Intentionality: Evolutionary Development in Healing

A Grounded Theory Study for Holistic Nursing

Rothlyn P. Zahourek, Ph.D., A.P.R.N., B.C., A.H.N.-B.C
Amherst, MA

Although intentionality has been implicated as a causal variable in healing research, its definition has been inconsistent and vague. The objective of this grounded theory study is to develop a substantive theory of intentionality in a naturalistic encounter between nurse-healers and their healee-clients, and to consider the implications for practice and research. Six expert nurse-healers and six healee-clients were interviewed as individuals and in dyads before and after treatments. Interviews and observational data were analyzed using the constant comparative method and synthesized analysis. Participants described their experience of intentionality in healing as an evolutionary process characterized by distinctive shifts. The theory of intentionality: the matrix for healing (IMH) includes definitions of intentionality and a conceptual framework of three developmental phases of intentionality (generic, healing, and transforming intentionalities).The predominant attribute, development, is described. The theory contributes to knowledge about healing and intentionality and has implications for practice and future research.

Keywords: *intentionality; healing; holistic nursing; grounded theory; evolutionary development*

Intentionality, called the "crown jewel of healing" (Fahrion, 1997, p. ii), has been viewed in the healing literature as essential for healing (Benor, 1996; Epstein, 1996; May, 1969). According to Krieger (1997),

---

AUTHOR'S NOTE: This study was done as a doctoral dissertation at New York University, School of Education, Division of Nursing, and was partially supported by grants from NYU Division of Nursing, The Massachusetts Nurse's Foundation, and Beta Zeta Chapter of Sigma Theta Tau. I would like to acknowledge the guidance of Dr. Carla Mariano in conducting the study.

JOURNAL OF HOLISTIC NURSING, Vol. 23 No. 1, March 2005 89-109
DOI: 10.1177/0898010104272026

the energetic impact of Therapeutic Touch (TT) depends on the therapist's intentionality and not on the characteristic hand movements. Usually associated with a healer's influence, intentionality is described as "focused attention" or "mental projection of awareness, with purpose and efficacy, toward some object or outcome, such as promoting change in one's self or another" (Braud & Schlitz, 1991, p. 31). Intentionality influences attitudes, behavior, interpersonal relationships, motives, motivation, and actions (Jonas & Chez, 2003; Jonas & Crawford, 2003; Schlitz & Braud, 1997). Some theorists question not only the role of intentionality on mind-body-spirit health but also whether it can be understood through linear, Western scientific paradigms (Dienstfrey, 1996a, 1996b). Others contend that intentionality should be conceptualized from a less causal, and more noetic, transpersonal view in which consciousness and intentionality work together in the "energetic field of emerging possibilities" (Watson, 2002, p. 14). Dossey (2002) understood it as a nonlocal phenomenon that is neither causal nor bounded in time or space. Within this nonlocal framework, intentionality is considered fundamental in the universe (Berry & Swimne, 1992), related to consciousness (Jacob, 1997; Seager, 1999; Searle, 1995, 1999; Watson, 1999), and involved in a caring, loving, and growth-enhancing transpersonal processes (Laskow, 1992; May, 1969). In healing, intentionality is one person's influence on another in a transformative encounter (Pilkington, 2000).

Selected Review of Literature

Classical and contemporary philosophers debated the nature of intentionality but consistently present it as greater than and different from intent, or a purposeful mental act (May, 1969; Searle, 1995). As a mental process (thinking about; Searle, 1995), intentionality is related to the essence of consciousness (Heidigger, 1926/1962; Merleau-Ponty, 1945/1995) and, according to existential philosopher and psychoanalyst Rollo May (1969), is fundamental to consciousness and the capacity for, or the quality of, intent and intentions. "It is our imaginative participation . . . out of which comes the awareness of our capacity to form, to mold, to change ourselves . . . in relation to each other. . . . Intentionality is at the heart of consciousness" (May, 1969, p. 223). This philosophical definition was helpful in the later construction of the theory presented in this article.

Some scholars contended that intentionality differs from philosophical conceptualizations when considering healing and mind-body interventions (Priest, 1991; Quinn, 1996). Some viewed intentionality as more similar to intent and, therefore, a causal link. It has been a minimally defined independent variable in several quantitative studies investigating such effects as distant as prayer on healing (Byrd, 1988; Dossey, 1993, 1996a, 1996b, 1997; Dusek, Astin, Hibberd, & Krukoff, 2003), mental imagery on cell growth and death (Braud & Schlitz, 1991; Schlitz & Braud, 1997), changing the pH of water (Laskow, 1992), and mental concentration on distant random computer-number generators (Radin, 1997). This research implies that intentionality is some sort of measurable mental process, focused attention, or plan of action that creates a clear outcome.

Such linear experiments have less relevance to the nonlinear and subjective experience of healing. Heidt (1990), in her qualitative study of Therapeutic Touch, identified *opening intent* as important for healer and healee at the start of the treatment. This entailed a quieting of mind, body, and emotions, affirming wholeness and unity of universal life energy, and intending to get that energy moving. No specific qualitative studies were found looking at the experience of intentionality in healing.

Recently intentionality has been described more fully. Schlitz et al. (2003) defined it as "an attribute of consciousness and willful action, while intention is a mental state associated with subjective response" (p. A32). A healer is considered intentional if she or he desires an outcome, believes that her or his actions would lead to an outcome, wants to perform the action, and is aware of fulfilling the intention while performing the action (Schlitz et al., 2003, p. A32). This description continues to focus on the healer. One aim of this grounded theory study was to understand the experiences of healers and healees. In this article, I propose a theory—intentionality: the matrix for healing—and present its predominant attribute, the development of three forms of intentionality.

Specific Aims of the Study

The goal of the current study was to examine intentionality in healing and develop a new theory. Such a theoretical basis would enrich and enlarge our capacity to practice, educate about, and research

intentionality in healing. This researcher accepts what many state in the literature, that intentionality is a capacity greater than intent and as such is important, if not essential, for healing. The specific research questions addressed in this article are:

Research Question 1: What is the nature of intentionality in healing?
Research Question 2: How do healers and healees who are engaged in healing experience, demonstrate, explain, and understand intentionality?

Design and Setting

The researcher adopted the qualitative approach of flexible theoretical purposive sampling, and an emergent design based on the questions generated in early data collection. Within such a design, participant characteristics, types of data, and data collection sites vary. In grounded theory research, detailed descriptions of peoples' experiences and their verbal and nonverbal behaviors in their social settings are logged, coded, and inductively analyzed (Lincoln & Guba, 1985; Patton, 1990). Analyses of participants' interactions include (a) self-definitions, (b) demonstrated shared meanings of experience, (c) patterns of interactions and their consequences, and (d) "symbolic meanings transmitted via actions" (Chenitz & Swanson, 1986, p. 6).

The beauty of qualitative research is its "interactive, holistic, flexible, dynamic and evolving" nature (Mariano, 1990, p. 354). The grounded theory method, based on symbolic interactionism philosophy, posits human beings derive meaning from interactive experience and their symbolic interpretation of those experiences (Blumer, 1969). Its purpose is to generate explanatory models of human psychosocial processes that are grounded in data (Morse & Field, 1995). The methodology uses detailed experiential data that is categorized in a hierarchical and recursive process (Morse & Field, 1995). As patterns emerge, theories are derived to understand peoples' complex holistic experiences and problems. This researcher assumed that individuals seek healing and become healers for multiple reasons and that, although diverse, these motivations could be identified. The current study was limited to understanding intentionality in a dyadic relationship between a client-healee and an expert nurse-healer.

Participants

The current study included a total of 12 individuals. Five nurse-healers engaged in treatment with five client-healees (10) formed five dyads. One unpaired nurse-healer and one client-healee (2) were added to the sample because each had unique and demonstrable experiences that the researcher felt would enrich the data. The additional healer practiced a set of modalities not previously included in the sample (reflexology and relaxation), and the healee was articulate about her healing process from advanced breast cancer. All participants were White women, ranging in age from 23 to 64 years; mean age 46.6 years. All were from middle-class backgrounds and lived in urban and semirural communities in the northeastern United States. Expert nurse-healers were sought because it was assumed they would be articulate about their experiences and more likely to demonstrate clear behaviors while engaged in healing modalities with their clients. These nurses were considered so-called experts because they averaged 27 years of nursing experience and 20 years experience with their chosen healing modality; all had certification and/or advanced degrees in nursing and their field of specialization. Healers practiced Therapeutic Touch, Reiki, imagery, Ericksonian hypnosis, and Amma therapy. Four healers had extensive treatment experience with their clients; one healer-healee dyad began their work as part of their participation in the study. Four of the six healees had major chronic illnesses (fibromyalgia, chronic pain, multiple sclerosis, Crohn's disease, scleraderma, advanced breast cancer); two were not ill but used the healing relationship for stress management. The study met criteria for Human Subjects Protection by New York University and for any institution where a nurse-healer was employed. Participants were assured of confidentiality; they would be referred to by pseudonyms in any written material, and their written consent was obtained.

Procedure

Prior to data collection, the researcher logged her assumptions and beliefs about healing and intentionality. Memos regarding her personal reactions and evolving conceptual beliefs were kept throughout the research process.

The researcher conducted pretreatment and posttreatment interviews with the nurse-healers and their client-healees and observed treatments. The goal was to observe two treatments for each dyad to allow participants to develop their ideas over time and to observe any marked differences in the treatment process. The researcher interviewed healers and healees individually as well as together a minimum of one pretreatment and one posttreatment interview. In the first semistructured individual interview participants were asked to share how they became a nurse-healer or determined their need for healing, and then what they believed about, and how they experienced, healing and intentionality. The pretreatment dyadic interview focused on what each expected or wanted to accomplish from the treatment experience. The treatment was observed and videotaped. The dyadic postinterview was less structured, eliciting the participants' thoughts and feelings about the treatment, and if, and how, intentionality played a role in their healing process. How did this treatment experience relate to their healing? How, and did, their experience of intentionality manifest in the treatment? Within 3 weeks after the treatment, individual postinterviews were conducted using the same semistructured format. These interviews were usually in person but sometimes for the participant's convenience conducted over the telephone.

Interviews were audiotaped and transcribed; treatments were videotaped. After each treatment, the researcher wrote field notes and then a memo, in which she summarized and conceptualized the experience of interviewing and observing the treatment. Early in the study, a structured observational tool was applied to guide observation of nonverbal behavior. This was abandoned because the tool focused on such specific behaviors that the gestalt of the treatment was lost. The goal of the research was to learn about and describe how the interactive process of healing and intentionality was experienced and evident. Conceptual memos were, therefore, more useful than the observational guide in the discovery process. The researcher viewed each videotape at least twice and wrote memos after each viewing.

In postindividual interviews, participants were invited to view all, or parts of, their videotape. This allowed participants to explain what they were feeling and thinking during the treatments which were largely nonverbal. Two treatments were observed for three dyads. For one dyad, three treatments were observed. This dyad was unusual because the healer and healee were colleagues who, at times, reversed roles and treated each other. This reflected the nature of their

relationship; they helped each other with stress management and promoted each other's learning and skill. The additional data from this dyad enhanced the process of obtaining saturation in analysis. For two dyads, only one treatment could be observed because one healee moved out of the area and another healee died. At the conclusion of the treatment episodes, a summary of the dyad's interactions was given to each participant to critique; an additional interview was conducted, usually over the telephone, to clarify any researcher misconceptions and allow participants to add to or modify how the researcher described them and their experience. A summary of an early version of the final theory was also sent to each participant and their reactions solicited. The nonpaired nurse-healer and client-healee completed two individual interviews and then critiqued the researcher's written summary of their views and the proposed theory. A total of 100 data sets were analyzed; these included transcribed interviews and logged observations of treatments and participant reactions to summaries. The researcher continuously wrote memos in which she asked theoretical and methodological questions, evaluated her reactions, and speculated about evolving themes. Constructing process and conceptual diagrams enhanced the theory building process.

Analysis

Grounded theory methodology utilizes the constant comparative method to analyze interview and observational data (Strauss & Corbin, 1998). All sets of data were compared with one another over time. This researcher chose a synthesized approach advocated by Eaves (2001) who combined ideas from Charmaz (1983), Glaser (1992), and Strauss and Corbin (1990, 1998). This method utilizes line-by-line coding in which the researcher underlines key terms in transcripts, finds clusters, reduces these into categories, links categories, defines a core category, and identifies a basic social psychological problem (BSPP) and then a basic social process (BSP). Strauss and Corbin (1998) described these larger categories as the "concepts that stand for phenomena"; these become the "building blocks" (p. 101) for the emerging theory.

The audiotaped interviews were transcribed, ideas underlined, and the initial open, and, later, axial codes named. Data were coded on paper and again in the computer program QSR*NUDist (Richards & Richards, 1995) that was used to store and sort the data. The theory

(constructed from the core category) was built on how the participants' described their experiences of intentionality in healing, what was observed in the treatments, and relating the themes derived from the categories. The participants' stories about their life experiences yielded more valuable data than data derived from such specific questions as "What do you think intentionality is in healing?" The patterns identified included definitions, attributes of intentionality in the context of healing, a developmental process and mediators, or influencing factors, for that process. Finally, concepts from the literature were integrated in the writing of the theory.

Rigor

Several procedures insure rigor and trustworthiness (credibility, dependability, confirmability, and transferability; Guba & Lincoln, 1981). Credibility or plausibility (Mariano, 1995, p. 487) is ensured through triangulation, which, in the current study, was accomplished through multiple sources of data collection (interview, observation, summary critiques). To ensure dependability and confirmability, all participants critiqued a summary of their experience and the proposed theory to determine if it "rang true" (member check). To enhance dependability and credibility, all data were collected over time (preinterviews and postinterviews of sequential treatments) so each participant had the opportunity to enlarge, and/or refine, her descriptions. To decrease researcher bias, eight experienced nurse practitioners and researchers participated in peer debriefing with the researcher (Lincoln & Guba, 1985, p. 3). Interview questions, coding schemes, and interpretations of data and evolving theory were all critiqued. Finally, an expert holistic nurse and qualitative researcher audited sample transcripts, coding schemes, sample memos, and the proposed theory to validate the researcher's logical process in deriving the theory. This, again, supported confirmability, dependability, and transferability.

Findings

Data analysis yielded the following concepts that were surprisingly similar for healer and healee: (a) The BSPP identified was a sense of lost wholeness and integrity and a need to find balance, meaning, and new or restored wholeness; (b) the BSP entailed a series

of overlapping recursive phases of a developing intentionality and the parallel process of healing; (c) the core category discovered in the data analysis was awareness of shift; this was later expanded to dynamic evolving perception of shift; (d) attributes of intentionality were described as three forms or phases (generic, healing, and transforming intentionality); (e) each phase was characterized by three additional attributes (development, dimension, direction); (f) mediators included stress and need, life experiences, association with mentors, access to learning, and willingness to search. The following describes selected aspects of the theory: the definition for intentionality in healing, the forms, and the process of evolution that characterizes the forms.

Intentionality Described

When first interviewed, participants equated intentionality with a dictionary definition of intention (i.e., mental focus, motivation, and purpose). In subsequent interviews, their descriptions became more abstract and complex. One TT healer experienced intentionality in healing as "encompassing many things. Your beliefs . . . what *calls to your heart* . . . Being clear with yourself why you're doing something and what motivates you." A healee who suffered with fibromyalgia described intentionality as diverse and dependent on cultural and religious values and beliefs. It reflects one's intuition and self-view; it evolves and is "sharpened through consciousness and awareness . . . and being in that moment." Another healee (with chronic pain and multiple sclerosis) captured the voices of the majority of healers and healees in describing four aspects of intentionality that she related to her healing: First, the experience of need affects the expression of intentionality. "Intentionality is more clear when you put your attention on it. Faced with stress or crisis, intentionality has to become focused and directionalized. You also have to want something to happen." Second, intentionality is related to thought and action. She stated,

> Intention is an inkling of a thought and intentionality is the molding of the thought into a plan . . . that sense of right before an action . . . You have some push. . . . If you don't have intention, you're not going to get off your ass and do anything; nothing will happen. . . . Intentionality is the manifestation of the person's plan; it's the energy and the spark that transforms the plan to action.

Third, intentionality is multifaceted and paradoxical.

> Intentionality is both broad and unfocused and focused and specific . . . it's all encompassing in your life. It is truly the dynamic of the universe . . . it's innate and like your personality; it's fundamentally a piece of us . . . it's very focused. I'm learning that you have to be specific and focused to live intentionally. You have to sit down . . . and decide what do I want to have manifest?

Finally, faith in the greater good is the desired focus for intentionality in healing: "[You] need to be in the driver's seat [but] faith and letting it flow is [also] important in intentionality and healing."

A TT practitioner expressed many participants' thoughts when she explained, "Intentionality is like the cursor on a computer screen. It is directed and points the way and the place, but it occurs within a whole process." The cursor (intentionality) is always running in the background whether observed or not; the operation of the computer (healing) depends on where the cursor points. She also described that intentionality in healing consists of several factors:

> Being motivated or being aware of the benefits and disadvantages of an action; instinct, which is a hard wired biological organization, the purpose of which is maintenance or restoration of integrity for the organism; purpose, which is desired outcome and similar to goals and objectives; desire which is a strong attraction for something; need which is something the organism's integrity depends on; perception which is sensory awareness, and appreciation which is an awareness of sensory information and, finally, meaning which is the attribution of significance of an experience or object.

As participants tried to communicate what intentionality was like for them, they described their lives and their relationships. Healers and healees experienced a time of crisis in how they viewed themselves and the world. All experienced a process of finding a new sense of meaning and purpose in their lives as they progressed in their healing and development of intentionality. They related their changes in intentionality to healing itself and equated this awareness of these changes with intentionality. The above qualities were incorporated into the theory as follows: First, intentionality is the person's basic capacity to be aware of and to differentiate his or her beliefs, perceptions, and knowledge. Second, intentionality is the person's evolving capacity to integrate these factors into new views of self and reality and, subsequently, into new behaviors. Intentionality is an integral

body-mind-spirit capacity of, and potential for, people to shift their perceptions of reality, engage purposefully in the world, and to grow as a result. Intentionality evolves in concert with a person's awareness of integration of experience and his or her subsequent changing perceptions of self and the world. It manifests not only in actions but also in how a person makes meaning of experiences. Intentionality, therefore, is inherent in, and essential for, the experience of healing. It holds and molds healing and is, therefore, the matrix of healing.

The theory, intentionality: the matrix of healing, delineates three propositions: (a) Several human characteristics and qualities characterize intentionality, (b) Intentionality is a fundamental evolving human capacity that molds the perception of the transformational process of shifts known as healing, and (c) Healing, the perception and experience of shift, does not occur without intentionality, but intentionality exists without healing. A matrix molds, shapes, and forms. Intentionality shapes the process of healing. The remainder of this article focuses on two interwoven conceptual frameworks that those propositions and became the basis for the theory. First, participants described three forms of intentionality that came to be called generic (GI), healing (HI), and transforming (TI) intentionality. Second, these forms are phases that evolve in a spiral, rather than linear, manner. The phases are not rigidly discreet but overlap. Finally, as intentionality evolves in healing it begins to resemble healing itself.

Forms or Phases of Intentionality

Generic intentionality (GI). Participants agreed with philosophers that all human beings have an inherent intentionality or the capacity to think, to perceive, to purposefully direct one's thoughts, feelings, and consciousness, and the ability to make choices, and initiate action. As a capacity and a quality, GI reflects the person's nature, temperament, personality, and talents. Primitive and malleable, it evolves as the person lives life. One healee was exemplar in describing GI: "[Intentionality] is fundamental . . . equivalent to your makeup . . . it's [also] a projection of what you want life to be. It's like you have your fundamental characteristics . . . your personality . . . those things that make you who you are."

Healers described a personal process in which intention and intentionality were basic, and essential, to their becoming healers. A

nurse-midwife and practitioner of Reiki and TT explained that she always knew she had a gift for helping people. Healers and healees described themselves as having caregiving, self-sacrificing temperaments (GI).

Healing intentionality (HI). This second form is characterized by learning and skill building, which in healing occurs in response to need. Healers and healees reacted to a sense of threatened, or real, loss of wholeness by actively learning modalities to restore balance and quality of life. In HI, conscious attention is purposefully focused and directed, and a high degree of effort is extended in skill building. Most learned they had to work at their healing by attending to themselves rather than selflessly devoting themselves to others. For healers and healees, their shift to self-care was aided by working with a holistic practitioner. They learned the value of daily meditation and relaxation exercises; many changed diets and modified physical activities. In HI, people focused on what promoted their unique healing and made their lives meaningful.

Transforming intentionality (TI). As healers and healees evolved to TI they experienced significant emotional and spiritual unrest. Their self-view and beliefs about the nature of the cosmos changed. They developed a serene philosophical worldview, and felt connected to a greater whole that they viewed as a positive and purposefully directed universe. They learned they had to let go of former negative attachments to people, places, and things. They solidified their belief in mind-body-spirit integration and became skilled with holistic coping mechanisms for stress. Trusting intuition and appreciating the balance of duality, complexity, and unpredictability in life, they recognized the paradox of needing to relinquish control of outcome and accepting the responsibility to be active in their own growth and healing. Healers and healees accepted and appreciated that opposites exist; however, paradoxically, they also viewed the world as many hues blending to make a unique, and ever evolving, patterned whole. Participants described their transition to TI as similar to healing and/or becoming a healer. Suffering was recognized as purposeful and as having meaning. Desire for specific outcomes in their process had to be relinquished; and, within that context, they trusted in a greater power and intended for a greater good rather than a specific result. Healing and TI were viewed as continuous processes with no predictable or defined end. The two processes seemed to merge.

Three healees described the recognition of their shifts as transformative and this awareness of change and heralded a new state of being—a different form of intentionality. One healee related intentionality to her awareness of commitment to being on a "healing journey." Although acknowledging her terminal illness, she explained,

> I believe the major factor of my survival . . . is my intent to do and be the best I can. I believe I have a purpose and a passion and by allowing whatever is needed to take place, it will take place. If my intent came from a place of needing the control, I would miss the endless possibilities available to me.

The Evolution of the Forms

In the theory, development is the most predominant attribute of intentionality in healing and refers to a person's growth through a series of shifts. According to participants, the process could be compared with the progression of novice to expert (Benner, 1984), or to an evolutionary process of differentiation and integration (Gould & Eldridge, 1977). Participants described that intentionality evolved during their lifetime. Figure 1 describes the overall process of healers and healees progressing through a series of phases from a basic sense of wholeness in GI through a phase of learning and work (HI) to a restored, or new wholeness in TI. In healing, this process begins with a sense of actual, or threatened, fragmentation and a subsequent recognition of the need to restore the experience of wholeness. Need provides the energy to start the process.

Healers and healees compared. Although qualitative differences were evident for healers and healees, the overall process was surprisingly the same. For example, healees demonstrated greater motivation to engage in healing because of their illness discomfort and their desire for survival and an increased quality of life and comfort. Healees emphasized that, "you don't heal unless you need to heal—it doesn't happen in a vacuum; if you're not aware of that need, you won't heal." Three healees who had suffered for many years with chronic, painful illnesses sought alternative and complementary practitioners because their experiences with conventional medical approaches had not helped, or worsened, their conditions. They felt their spiritual and emotional needs were also not met. Four healees who had major chronic illnesses spent months and years searching for solutions to

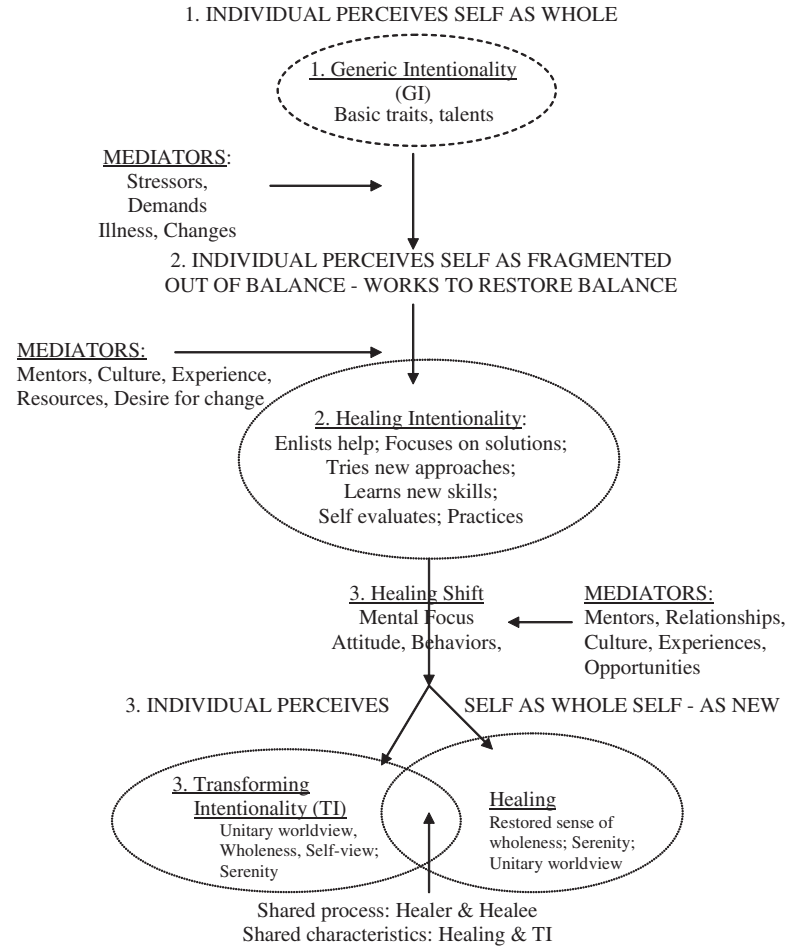

Figure 1: Intentionality: The Matrix of Healing: Basic Developmental Process

their problems. Suffering through what they called the 'dark night of the soul,' they had to reevaluate their lives and decide how to expend their limited energies. These women became introspective and recognized that they had to make major changes in their lifestyles and relationships. They reevaluated their purpose in "this life, and on this planet" and experienced a "shift." They let go of trying to care for and control others and set limits on demands that others made on them.

As a result, they became more serene and accepting of needing to change in terms of living with their conditions. They were active in their self-care practices. All experienced increased periods of pain relief, remission of symptoms, increased energy, a renewed sense of purpose, and an enhanced quality of life.

Healers were motivated by dissatisfaction in their work environments and a strong desire to fulfill a commitment they made to themselves to be the best nurse possible. Several healers described their development as progressing from a childhood idealistic need to help others to their decision to become a nurse. When they felt they could not practice therapeutically and holistically, they suffered a crisis in professional identity. They discovered integrative energetic modalities and sought an environment that supported those approaches. These approaches required self-reflection and development, which they knew enhanced their capacity to help others and to grow themselves. One healer described how as a child she nursed injured birds, as an adolescent cared for parents who were ill, and then became a nurse. Following an injury, she defied a medical prognosis of paralysis and chronic pain by using massage, imagery, meditation, and biofeedback. She worked in a general hospital and often felt dissatisfied; she believed that the health care system thwarted her ability to holistically care for others. Open to change and committed to her own healing and the healing of others, she began studying TT, Reiki, and Healing Touch. She viewed this learning as a transitional phase in her developing intentionality.

> There was a time when I was exposed to TT and decided to pursue it . . . had I turned my attention away at that moment I would have not been given any more experiences in that direction . . . intention was set way back (in my life). As long as you keep your mind open it comes to you . . . once you get into that moment, that intentional piece where you say "Ok, I'm open to this" then you open up a new flood gate . . . new experiences come to you. . . . We have many choices depending on what we open ourselves to.

Mediators. Participants described influencing factors in their development including learning to change their conscious focus, altering their level of consciousness, evaluating life experiences, and utilizing mentors and teachers. Healers and healees learned they had to shift their focus to themselves to heal. Altering their usual level of consciousness through centering and meditation aided that process. Their intentionality enhanced their understanding of previous and

coexisting life experiences, including trauma and loss. They appreciated mentors and role models and recognized that their culture and religious backgrounds played a role in how they developed intentionality. The opportunity for supportive change and education about healing and complementary modalities also influenced their development.

Blending Phenomena

As the earlier phases of intentionality evolved to TI, participants described a reciprocal and mutual relationship—healer and healee benefited. Full appreciation of this mutual process became a hallmark of TI. Participants emphasized that each individual is healer and healee: "As I heal, I am healed" and "As I am healed, I become more capable of helping others." In TI, healers experienced a sense of fulfilled purpose, and healees felt less preoccupied with their illness and, therefore, able to reach out and help others.

As data were analyzed, it became apparent that the phenomenon called TI resembled how participants described healing. Participants experienced the following sensations that were similar to healing and to transforming intentionality: connection with others, oneness with the universe, a shift in the sense of self, and a new sense of meaning, wholeness, and completeness. In healing and TI, individuals were aware of an energetic reservoir within themselves that they could use for sustenance during difficult times. Figure 2 summarizes this overlap. In a holistic paradigm, all things in the universe are connected and intertwined in a unitary whole. Thus, the melding of the characteristics of healing and intentionality is not surprising. In the theory, healing continues to refer to a process and an outcome; intentionality continues to be the capacity to shape and make meaning of experience and to choose actions related to that experience.

Discussion

Limitations

The current study was limited to the population of female expert nurses and female healees from White, educated, middle-class backgrounds. Although some participants were first- and second-generation European immigrants, no participant represented any ethnic group of color. Similar studies need to be conducted with ethnic and

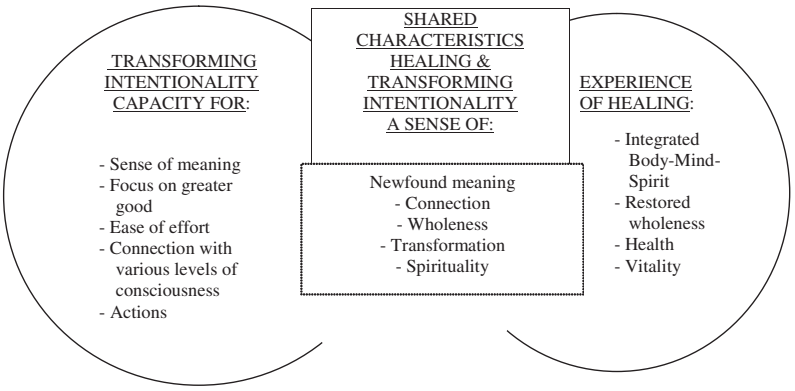

Figure 2: Shared Characteristics Intentionality and Healing

professional groups, other disciplines, and with men. Further study needs to also address novice caregivers. The evolutionary framework appeared comparable for healers and healees; however, that similarity needs to be explored in future populations that include other disciplines and healees with a variety of problems.

Conclusions

Because intentionality is essential for healing, its definition and conceptualization need to be clarified before it is measured. This theory expands the understanding of healing and intentionality by proposing a new definition of intentionality and a framework from which larger and more diversified data samples can be compared. Instruments and tools to measure or evaluate intentionality might be developed from the theory for future research. In addition to enhancing the knowledge base and providing a structure on which to do future research, this delineated theory of intentionality enhances our capacity to participate in healing. In practice, the theory is a framework for healers and healees to evaluate development of intentionality in their healing process and practice. Evaluating this process may provide markers on which individuals might focus attention. For example, a person feeling stuck in her or his career or in a painful phase of an illness might focus on a new approach to promoting

comfort or resolving a problem; this is actively and purposefully engaging in HI.

The process outlined in the theory supports healers' and healees' appreciating, and utilizing, stressors in their lives as potential motivators toward change and healing. How one learns and develops skills, utilizes various levels of consciousness, enlists the help of others, forms goals, and directs attention can all be learned and evaluated in terms of the theory.

Intentionality plays a key role in perceiving mind-body-spirit unity in healing. According to the theory, intentionality is more than purposeful thought and subsequent action. As the capacity for developing the quality and direction of one's intention, intentionality seems to profoundly affect a person's worldview, self-view, and relationships with others. On a larger scale, the theory has implications for how we interact with the systems in which we work as well as the world at large.

The theory expands the conceptual basis for understanding intentionality and healing. It provides a perspective that melds ideas from philosophy, psychology, and holistic-complementary science and practice. The theory supports what many contend, that intentionality plays an essential role in healing. In the past, intentionality was defined as a powerful, purposeful mental process and tested as a linear, causal phenomenon in studies in healing and mental influence. This qualitative grounded theory approach examined healers and healees in their naturalistic settings and used their words to develop a more comprehensive view of how intentionality manifests in healing.

Intentionality is a human capacity that is closely related to consciousness, to mental, emotional and spiritual representations, and to physiological responses and action. Two forms or phases of intentionality evolve from a generic intentionality (GI) in the context of healing: healing intentionality (HI) and transforming intentionality (TI). Development is the predominant attribute. The theory postulates that healing is contained in the larger whole (matrix) of intentionality. In the context of healing, intentionality evolves from a primitive reality-based drive for relief (GI→HI) to a highly specific and goal-directed phase focused on repair (HI). With additional learning and self-development, intentionality may then evolve to a transforming form (HI→TI). This process is evolutionary; it is characterized by spiraling, sudden progressions and regressions rather than an organized, linear progression. The final phase of developing intentionality, TI, and healing have similar characteristics: a new

experience of wholeness, connections and meaning in the universe. Even though the disease process or life difficulties continue, the individual feels changed. The perception of that transformative change (healing) is dependent on intentionality.

References

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

Benor, D. J. (1996). Intention: An experimental focus. *Advances: The Journal of Mind-Body Health*, *12*, 4-9.

Berry, T., & Swimne, B. (1992). *The universe story: From the flaring forth to the Ecozoic Era*. New York: HarperCollins.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice Hall.

Braud, W., & Schlitz, M. (1991). Conscious interactions with remote biological systems: Anomalous intentionality effects. *Subtle Energies*, *2*, 1-45.

Byrd, R. C. (1988). Positive therapeutic effects of intercessory prayer in a coronary care unit population. *Southern Medical Journal*, *81*, 826-829.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R. M. Emerson (Ed.), *Contemporary field research: A collection of readings* (pp. 109-126). Prospect Heights, IL: Waveland Press.

Chenitz, C., & Swanson, J. (1986). *From practice to grounded theory*. Menlo Park, CA: Addison-Wesley.

Dienstfrey, H. (Ed.). (1996a). Five questions on intentionality, science, and mind-body medicine [Special issue]. *Advances: The Journal of Mind-Body Health*, *12*, 3-39.

Dienstfrey, H. (Ed.). (1996b). One view of fourteen responses to five questions [Special issue]. *Advances: The Journal of Mind-Body Health*, *12*, 36-39.

Dossey, L. (1993). *Healing words: The power of prayer and the practice of medicine*. San Francisco: HarperCollins.

Dossey, L. (1996a). Distant intentionality: An idea whose time has come. *Advances: The Journal of Mind-Body Health*, *12*, 9-13.

Dossey, L. (1996b). *Prayer is good medicine*. San Francisco: HarperCollins.

Dossey, L. (1997). The forces of healing: Reflections on energy, consciousness, and the beef stroganoff principle. *Journal of Alternative Therapies in Health and Medicine*, *3*, 8-14.

Dossey, L. (2002). How healing happens: Exploring the nonlocal gap [Editorial]. *Alternative Therapies in Health and Medicine*, *8*, 12-16, 103-110.

Dusek J. A., Astin, J. A., Hibberd, P. L., & Krukoff, M. W. (2003). Healing prayer outcome studies: Consensus recommendations. In W. B. Jonas & R. A. Chez (Eds.), *Alternative Therapies in Health and Medicine: Definitions and Standards in Healing Research*, *9*, A44-A53.

Eaves, Y. D. (2001). A synthesis technique for grounded theory data analysis. *Journal Advanced Nursing*, *35*, 654-663.
Epstein, G. (1996). Mind-body medicine and biological medicine: An unbridgeable gap. *Advances: The Journal of Mind-Body Health*, *12*, 16-18.
Fahrion, S. L. (1997). Intention [Editorial]. *Subtle Energies*, *8*, i-iii.
Glaser, B. (1992). *Emergence vs. forcing: Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
Gould, S. J., & Eldridge, N. (1977). Punctuated equilibria. *Paleobiology*, *3*, 115-151.
Guba, E., & Lincoln, Y. (1981). *Effective evaluation*. San Francisco: Jossey-Bass.
Heidigger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). San Francisco: Harper. (Original work published 1926)
Heidt, P. R. (1990). Openness: A qualitative analysis of the nurses' and patients' experience of Therapeutic Touch. *Image: Journal of Nursing Scholarship*, *22*, 180-186.
Jacob, P. (1997). *What minds can do: Intentionality in a non-intentional world*. Cambridge, UK: Cambridge University Press.
Jonas, B., & Crawford, C. C. (Eds.). (2003). *Healing, intention, and energy medicine*. Philadelphia: Churchill Livingston.
Jonas, W. B., & Chez, R. A. (Eds.). (2003). *Alternative Therapies in Health and Medicine: Definitions and Standards in Healing Research*, *9*, A1-A104.
Krieger, D. (1997). *Therapeutic Touch: Inner workbook*. Santa Fe, NM: Bear & Co.
Laskow, L. (1992). *Healing with love: The art of holoenergetic healing*. Mill Valley, CA: Wholeness Press.
Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
Mariano, C. (1990). Qualitative research: Instructional strategies and curricular considerations. *Nursing and Health Care*, *11*, 354-359.
Mariano, C. (1995). The qualitative research process. In L. A. Talbot (Ed.). *Principles and practice of nursing research* (pp. 463-491). St. Louis, MO: Mosby Year Book.
May, R. (1969). *Love and will*. New York: Dell.
Merleau-Ponty, M. (1995). Phenomenology of perception (C. Smith, Trans.). London: Routledge. (Original work published 1945)
Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for the health professionals* (2nd ed.). Thousand Oaks, CA: Sage.
Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
Pilkington, B. F. (2000). A unitary view of persistence-change. *Nursing Science Quarterly*, *13*, 5-11.
Priest, S. (1991). *Theories of the mind*. New York: Houghton Mifflin.
Quinn, J. F. (1996). The intention to heal: Perspectives of a Therapeutic Touch practitioner and researcher. *Advances: The Journal of Mind-Body Health*, *12*, 26-29.

Radin, D. (1997). *The conscious universe: The scientific truth of psychic phenomenon*. San Francisco: Harper Edge.

Richards, T., & Richards, L. (1995). Using hierarchical categories in qualitative data analysis. In U. Kelle (Ed.), *Computer-aided qualitative data analysis: Theory, methods, and practice* (pp. 80-96). London: Sage.

Schlitz, M. J., & Braud, W. (1997). Distant intentionality and healing: Assessing the evidence. *Journal of Alternative Therapies in Health and Medicine*, *3*, 62-73.

Schlitz, M. J., Radin, D., Malle, B. F., Schmidt, S., Utts, J., & Yount, G. L. (2003). Distant healing intention: Definitions and evolving guidelines for laboratory studies. In W. B. Jonas & R. A. Chez (Eds.), *Alternative Therapies in Health and Medicine: Definitions and Standards in Healing Research*, *9*, A31-A43.

Seager, W. (1999). *Theories of consciousness: An introduction and assessment*. London: Redwood Books.

Searle, J. R. (1995). *Intentionality: An essay in the philosophy of mind*. Cambridge, UK: Cambridge University Press.

Searle, J. R. (1999). *Mind, language, and society: Philosophy in the real world*. New York: Basic Books.

Strauss, A., & Corbin, J. (1990). *The basics of qualitative research*. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). *The basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Newbury Park, CA: Sage.

Watson J. (1999). *Postmodern nursing and beyond*. London: Churchill Livingston.

Watson J. (2002). Intentionality and caring-healing consciousness: A practice of transpersonal nursing. *Holistic Nursing Practice*, *16*, 12-19.

Rothlyn P. Zahourek, Ph.D., A.P.R.N., B.C., A.H.N.-B.C., is a clinical nurse specialist in private psychotherapy practice in Amherst, Massachusetts. She is also an adjunct assistant clinical professor at the University of Massachusetts School of Nursing, Amherst. She is cochair of the Research Committee for the American Holistic Nurses' Association. She conducts workshops nationally and internationally on intentionality and healing, hypnosis and imagery, and substance abuse and dual diagnosis. Recent publications include "Trance and Suggestion: Timeless Interventions and Implications for Nurses in the New Millennium" in Holistic Nursing Practice *(2001) and "Ericksonian Hypnosis in Psychiatric Mental Health Nursing" in* Perspectives in Psychiatric Care: Journal for Advanced Practice Psychiatric Nurses *(2002).*