilford Press.

Bruyere, R. (1994). *Wheels of light: Chakras, auras, and the healing energy of the body*. (J. Farrens, Ed.). New York: Fireside.

Burkhardt, P. (2015). Holistic and intrgrative nursing: understanding our roots. *Beginning*,

February, 5, 32–33.

Calhoun, K. S., & Atkeson, B. M. (1991). *Treatment of rape victims: Facilitating psychosocial adjustment*. BOOK, Pergamon Press Elmsford, NY.

Calvert, R., Kellett, S., & Hagan, T. (2015). Group cognitive analytic therapy for female survivors of childhood sexual abuse. *British Journal of Clinical Psychology*, *54*(4), 391–413.

Cardena, E. (1994). The domain of dissociation. In S. J. Lynn & J. Rhue (Eds.), *Dissociation: Clinical and Pheoretical perspectives* (pp. 15–31). New York.

Cater, J. (2011). Using skype for qualitative interview research.

CDC. (2014). Child Maltreatment: Definitions. Retrieved from http://www.cdc.gov/ViolencePrevention/childmaltreatment/definitions.html

CDC. (2014). Cost of Child Abuse and Neglect Rival Other Major Health Problems. Retrieved from www.cdc.gov/violenceprevention/childmaltreatment/economiccost.html

CDC. (2014). National Health Interview Survey.

Celano, M. P. (1992). A developmental model of victims' internal attributions of responsibility for sexual abuse. *Journal of Interpersonal Violence*, *7*(1), 57–69. JOUR.

Center for Health and Healing. (2012). Therapeutic Touch-How it works and when to use it. Retrieved from http://www.healthandhealingny.org/complement/therap_how.asp

Chadha, M., Malhotra, S., & Srivastava, P. (2013). Issues in the psychological assessment of trauma victims. *Delhi Psychiatry Journal*, *16*(1), 196–203.

Chard, K.-M. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, *73*, 965–971.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., … Zirakzadeh, A. (2010). Sexual Abuse and Lifetime Diagnosis of Psychiatric Disorders: Systematic Review and Meta-analysis. *Mayo Clinic Proceedings*, *85*(7), 618–629. JOUR. http://doi.org/http://dx.doi.org/10.4065/mcp.2009.0583

Child Welfare Information Gateway Child Abuse and Neglect. (2009). Retrieved from http://www.childwelfare.gov/

Children's Bureau. (n.d.). Child Welfare. Retrieved January 1, 2015, from www.childwelfare.gov/topics/can/

Clarke, T. C., Black, L. I., Stussman, B. J., Barnes, P. M., & Nahin, R. L. (2015). Trends in the use of complementary health approaches among adults: United States, 2002-2012. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/25671660\nhttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC4573565

Classen, C. C., Palesh, O. G., & Aggarwal, R. (2005). Sexual revictimization a review of the empirical literature. *Trauma, Violence, & Abuse*, *6*(2), 103–129. JOUR.

Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R. T. (1996). The relation between methods of coping during adulthood with a history of childhood sexual abuse and current psychological adjustment. *Journal of Consulting and Clinical Psychology*, *64*(5), 1090. JOUR.

Cole, P. M., & Putnam, F. W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology*, *60*(2), 174. JOUR.

Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C., & Maughan, B. (2007). Resilience

to adult psychopathology following childhood maltreatment: evidence from a community sample. *Child Abuse & Neglect*, *31*(3), 211–29. http://doi.org/10.1016/j.chiabu.2007.02.004

Congregation of the Sisters of Mercy. (2015). History. Retrieved April 29, 2015, from http://www.sistersofmercy.ie/

Cornman, J. B. (1997). Female adolescent response to childhood sexual abuse. *Journal of Child and Adolescent Psychiatric Nursing*, *10*(2), 17–25. JOUR.

Costandi, M. (2011). Consciousness Explained in 30 Seconds. Retrieved from http://www.theguardian.com/science/neurophilosophy/2011/aug/12/consciousness-explained-30-second-psychology

Cougle, J. R., Timpano, K. R., Sachs-Ericsson, N., Keough, M. E., & Riccardi, C. J. (2010). Examining the unique relationships between anxiety disorders and childhood physical and sexual abuse in the National Comorbidity Survey-Replication. *Psychiatry Research*, *177*(1–2), 150–5. http://doi.org/10.1016/j.psychres.2009.03.008

Courtois, C. A., & Ford, J. D. (2009). *Treating Complex Traumatic Stress Disorders: An Evidenced-Based Guide*. (C. A. Courtois & J. D. Ford, Eds.) (First). New York: Guilford Press.

Creswell, J. (2007). *Qualitative Inquiry and research Design: Choosing Among Five Approaches* (2nd ed.). Thousand Oaks: Sage Publications.

Curran, T. (2008). The Irish Sisters of Mercy and the Crimean War.

Cutajar, M. C., Mullen, P. E., Ogloff, J. R. P., Thomas, S. D., Wells, D. L., & Spataro, J. (2010). Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse & Neglect*, *34*(11), 813–22. http://doi.org/10.1016/j.chiabu.2010.04.004

Darkness to Light. (2013). The Five Steps to Protecting Our Children. Retrieved from

http://www.d2l.org/site/c.4dICIJOkGcISE/b.6241177/k.28B8/The_5_Steps_to_Protecting_Our_Children.htm

Daughters of Charity. (n.d.). Daughters of Charity of St Vincent De Paul. Retrieved April 23, 2015, from http://www.daughtersofcharity.com/who-we-are/

Daughters of Charity Health System. (2015). Our History. Retrieved April 23, 2015, from http://dochs.org/who-we-are/our-mission-history/our-history/

Daughters of Charity of Saint Vincent de Paul. (n.d.-a). Origins of the Company. Retrieved April 23, 2015, from http://filles-de-la-charite.org/history/origin-of-the-company/

Daughters of Charity of Saint Vincent de Paul. (n.d.-b). Saint Louise De Marillac. Retrieved April 23, 2015, from http://www.daughtersofcharity.com/who-we-are/founders/

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale--preliminary report. *Psychopharmacology Bulletin*.

Dobkin, P. L., De Civita, M., Bernatsky, S., Kang, H., & Baron, M. (2003). Does psychological vulnerability determine health-care utilization in fibromyalgia? *Rheumatology*, *42*(11), 1324–1331. JOUR.

Douglas, E., & Finkelhor, D. (2005). Child sexual abuse fact sheet. Retrieved from http://unh.edu/ccrc/factsheet/pdf/ChildMaltreatmentFatalitiesFactSheet.pdf

Draucker, C. B., Martsolf, D. S., Roller, C., Knapik, G., Ross, R., & Stidham, A. W. (2011). Healing from childhood sexual abuse: a theoretical model. *Journal of Child Sexual Abuse*, *20*(4), 435–466.

Draucker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W., & Mweemba, P. (2009). The essence of healing from sexual violence: a qualitative metasynthesis. *Research in Nursing & Health*, *32*(4), 366–78. http://doi.org/10.1002/nur.20333

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine*, *28*(5), 430–8. http://doi.org/10.1016/j.amepre.2005.01.015

Dubowitz, H., Kim, J., Black, M. M., Weisbart, C., Semiatin, J., & Magder, L. S. (2011). Identifying children at high risk for a child maltreatment report. *Child Abuse & Neglect*, *35*(2), 96–104. JOUR. http://doi.org/http://dx.doi.org/10.1016/j.chiabu.2010.09.003

Dutton, M. A., & Greene, R. (2010). Resilience and crime victimization. *Journal of Traumatic Stress*, *23*(2), 215–222. http://doi.org/10.1002/jts.

Edwardson, S. (2013). Integrative Health and Healing. Retrieved from http://www.nursing.umn.edu/about/history/program-histories/integrative-health-and-healing

Ehring, T., Welboren, R., Morina, N., Wicherts, J. M., Freitag, J., & Emmelkamp, P. M. G. (2014). Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. *Clinical Psychology Review*, *34*(8), 645–657. http://doi.org/10.1016/j.cpr.2014.10.004

Eliade, M. (2004). *Shamanism: Archaic Techniquecs of Ecstast*. Princeton: Princeton University Press.

Elliott, D. M., Mok, D. S., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. *Journal of Traumatic Stress*, *17*(3), 203–211. JOUR.

Emmitsburg Area Historica Society. (n.d.). A Short History of the Sisters of Charity. Retrieved April 29, 2015, from http://www.emmitsburg.net/archive_list/articles/history/stories/sisters_of_charity.htm

Erickson, H. L. (2007). Philosophy and theory of holism. *The Nursing Clinics of North America*,

42(2), 139–63, v. http://doi.org/10.1016/j.cnur.2007.03.001

Eriksson, K. (2007). The Theory of Caritative Caring: a vision. *Nursing Science Quarterly*, *20*(3), 201–202. http://doi.org/10.1177/0894318407303434

Eye Movement Desensitization and Reprocessing Inc. (2016). What is EMDR. Retrieved from http://www.emdr.com/what-is-emdr/

Faircloth, A. (2015). Acupuncture: History from the yellow emperor to modern anesthesia practice. *American Association Nurse Anesthetists*, *83*(4), 282–295. Retrieved from http://www.aana.com/newsandjournal/20102019/jcourse3-0815-pp289-295.pdf

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, *36*(2), 156–65. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22300910

Farthing, G. W. (1992). The Concept of Consciousness. Retrieved March 20, 2015, from http://www.smccd.edu/accounts/larson/psyc390/Docs/Concept of Consc Ch 1.pdf

Feliciano, M. (2009). An Overview of PTSD for the Adult Primary Care Provider. *The Journal for Nurse Practitioners*, *5*(7), 516–522. http://doi.org/10.1016/j.nurpra.2008.12.009

Filipas, H. H., & Ullman, S. E. (2001). Social reactions to sexual assault victims from various support sources. *Violence and Victims*. JOUR.

Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse & Neglect*, *18*(5), 409–417. JOUR.

Finkelhor, D. (2012). Child Sexual Abuse Statistics. Retrieved from https://www.victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics

Finkelhor, D., & Berliner, L. (1995). Research on the treatment of sexually abused children: A

review and recommendations. *Journal of the American Academy of Child & Adolescent Psychiatry*, *34*(11), 1408–1423. JOUR.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, *55*(4), 530. JOUR.

Finkelhor, D., Hamby, S. L., Ormrod, R., & Turner, H. (2009). Violence, abuse, & crime exposure in a national sample of children & youth. *Pediatrics*, *124*(5), 1–14.

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: a comprehensive, national survey. *Child Maltreatment*, *10*(1), 5–25. http://doi.org/10.1177/1077559504271287

Finkelhor, D., Turner, H., Shattuck, A., & Hamby, S. L. (2013). Upset among youth in response to questions about exposure to violence, sexual assault and family maltreatment. *Jama Pediatrics*, *167*(7), 614–621.

Forbey, J. D., Ben-Porath, Y. S., & Davis, D. L. (2000). A comparison of sexually abused and non-sexually abused adolescents in a clinical treatment facility using the MMPI-A. *Child Abuse & Neglect*, *24*(4), 557–568. JOUR.

Franey, K., Geffner, R., & Falconer, R. (Eds.). (2001). *The cost of child maltreatment: Who pays? We all do.* BOOK, San Diego: Family Violence & Sexual Assault Institute.

Frazier, P., Tashiro, T., Berman, M., Steger, M., & Long, J. (2004). Correlates of levels and patterns of positive life changes following sexual assault. *Journal of Consulting and Clinical Psychology*, *72*(1), 19. JOUR.

Freshwater, K., Leach, C., & Aldridge, J. (2001). Personal constructs, childhood sexual abuse and revictimization. *British Journal of Medical Psychology*, *74*(3), 379–397. JOUR.

Friedman, M. J., & McEwen, B. S. (2004). Posttraumatic stress disorder, allostatic load, and

medical illness. JOUR.

Futa, K. T., Nash, C. L., Hansen, D. J., & Garbin, C. P. (2003). Adult survivors of childhood abuse: An analysis of coping mechanisms used for stressful childhood memories and current stressors. *Journal of Family Violence*, *18*(4), 227–239. JOUR.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet*, *373*(9657), 68–81. http://doi.org/10.1016/S0140-6736(08)61706-7

Ginzburg, K., Butler, L., Giese-Davis, J., Cavanaugh, C., Neri, E., Koopman, C., … Spiegel, D. (2009). Shame, guilt, and posttraumatic stress disorder in adult survivors of childhood sexual abuse at risk for Human Immunodeficiency Virus: Outcomes of a randomized clinical trial of group psychotherapy treatment. *The Journal of Nervous and Mental Disease*, *197*(7), 536–542.

Golden-Kreutz, D. M., Thornton, L. M., Wells-Di Gregorio, S., Frierson, G. M., Jim, H. S., Carpenter, K. M., … Andersen, B. L. (2005). Traumatic stress, perceived global stress, and life events: prospectively predicting quality of life in breast cancer patients. *Health Psychology*, *24*(3), 288. JOUR.

Golding, J. (1999). Sexual-Assault History and Long-Term Physical Health Problems Evidence From Clinical and Population Epidemiology. *Current Directions in Psychological Science*, *8*(6), 191–194. JOUR.

Golding, J., Taylor, D. L., Menard, L., & King, M. J. (2000). Prevalence of sexual abuse history in a sample of women seeking treatment for premenstrual syndrome. *Journal of Psychosomatic Obstetrics & Gynecology*, *21*(2), 69–80. JOUR.

Golding, J., Wilsnack, S., & Cooper, M. L. (2002). Sexual assault history and social support: Six

general population studies. *Journal of Traumatic Stress*, *15*(3), 187–197. JOUR.

Green, J. G., McLaughlin, K. A., Berglund, P. A., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2010). Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. *Archives of General Psychiatry*, *67*(2), 113–123. JOUR.

Griffing, S., Lewis, C. S., Chu, M., Sage, R., Jospitre, T., Madry, L., & Primm, B. J. (2006). The process of coping with domestic violence in adult survivors of childhood sexual abuse. *Journal of Child Sexual Abuse*, *15*(2), 23–41. JOUR.

Guba, E., & Lincoln, Y. (2005). Paradigmatic controversies, contradictions, and emerging influences. In Y. Denzin, Norman & Lincoln (Ed.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 191–215). Thousand Oaks: Sage Publications.

Guelzow, J. W., Cornett, P. F., & Dougherty, T. M. (2003). Child sexual abuse victims' perception of paternal support as a significant predictor of coping style and global self-worth. *Journal of Child Sexual Abuse*, *11*(4), 53–72. JOUR.

Hager, A. D., & Runtz, M. G. (2012). Physical and psychological maltreatment in childhood and later health problems in women: an exploratory investigation of the roles of perceived stress and coping strategies. *Child Abuse & Neglect*, *36*(5), 393–403. http://doi.org/10.1016/j.chiabu.2012.02.002

Hall, J. M. (1999). Lesbians in alcohol recovery surviving childhood sexual abuse and parental substance misuse. *The International Journal of Psychiatric Nursing Research*, *5*(1), 507–515. JOUR.

Hall, J. M. (2000). Core issues for female child abuse survivors in recovery from substance misuse. *Qualitative Health Research*, *10*(5), 612–631. JOUR.

Harner, M. (1990). *The Way of the Shaman*. New York: Harper and Row.

Harper, D. C., Davey, K. S., & Fordham, P. N. (2014). Leadership Lessons in Global Nursing and Health From The Nightingale Letter jhn Collection at the University of Alabama at Birmingham. *Journal of Holistic Nursing*, *32*(1), 44–53.

Harris, P. E., Cooper, K. L., Relton, C., & Thomas, K. J. (2012). Prevalence of complementary and alternative medicine (CAM) use by the general population: a systematic review and update. *International Journal of Clinical Practice*, *66*(10), 924–39. http://doi.org/10.1111/j.1742-1241.2012.02945.x

Health and Human Services. (2013). Child Maltreatment 2012 HHS Report.

Helms, J. E. (2006). Complementary and Alternative Therapies : A New Frontier for Nursing Education ?, *45*(3), 117–124.

Herman, J. (1992a). *Trauma and Recovery, The Aftermath of Violence from Domestic Abuse to Political Terror*. New York: Basic Books New York, NY.

Herman, J. (1992b). Trauma and Recovery. 1992. *Herman Compares the Trauma of Victims of Domestic Violence to that of Combat Veterans and Survivors of Political Torture*. JOUR.

Herman, J., Russell, D., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. *American Journal of Psychiatry*, *143*(10), 1293–1296. JOUR.

Hill, A. (2006). Play therapy with sexually abused children: Including parents in therapeutic play. *Child & Family Social Work*, *11*(4), 316–324. JOUR.

Himelein, M. J., & McElrath, J. A. V. (1996). Resilient child sexual abuse survivors: Cognitive coping and illusion. *Child Abuse & Neglect*, *20*(8), 747–758. JOUR.

Hornor, G. (2010). Child sexual abuse: consequences and implications. *Journal of Pediatric Health Care : Official Publication of National Association of Pediatric Nurse Associates &*

Practitioners, *24*(6), 358–64. http://doi.org/10.1016/j.pedhc.2009.07.003

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology*, *56*, 885–892.

Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychsomatic Medicine*, *41*, 209–218.

Howell, E. F. (2005). *The Dissociative Mind*. New York: Routledge.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(9), 1277–1288.

Ingerman, S. (1991). *Soul Retrieval: Mending the Fragmented Self*. New York: Harper Collins.

Ingerman, S. (2008). *Shamanic Journeying: A beginner's Guide*. Boulder: Sounds True, Inc.

Janet, P. (1907). *The major symptoms of hysteria.* New York: MacMillan.

Jepsen, E. K., Svagaard, T., Thelle, M. I., McCullough, L., & Martinsen, E. W. (2009). Inpatient treatment for adult survivors of childhood sexual abuse: A preliminary study. *Journal of Trauma Dissociation*, *10*(3), 315–333.

Johnsen, L. W., & Harlow, L. L. (1996). Childhood sexual abuse linked with adult substance use, victimization, and AIDS risk. *AIDS Education and Prevention*. JOUR.

Johnson, B. K., & Kenkel, M. B. (1991). Stress, coping, and adjustment in female adolescent incest victims. *Child Abuse & Neglect*, *15*(3), 293–305. JOUR.

Johnson, P. J., Ward, A., Knutson, L., & Sendelbach, S. (2012). Personal use of complementary and alternative medicine (CAM) by U.S. health care workers. *Health Services Research*, *47*(1), 211–227.

Kalsched, D. E. (2010). Working with Trauma in Analysis. *Jungian Psychoanalysis: Working in*

the Spirit of C.G. Jung, 281–295.

Kalsched, D. E. (2013). *Trauma and the Soul: A Psycho-Spiritual Approach to Human Development and Its Interruption* (First). New York: Routledge.

Kalweit, H. (2000). *Shamans, Healers, and Medicine Men*. Boston: Shambhala.

Kendall-Tackett, K. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, *113*(1), 164–180. Retrieved from http://psycnet.apa.org/journals/bul/113/1/164/

Kia-Keating, M., Sorsoli, L., & Grossman, F. K. (2010). Relational challenges and recovery processes in male survivors of childhood sexual abuse. *Journal of Interpersonal Violence*, *25*(4), 666–83. http://doi.org/10.1177/0886260509334411

Kim, J., Talbot, N. L., & Cicchetti, D. (2009). Childhood abuse and current interpersonal conflict: the role of shame. *Child Abuse & Neglect*, *33*(6), 362–71. http://doi.org/10.1016/j.chiabu.2008.10.003

Kirmayer, L. J., Groleau, D., Looper, K. J., & Dominicé, M. (2004). Explaining medically unexplained symptoms. *The Canadian Journal of Psychiatry/La Revue Canadienne de Psychiatrie*. JOUR.

Kleindienst, N., Priebe, K., Gö Rg, N., Dyer, A., Steil, R., Lyssenko, L., … Bohus, M. (2016). State dissociation moderates response to dialectical behavior therapy for posttraumatic stress disorder in women with and without borderline personality disorder, *1*, 1–9. http://doi.org/10.3402/ejpt.v7.30375

Knisely, J. S., Barker, S. B., Ingersoll, K. S., & Dawson, K. S. (2000). Psychopathology in substance abusing women reporting childhood sexual abuse. *Journal of Addictive Diseases*, *19*(1), 31–44. JOUR.

Krierger, D. (1993). *Accepting your power to heal: The personal practice of Therapeutic Touch*. Rochester: Bear and Company.

Kruczek, T., & Vitanza, S. (1999). Treatment effects with an adolescent abuse survivor's group. *Child Abuse & Neglect*, *23*(5), 477–485. JOUR.

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. *The Lancet*, *360*(9339), 1083–1088. JOUR.

Lanza, R. (2011). *Biocentrism*. Dallas: Benbella Books, Inc.

LeBlance, A. (2001). The Origins of the Concept of Dissociation: Paul Janet, His Nephew Pierre, andthe Problem ofPost-Hypnotic Suggestions. *History of Science*, *39*, 57–69.

Leeners, B., Neumaier-Wagner, P., Quarg, A. F., & Rath, W. (2006). Childhood sexual abuse (CSA) experiences: an underestimated factor in perinatal care. *Acta Obstetricia et Gynecologica Scandinavica*, *85*(8), 971–976. JOUR.

Leitenberg, H., Gibson, L. E., & Novy, P. L. (2004). Individual differences among undergraduate women in methods of coping with stressful events: The impact of cumulative childhood stressors and abuse. *Child Abuse & Neglect*, *28*, 181−192.

Leitenberg, H., Greenwald, E., & Cado, S. (1992). A retrospective study of long-term methods of coping with having been sexually abused during childhood. *Child Abuse & Neglect*, *16*, 399−407.

Leserman, J. (2005). Sexual abuse history: prevalence, health effects, mediators, and psychological treatment. *Psychosomatic Medicine*, *67*(6), 906–915. JOUR.

Lev-Wiesel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Children and Youth Services Review*, *30*(6), 665–673. http://doi.org/10.1016/j.childyouth.2008.01.008

Levine, P. A., & Fredrick, A. (1997). *Waking the tiger: Healing trauma*. Berkley: North Atalntic Books.

Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. Thousand Oaks: Sage Publications.

Loftus, E. F. (1993). The reality of repressed memories. *American Psychologist*, *48*(5), 518. JOUR.

Lynch, D., & Lyons, M. (2014). Sisters of Mercy in the Crimea. Retrieved from http://www.sistersofmercy.ie/news/article_display.cfm?article_id=3168

Mason, D. M. (2014). Holism and embodiment in nursing: using Goethean science to join 2 perspectives on patient care. *Holistic Nursing Practice*, *28*(1), 55–64. http://doi.org/10.1097/HNP.0000000000000010

McDonagh, A., Friedman, M., McHugo, G., Ford, J., Sengupta, A., Mueser, K., … Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Counseling and Clinical Psychology*, *73*(3), 515–524.

Merrill, L. L., Thomsen, C. J., Sinclair, B. B., Gold, S. R., & Milner, J. S. (2001). Predicting the impact of child sexual abuse on women: the role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology*, *69*(6), 992. JOUR.

Messman-Moore, T. L., Brown, A. L., & Koelsch, L. E. (2005). Posttraumatic symptoms and self-dysfunction as consequences and predictors of sexual revictimization. *Journal of Traumatic Stress*, *18*(3), 253–261. JOUR.

Miles, M., & Huberman, M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.). Thousand Oaks: Sage Publications.

Mittelman, M., & Synder, S. (2009). Mary Jo Kreitzer, PhD, RN: Inspiring Whole-Person Care

Through Integrative Models of Research, Education, and Clinical Practice. *Alternative Therapies*, *15*(3), 66–75.

Morse, J., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods*, *1*(2), 13–22. Retrieved from http://www.ualberta.ca/~iiqm/backissues/1_2Final/pdf/morseetal.pdf

Moylan, A., Derr, A. S., & Lindhorst, T. (2015). Increasingly Mobile: How New Technologies can Enhance Qualitative Research. *Qualitative Social Work*, *14*(1), 48–64.

Munhall, P. L. (2007). *Nursing Research: A Qualitative Perspective*. Boston: Jones and Bartlett Publishers.

Murthi, M., & Espelage, D. L. (2005). Childhood sexual abuse, social support, and psychological outcomes: A loss framework. *Child Abuse & Neglect*, *29*(11), 1215–1231. JOUR.

Nahin, R. L., Barnes, P. M., Stussman, B., & Bloom, B. (2009). Costs of Complementary and Alternative Medicine (CAM) and Frequency of Visits to CAM Practitioners : United States , 2007. *National Health Statistics, Reports*, (18), 15.

National Center for Complementary and Integrative Health. (2015). Complementary, Alternative, or Integrative Health: What's In a Name? Retrieved from https://nccih.nih.gov/health/integrative-health

National Center for Complementary and Integrative Health. (2016a). Acupuncture. Retrieved from https://nccih.nih.gov/health/acupuncture

National Center for Complementary and Integrative Health. (2016b). Paying for complementary and integrative health approaches. Retrieved from https://nccih.nih.gov/health/financial

Newman, M. (1994). Theory for Nursing Practice. *Nursing Science Quarterly*, *7*(2), 153–157.

Newman, M. (2008). *Transforming presence: The difference that nursing makes*. Philadelphia: F.A. Davis Company.

Newman, M. (2010). Health as Expanding Consciousness. Retrieved January 1, 2010, from http://healthasexpandingconsciousness.org/home/

Newman, M. G., Clayton, L., Zuellig, A., Cashman, L., Arnow, B., Dea, R., & Taylor, C. B. (2000). The relationship of childhood sexual abuse and depression with somatic symptoms and medical utilization. *Psychological Medicine*, *30*(5), 1063–1077. JOUR.

Nightingale, F. (1860). *Notes on Nursing: What It Is, and What It Is Not.* New York: D. Appleton and Company.

NIH. (2015). Complementary,Alternative, or Integrative Health: What's in a Name? Retrieved from https://nccih.nih.gov/health/integrative-health

NIH. (2015). National Center for Complementary and Integrative Health. Retrieved from http://www.nih.gov/about/almanac/organization/NCCIH.htm

NIH. (2015). NCCIH Facts-at-aGlance and Mission. Retrieved from https://nccih.nih.gov/about/ataglance

Nijenhuis, E. R. S., & van der Hart, O. (1999). Forgetting and reexperiencing trauma. In J. Goodwin & R. Attias (Eds.), *Splintered reflections: Images of the Body in Treatment* (pp. 39–65). New York: Basic Books.

Nijenhuis, E. R. S., & van der Hart, O. (2011). Dissociation in trauma: a new definition and comparison with previous formulations. *Journal of Trauma & Dissociation : The Official Journal of the International Society for the Study of Dissociation (ISSD)*, *12*(4), 416–45. http://doi.org/10.1080/15299732.2011.570592

Noll, J. G., Shenk, C. E., & Putnam, K. T. (2009). Childhood sexual abuse and adolescent

pregnancy: A meta-analytic update. *Journal of Pediatric Psychology*, *34*(4), 366–378.

O'Neill, K., & Gupta, K. (1991). Post-traumatic stress disorder in women who were victims of childhood sexual abuse. *Irish Journal of Psychological Medicine*. JOUR.

Okoro, C., Zhao, Gu., Li, C., & Balluz, L. (2013). Has the Use of Complementary and Alternative Medicine Therapies by U.S. Adults with Chronic Disease-Related Functional Limitations Changed from 2002 to 2007? *Journal of Alternative and Complementary Medicine*, *19*(3), 217–223.

Oleske, D. M., Lavender, S. A., Andersson, G. B. J., Morrissey, M. J., Zold-Kilbourn, P., Allen, C., & Taylor, E. (2006). Risk factors for recurrent episodes of work-related low back disorders in an industrial population. *Spine*, *31*(7), 789–798. JOUR.

Paras, M., Murad, M. H., Chen, L. P., Goranson, E. N., Sattler, A. L., Colbenson, K. M., … Zirakzadeh, A. (2009). Sexual Abuse and Lifetime Diagnosis of Somatic Disorders: A Systematic Review and Meta-analysis. *Journal of the American Medical Association*, *302*(5), 550–561.

Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: a meta-analysis. *Clinical Psychology Review*, *29*(4), 328–38. http://doi.org/10.1016/j.cpr.2009.02.007

Peregoy, J., Clarke, T., Jones, L., Sussman, B., & Nahim, R. (2014). Regional Variation in Use of Complementary Health Approaches by U . S . Adults. *NCHS Data Brief*, (146).

Pérez-Fuentes, G., Olfson, M., Villegas, L., Morcillo, C., Wang, S., & Blanco, C. (2013). Prevalence and correlates of child sexual abuse: a national study. *Comprehensive Psychiatry*, *54*(1), 16–27. http://doi.org/10.1016/j.comppsych.2012.05.010

Petitrin, A. (2016a). Health as Expanding Consciousness. Retrieved from www.nursing-

theory.org/theories-and-models/newman-health-as-expanding-consciousness.php

Petitrin, A. (2016b). Science of Unitary Human Beings. Retrieved from www.nursing-theory.org/theories-and-models/roger-theory-of-unitary-human beings.php

Prevent Child Abuse America. (n.d.). Prevent Child Abuse. Retrieved February 2, 2015, from http://www.preventchildabuse.org/images/docs/sexualabusebrochure.final.pdf

Price, C. (2005). Body-oriented therapy in recovery from childhood sexual abuse: An efficacy study. *Alternative Therapies in Health and Medicine*, *11*(5), 46–57.

Price, C. (2007). Dissociation reduction in body therapy during sexual abuse recovery. *Complementary Therapies in Clinical Practice*, *13*, 116–128.

Price, C. (2012). Massage for adults with a history of sexual trauma. In D. Dryden & C. Moyer (Eds.), *Massage Therapy: Integrating Research and Practice* (pp. 165–170). Champaign: Human Kinetics.

Rhead, J. C. (2014). The deeper significance of integrative medicine. *Journal of Alternative and Complementary Medicine*, *20*(5), 329.

Roberts, S. J. (1996). The sequelae of childhood sexual abuse: a primary care focus for adult female survivors. *The Nurse Practitioner*, *21*(12), 42–56. JOUR.

Rodgers, C. S., Lang, A. J., Laffaye, C., Satz, L. E., Dresselhaus, T. R., & Stein, M. B. (2004). The impact of individual forms of childhood maltreatment on health behavior. *Child Abuse & Neglect*, *28*(5), 575–86. http://doi.org/10.1016/j.chiabu.2004.01.002

Rodriguez, N., Ryan, S. W., Rowan, A. B., & Foy, D. W. (1996). Posttraumatic stress disorder in a clinical sample of adult survivors of childhood sexual abuse. *Child Abuse & Neglect*, *20*(10), 943–952. JOUR.

Rogers, M. (1994). The Science of Unitary Human Beings: Current Perspectives. *Nursing*

Science Quarterly, *7*(1), 33–35.

Romans, S., Belaise, C., Martin, J., Morris, E., & Raffi, A. (2002). Childhood abuse and later medical disorders in women. *Psychotherapy and Psychosomatics*, *71*(3), 141–150. JOUR.

Rovi, S., Chen, P., & Johnson, M. S. (2004). The Economic Burden of Hospitalizations Associated With Child Abuse and Neglect, *94*(4), 586–590.

Runtz, M. G., & Schallow, J. R. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse & Neglect*, *21*(2), 211–226. JOUR.

Rust, J. O., & Troupe, P. A. (1991). Relationships of treatment of child sexual abuse with school achievement and self-concept. *The Journal of Early Adolescence*, *11*(4), 420–429. JOUR.

Sandberg, D. A., Matorin, A. I., & Lynn, S. J. (1999). Dissociation, posttraumatic symptomatology, and sexual revictimization: A prospective examination of mediator and moderator effects. *Journal of Traumatic Stress*, *12*(1), 127–138. JOUR.

Sandelowski, M. (1995a). Qualitative Analysis: What It Is and How to Begin. *Research in Nursing and Health*, *18*(4), 371–375.

Sandelowski, M. (1995b). Sample Size in Qualitative Research. *Research inNursing and Health*, *18*(2), 179–183.

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description? *Research in Nursing and Health*, 334–340. Retrieved from http://www.wou.edu/~mcgladm/Quantitative Methods/optional stuff/qualitative description.pdf

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. http://doi.org/10.1002/nur.20362

Sandelowski, M., & Sandelowski, M. (2000). Focus on Research Methods Whatever Happened to Qualitative Description? *Research in Nursing & Health*, *23*, 334–340. http://doi.org/10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g

Saunders, E. A. (1991). Rorschach indicators of chronic childhood sexual abuse in female borderline inpatients. *Bulletin of the Menninger Clinic*. JOUR.

Schimmenti, A., & Caretti, V. (2014). Linking the Overwhelming with the Unbearable: Developmental Trauma , Dissociation, and the Disconnected Self. *Psychoanalytic Psychology*.

Sharoff, F. M. (2011). Conceptualizing holism in international interdisciplinary critical perspective: Toward a framework for understanding holistic health. *Social Theory & Health*, *9*(3), 244–255. http://doi.org/10.1057/sth.2011.6

Sharoff, L. (2008). Exploring nurses' perceived benefits of utilizing holistic modalities for self and clients. *Holistic Nursing Practice*, *22*(1), 15–24. http://doi.org/10.1097/01.HNP.0000306324.49332.a4

Sharpe, D., & Faye, C. (2006). Non-epileptic seizures and child sexual abuse: a critical review of the literature. *Clinical Psychology Review*, *26*(8), 1020–1040. JOUR.

Shengold, L. (1989). *Soul Murder- The effects of Child Abuse and Deprivation*. New Haven, Conn: Yale University Press.

Shukla, G., Rai, P., & Ahmed, D. (2015). Comparative Efficacy of Homeopathy, Cognitive Behavior Therapy and Placebo on Depression. *International Journal of Pharmaceutical Sciences and Research*, *6*(3), 1302–1313. http://doi.org/10.13040/IJPSR.0975-8232.6(3).1302-13

Sieff, D. (2008). Unlocking the Secrets of the Wounded Psyche: Interview with Donald

Kalsched. *Psychological Perspectives: A Quarterly Journal of Jungian Thought*, *51*(2), 190–207.

Sigmon, S. T., Greene, M. P., Rohan, K. J., & Nichols, J. E. (1996). Coping and adjustment in male and female survivors of child sexual abuse. *Journal of Child Sexual Abuse*, *5*, 57−76.

Simpson, T. L., & Miller, W. R. (2002). Concomitance between childhood sexual and physical abuse and substance use problems: A review. *Clinical Psychology Review*, *22*, 27–77.

Sisters of Mercy. (2015). Our History. Retrieved April 29, 2015, from http://www.sistersofmercy.org/about-us/our-history/

Society of Rogerian Scholars. (2016). Retrieved from www.societyofrogerianscholars.org/theory.html

Spiegel, D., Loewnstein, R. J., Vermetten, E., & Dell, P. (2011). Dissociative disorders in DSM-5. *Depression and Anxiety*, *28*, 824–852.

Steel, J., Sanna, L., Hammond, B., Whipple, J., & Cross, H. (2004). Psychological sequelae of childhood sexual abuse: Abuse-related characteristics, coping strategies, and attributional style. *Child Abuse & Neglect*, *28*(7), 785–801. JOUR.

Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse : A pilot study of an intensive residential treatment program. *Journal of Trauma & Dissociation*, *24*(1), 102–106.

Sullivan-Bolyai, S., Bova, C., & Harper, D. (2010). Developing and refining interventions in persons with health disparities: the use of qualitative description. *Nursing Outlook*, *53*(3), 127–33. http://doi.org/10.1016/j.outlook.2005.03.005

Swannell, S., Martin, G., Page, A., Hasking, P., Hazell, P., Taylor, A., & Protani, M. (2012). Child maltreatment, subsequent non-suicidal self-injury and the mediating roles of

dissociation, alexithymia and self-blame. *Child Abuse & Neglect*, *36*(7–8), 572–84. http://doi.org/10.1016/j.chiabu.2012.05.005

The Four Winds Society. (2015a). Energy Medicine School-The Four Winds Society. Retrieved from http://thefourwinds.com/energy-medicine-training/

The Four Winds Society. (2015b). The Light Body School of Energy Medicine. Retrieved from http://thefourwinds.com/energy-medicine-training/beginning-journey/

The National Center for Victims of Crime. (2012). Child Sexual Abuse Statistics. Retrieved from http://www.victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics

The National Shrine of Staint Elizabeth Ann Seton. (2015). Civil War History at the Shrine. Retrieved from http://www.setonheritage.org/learn-and-explore/civil-war-history-shrine/

Thoits, P. A. (2010). Stress and health major findings and policy implications. *Journal of Health and Social Behavior*, *51*(1 suppl), S41–S53. JOUR.

Tindle, H. A., Davis, R. B., Phillips, R. S., & Eisenberg, D. M. (2005). Trends in use of complementary and alternative medicine by US adults: 1997-2002. *Alternative Therapies in Health and Medicine*, *11*(1), 42–49.

Townsend, C., & Rheingold, A. a. (2013). Estimating a Child Sexual Abuse Prevalence Rate for Practitioners: A Review of Child Sex Abuse Prevalence Studies, 1–28.

Ullman, S. E., & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse & Neglect*, *29*(7), 767–782. http://doi.org/10.1016/j.chiabu.2005.01.005

Ullman, S. E., Townsend, S. M., Filipas, H. H., & Starzynski, L. L. (2007). Structural Models of the Relations of Assault Severity, Social Support, Avoidance Coping, Self-blame, and

PTSD Among Sexual Assault Survivors. *Psychology of Women Quarterly*, *31*(1), 23–37. JOUR.

van der Hart, O., & Dorahy, M. (2005). Pierre Janet: The Pioneer on Trauma and Dissociation. Retrieved from http://estd.org

van der Hart, O., & Horst, R. (1989). The Dissociation Theory of Pierre Janet. *Journal of Traumatic Stress*, *2*(4), 1–11.

van der Kolk, B. McFarland, A. Weisaeth, L. (1996). *Traumatic Stress: The Effects of Overwhelming Experience on the Mind, Body and Society*. New York, NY: Guilford Press.

van der Kolk, Bessel, van der Hart, Onno, Marmar, C. R. (2007). Dissociation and Information Processing in Posttraumatic Stress Disorder. In L. van der Kolk, Bessel A., McFarlane, Alexander C.,, Weisaeth (Ed.), *Traumatic Stress The Effects of Overwhelming experience on the Mind, Body and Society* (pp. 303–331). New York: Guilford Press.

van der Kolk, B., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma. *Journal of Traumatic Stress*, *18*(5), 389–99.

Villoldo, A. (2005). *Mending the Past and Healing the Future with Soul Retrieval*. Carlsbad: Hay House Inc.

Villoldo, A. (2015a). Munay-Ki The Next Step in Evolution. Retrieved December 1, 2015, from http://munay-ki.org/rites-of-passage/

Villoldo, A. (2015b). What is a Shaman? Retrieved from http://albertovilloldophd.com/what-is-a-shaman/

VSee. (2015). A HIPAA-compliant way to Video Collaboration. Retrieved from www.vsee.com

Vuckovic, N. H., Williams, L. A., Schneider, J., Ramirez, M., & Gullion, C. M. (2012). Long-

term outcomes of shamanic treatment for temporomandibular joint disorders. *The Permanente Journal*, *16*(2), 28–35. Retrieved from http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3383158&tool=pmcentrez&rendertype=abstract

Walsh, R. (2007). *The World of Shamanism*. Woodbury: Llewellyn Publications.

Watson, J. (2008). *Nursing: The philosophy and science of caring*. Boulder: University Press.

Watson, J. (2010). Core Concepts of Jean Watson's Theory of Human Caring/Caring Science Watson Caring Science Institute. Retrieved from https://www.watsoncaringscience.org/files/Cohort 6/watsons-theory-of-human-caring-core-concepts-and-evolution-to-caritas-processes-handout.pdf

Watson, J. (2016). Watson Caring Science Institute. Retrieved from www.watsoncaringscience.org/jean-bio/caring-science-theory

Wheeler, K. (2014). *Psychotherapy for the advanced practice psychiatric nurse: A how to guide for evidenced-based practice* (2nd ed.). New York: Springer Publishing Co.

Williams, J. E. (2005). *The Andean codex: Adventures and initiations among the Peruvian Shaman*. Charlottesville: Hampton Roads Publishing.

Willis, D. G., DeSanto-Madeya, S., Ross, R., Sheehan, D. L., & Fawcett, J. (2015). Spiritual healing in the aftermath of childhood maltreatment: Translating men's lived experiences utilizing nursing conceptual models and theories. *Advances in Nursing Science*, *38*(3), 162–74.

Willis, D. G., Grace, P. J., & Roy, C. (2008). A Central Unifying Focus for the Discipline Facilitation Humanization, Meaning, Choice, Quality of Life and Healing in Living and Dying. *Advances in Nursing Science*, *31*(1), 28–40.

Wilsnack, S. C., Vogeltanz, N. D., Klassen, A. D., & Harris, T. R. (1997). Childhood sexual abuse and women's substance abuse: National survey findings. *Journal of Studies on Alcohol and Drugs*, *58*(3), 264. JOUR.

Wilson, B. (2013). Metaphysics and medical education: taking holism seriously. *Journal of Evaluation in Clinical Practice*, *19*(3), 478–84. http://doi.org/10.1111/jep.12043

Wilson, D. R. (2010). Health consequences of childhood sexual abuse. *Perspectives in Psychiatric Care*, *46*(1), 56–64. http://doi.org/10.1111/j.1744-6163.2009.00238.x

Wright, M. O., Crawford, E., & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding and meaning-making. *Journal of Family Violence*, *22*(7), 597–608. JOUR.

Wyatt, G. E., & Newcomb, M. D. (1990). Internal and external mediators of women's sexual abuse in childhood. *Journal of Consulting and Clinical Psychology*, *58*(6), 758. JOUR.

Yalom, V., & Yalom, M.-H. (2010). Peter Levine on Somatic Experiencing. Retrieved from https://www.psychotherapy.net/interview/interview-peter-levine

Zielinski, D. S. (2009). Child maltreatment and adult socioeconomic well-being. *Child Abuse & Neglect*, *33*(10), 666–78. http://doi.org/10.1016/j.chiabu.2009.09.001

Martha W. Healey, FNP
Boston College
William F. Connell School of Nursing
Dissertation Interview Guide

Content	Research Questions	Interview Questions with Probes
Introduction		This interview is divided into six sections in which I will ask a variety of questions related to specific topics. The topics will include questions that will help me understand your path towards shamanic healing and your current shamanic practice. We will talk about your perspectives on healing and trauma, the affect trauma has on individuals, issues with fragmentation/soul loss, especially related to adult CSA survivors. We will discuss your methods of assessment, treatment, and evaluation of your clients, for example, how you determine the problem, decide what treatment method to use and how you know if the treatment was helpful. Finally, we will focus on your perspectives regarding the use shamanic healing techniques like soul journeying and soul retrieval for the treatment of fragmentation/soul loss for adult survivors of CSA. **Please avoid using any information throughout our discussion that may identify any of your clients.**
Opening Questions		To begin, please tell me a little about what you did before you started your shamanic practice. What was your initial introduction to shamanism? What encouraged you to seek training in shamanic healing? What was the training like and how long did it take you to complete it? Would you describe how you established your shamanic healing practice? Where do you meet with people do you have an office or do you travel to your clients homes? Do create a specific environment for the healing sessions and if so what is that like? What, if any equipment do you use or need to conduct the healing session? Do you conduct distant healing, if so would you provide a brief explanation of that for me? Do you incorporate shamanic healing into your conventional western healing practice? (If the participant was in a healing profession before starting shamanic healing) Do you practice any other complementary health approaches? (reiki, acupuncture, massage, healing touch)

Martha W. Healey, FNP
Boston College
William F. Connell School of Nursing
Dissertation Interview Guide

Perspectives on Healing	What are the shamanic practitioners' perspectives on the nature of healing and the role of shamanism in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/soul loss?	This section will address questions related to trauma and healing as it applies to the adult survivor of CSA. I am interested in your perspective of both the conventional biomedical treatment model and shamanic healing.
		What is your understanding of trauma and what affect does it have on health and wellbeing from the perspective of shamanism?
		How does trauma related to CSA impact a person's health and wellbeing... what happens following the trauma?
		How do you define healing from the perspective of the conventional biomedical model?
		How do you define shamanic healing?
		Generally, in what ways are the convention biomedical model and shamanic healing similar?
		In what ways do you view them differently? Different in general and specifically in regards to the treatment of trauma?
		Now that we have discussed healing in general from in terms of both both conventional medical and shamanic healing, can you tell me your thoughts about how they might be similar or different regarding healing after trauma.
		How does shamanic healing facilitate wellbeing following trauma related to CSA?
		How does shamanic healing help individuals with a sense of soul loss return to a sense of integration and wellness?

Martha W. Healey, FNP
Boston College
William F. Connell School of Nursing
Dissertation Interview Guide

Assessment	What are the shamanic practitioners' perspectives on the nature of healing and the role of shamanism in facilitating healing and integration for the adult CSA survivor who experiences sense of fragmentation/soul loss?	I would like to move onto the next section and learn how you, as a shamanic practitioner, asses your clients for soul loss and CSA before your begin the healing session.
		Would you describe how you assess your clients when they come to you?
		What shamanic skills or tools are use to assist with the assessment?
		How do you know if a client is an adult survivor of CSA?
		How do you determine if there is an issue with soul loss?
		Are there common attributes associated with soul loss, if so what are they?
Shamanic Healing Techniques	What are the perspectives of shamanic practitioners regarding the use of specific shamanic healing techniques including soul journeying and soul retrieval for issues related to sense fragmentation/soul loss, to facilitate	Lets move on to the next section of questions, here we will discuss the shamanic healing techniques, methods, modalities used to treat soul loss. This will be followed by questions related to the evaluation of shamanic healing intervention.
		Would you describe the different shamanic healing techniques/modalities (such as soul journeying and soul retrieval or others) that you use to facilitate healing and integration when treating individuals experiencing soul loss as a result of CSA?
		When journeying, do you always discover the lost soul part?
		How does the shaman determine if the lost soul part wants to or is ready to return?
		What happens if the soul part is not ready or does not want to return?

	healing and integration?	Would you describe how is a lost soul part(s) reintegrated? Can you provide a case study or vignette illustrates this type of shamanic healing?
Evaluation of Shamanic Healing	What are the methods shamanic practitioners use to evaluate healing in relation to sense of fragmentation/soul loss and improvement in sense of healing and integration for adult CSA survivors?	How do you evaluate healing and integration following soul journeying, soul retrieval, or other shamanic healing techniques/modalities? What attributes do you notice in your clients following the reintegration of a lost soul part(s)? Are there noticeable changes in affect, demeanor, confidence...? Do the changes generally happen right away or is it a process over time? How often does an individual need to be treated? How do you determine if more than one treatment is needed?
Perspectives on shamanic healing as a method to facilitate healing and integration for Adult CSA survivors	What are the effects of shamanic healing on the sense of fragmentation/soul loss as perceived by the shamanic practitioner based on their evaluations of adult CSA survivors healing from fragmentation/soul loss in their practices?	Based on your shamanic practice, what is your perspective regarding the use of shamanic healing techniques/modalities to facilitate healing and integration for adult survivors of CSA with a sense of soul loss? Do you notice a difference in the client and if so what is it you notice? How does shamanic healing impact integration and a sense of wholeness? Regarding the impact of integration and the sense of wholeness, is the integration related to the client as an individual or does it extend from the individual to include a greater sense of oneness with the community, nature, and the comos?

Conclusion		Is there anything else you would like to add about shamanic healing, soul journeying, soul retrieval or other shamanic techniques/modalities used to facilitate healing and integration among adult survivors of CSA?
		Do you have any other closing comments?
		Thank you very much for your time and all of the information you provided and for all that you have contributed to this research.

Appendix B. Demographic Survey

1. Please indicate your gender

   Female

   Male

2. Please select the category that includes your age

   18-24

   25-34

   35-44

   45-54

   55-64

   65 or Above

3. What describes your marital status

   Single, not married

   Married

   Living with partner

   Separated

   Divorced

   Widowed

   Prefer not to answer

4. What best describes your level of education

   Some high school

   High school graduate or equivalent

   Trade or Vocational degree

   Some college

   Associate degree

   Bachelor's degree

   Graduate or Professional degree

   Doctoral degree

Prefer not to answer

5. What best describes your ethnicity

Hispanic/Latino

Non-Hispanic/Latino

6. What best describes your race

American Indian/Alaska Native

Asian

Black/African American

Native Hawaiian /Pacific Islander

White

7. How many years have you been practicing Shamanic Healing

8. What other types of healing modalities do you use in your healing practice

Acupuncture

Massage

Reiki

Healing Touch

Other