

It helps me to love my work

An Interpretative Phenomenological Analysis of the
Senior Therapist Experience of using
Energy Psychology In Psychotherapy for Trauma

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The thesis is submitted to the Quality and Qualifications Ireland (QQI) for the degree MA in
Counselling and Psychotherapy from Dublin Business School, School of Arts.

June 2014

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Table of Contents

Chapter 1: Introduction	7
1.1 Setting the Context	7
1.2 Aims and Objectives	8
Chapter 2: Literature Review	10
2.1 Overview of EP	10
2.1.1. An Uneasy Alliance between Ancient Wisdom and Western Psychology	11
2.1.2. Research on EP	13
2.2 Psychotherapy for Trauma	15
2.2.1. Research on Efficacy	15
2.2.2. A Humanistic and Integrative Context	18
2.3 The Lifespan Development of Therapists	19
2.4 Spiritual Practice and Psychotherapy	22
Chapter 3: Methodology	24
3.1 Overview	24
3.1 Rationale for a Qualitative Approach	24
3.1.1. Research Strategy: Interpretive Phenomenological Analysis	24
3.1.2. Semi-Structured Interviews	25
3.1.3. Reflexivity	25
3.2 Planning for Quality	25
3.2 Research Design	27
3.2.1. The Sample	27
3.2.2. Demographic Questionnaire	27
3.2.3. Pilot Interview	28
3.2.4. Data Collection	28
3.2.5. Secondary Research Questions	28
3.2.6. Data Analysis	28
3.2.7. Ethical Considerations	29
Chapter 4: Findings	31
4.1 Introduction	31
4.2 Transformation	32
4.3 Paradigm Shift	35
4.4 A State of Presence	39
4.5 Spiritual Realization	40
Chapter 5: Discussion	43
5.1 Introduction	43
5.2 Research on EP	43
5.3 Trauma	46
5.3.1. EP and Autonomic Dysregulation	46
5.3.2. A Common Factors Context	47
5.4 Presence	48
5.5 Transformation	51
5.6 Paradigm Shift	54
Chapter 6: Conclusion	58
6.1.1. Limitations	60
6.1.2. Strengths	60
6.1.3. Suggestions for Further Research	60
6.1.4. Implications for Clinical Practice	61
6.1.5. Implications for Training and Development of Psychotherapists	62

References	63
Appendix A. Glossary	78
Appendix B. Reflexive Statement	79
Appendix C. Participant Information Sheet	80
Appendix D. Email with Consent Statement	82
Appendix E. Demographic Questionnaire	83
Appendix F. Semi-Structured Interview	86
Appendix G. Secondary Research Questions	87
Appendix H. Sample from Transcript	88
Appendix I. Emergent Themes in Chronological Order	93
Appendix J. Themes Clustered by Category	94
Appendix K. Categories and Themes	97

List of Figures

Figure 1. Healing involvement vs. stressful involvement over lifetime span	21
Figure 2. Themes	32

List of Tables

Table 1. Comparison of TFT, EFT, and TAT	11
Table 2. Summary of currently theorized active mechanisms in EP	13
Table 3. Quality Plan	26
Table 4. Demographics of the participants	27
Table 5. Analysis of qualitative studies on therapists' experience of EP	44
Table 6. Non-specific factors that contribute to treatment of PTSD	48
Table 7. Active Mechanisms in EP, including findings from this study	59

Acknowledgements

I would like to thank the following people:

Siobáin O'Donnell, my thesis supervisor, for her support, insight, and exceptionally fast response to all my queries, and Dr Grainne O'Donohue for her curiosity and insight during research group meetings.

The participants, who were generous in sharing their experiences with me, trusting me with rich and deeply felt narratives.

Professor Ivor Browne, and his colleagues at the Institute of Psychosocial Medicine, who encouraged me to study psychotherapy, supported me when I felt like giving up, and believe that I can contribute to how psychotherapy constructs trauma.

And last but certainly not least, my two daughters, who make my days sing and dance, and who have eaten a lot of fish and chips recently; my adult children, who are always a joy to me; and their father, who has been a great support in my life.

Abstract

Energy psychology is a novel and controversial family of mind/body approaches used in the treatment of a variety of psychological disorders including post-traumatic stress disorder, anxiety, and depression. The approaches are based on combining concepts from traditional Chinese medicine with simple cognitive interventions. Initial empirical investigation supports claims of efficacy.

The aim of this study is to expand and enrich existing research about the use of energy psychology in psychotherapy for trauma, through analysing the accounts of three experienced psychotherapists. Interpretative phenomenological analysis (IPA) was applied to the central research question: *How does Energy Psychology impact and inform the life and work of experienced psychotherapists who use Energy Psychology in the treatment of trauma?*

Four themes emerged: transformation; paradigm shift; state of presence; and spiritual realization. The participants attributed significant changes in their understanding of psychotherapeutic change, personal philosophy, and overall contentment in life to their experience of using energy psychology, leading to the central hypothesis of this study – energy psychology has the potential to catalyse a process of transformation that results in a lived experience of serenity and flourishing.

Two new understandings of underlying mechanisms that contribute to the efficacy of energy psychology are theorized: 1) energy psychology shares mechanisms in common with meditative practices that may contribute to positive impacts on autonomic dysregulation; 2) energy psychology provides a manual technique that supports the process known as focusing. Non-specific factors that are common to many forms of psychotherapy also contribute to efficacy.

Energy psychology is a suitable treatment in evidence based practice for clients presenting with trauma who: 1) do not favour or may experience re-traumatization during exposure or reliving experiences; 2) are at risk of decompensation due to flooding of traumatic material in the early stages of treatment.

Accept the idea that you will never see what they have seen – and go on seeing now, that you will never know the faces that haunt their nights, that you will never hear the cries that rent their sleep. Accept the idea that you will never penetrate the cursed and spellbound universe they carry within themselves with unfailing loyalty.

Elie Wiesel, *A Plea for the Survivors*

Chapter 1: Introduction

1.1 Setting the Context

Psychotherapy's response to trauma is constructed in the crucible of the wider socio-cultural responses to the perpetrators and victims of trauma. Early understandings of the profound cost of trauma were lost from psychoanalytic theory when Freud dropped his theories about the impact of childhood sexual abuse (CSA)¹ in favour of seduction theory, theorizing that his patients had imagined and possibly even longed for the sexual abuse they described (Esterson, 1998; Herman, 1997). For almost a century traumatised women were assigned the diagnosis of hysteria. The involvement of trauma and posttraumatic stress disorder (PTSD) in a variety of mental health issues continues to be underestimated and underreported (Cusack, Frueh, Hiers, Suffoletta-Maierle, & Bennett, 2003; Cusack, Grubaugh, Knapp, & Frueh, 2006; Grubaugh, Zinzow, Paul, Egede, & Frueh, 2011; Mueser, Rosenberg, Goodman, & Trumbetta, 2002). Trauma, as a major contributory factor to psychological distress, remains largely unarticulated in the primary discourse of psychotherapy resulting in treatment approaches that only partially address the lived experience of traumatic stress.

Each school of psychotherapy frames the treatment of trauma within the context of the school's underlying theories of human development and psychological distress. Cognitive and behavioural therapy (CBT) helps the traumatised individual to restructure faulty cognitions and overcome the avoidance of stimuli that lead to a maladaptive response (Abramowitz, Deacon, & Whiteside, 2012). Humanistic psychotherapy offers the traumatised individual a holistic and reparative relationship that supports post-traumatic growth (Scholl, McGowan, & Hansen, 2011). Psychodynamic psychotherapy explores unconscious dynamics related to early childhood experiences in an attempt to resolve the presenting issues related to trauma (Jacobs, 2012).

Traumatic stress has proven remarkably resistant to psychotherapeutic approaches based on insight and talking, and consequently there has been a movement among clinicians who work with severe trauma to expand their understanding beyond the psychological

¹ All acronyms are listed in Appendix A

realm, integrating research on the physiological and neurological impacts of trauma (van der Kolk & Najavits, 2013). Within this context, a family of therapies loosely designated as Energy Psychology (EP) has emerged and is gaining popularity among complementary practitioners and psychotherapists. A recent US Internet survey of psychotherapists found that 43% of respondents use or plan to use EP (Gaudiano, Brown, & Miller, 2012). There have been a number of studies showing efficacy for the treatment of PTSD and calls for EP to be established as an empirically supported treatment² (EST) for PTSD (Feinstein, 2012).

EP uses a mixture of psychological interventions combined with somatic components that involve the client tapping on the acupoints³ of Traditional Chinese Medicine (TCM). Indeed proponents of the approaches theorize that trauma is encoded in the ‘energy system’ of the body and can be ‘cleared’ through stimulation of acupoints. Complementary practitioners with no psychological training advertise instantaneous ‘cures’ for complex psychological disorders. Implausible claims about efficacy, combined with unsubstantiated theories about ‘energy’ and the ‘energy system’, result in justifiable scepticism. Some authors contend that EP is based on pseudoscience co-opting ideas from ancient healing traditions and quantum physics in an attempt to create a veneer of orthodoxy (Deville, 2005; Lilienfeld, 2011).

1.2 Aims and Objectives

The overarching goal of this study is to broaden and enrich existing research on the role of EP in the treatment of trauma through understanding how experienced clinicians find meaning in and make sense of the use of EP. The central research question addressed by the study is:

‘How does integrating EP into the psychotherapeutic process inform and impact the work and life of experienced psychotherapists who work with trauma?’

The answers to this question are analysed in the context of:

- Existing research on EP

² ESTs are supported by evidence of efficacy from experimental studies based on manualised treatments for specific mental health diagnoses (APA Division 12, n.d.; National Institute for Clinical Excellence, 2014).

³ ‘Any of the supposed energy points on the body where acupuncture needles are inserted or manual pressure is applied during acupressure’ (Oxford Dictionary, 2014).

- Research on ESTs and evidenced based practice⁴ (EBP) for trauma
- Theories of integrative psychotherapy within a humanistic and psychodynamic framework.

⁴ The American Psychological Association (APA) defines EBP as ‘the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences’(APA, 2005)

Chapter 2: Literature Review

This chapter reviews literature relevant to this study based on a systematic search of ERIC, JSTOR, PsycArticles, PsycInfo, Pubmed, Pep Archive, Academic Search Complete, and Google Scholar. The topics reviewed include:

- Underlying theories of EP
- Efficacy research on EP
- Qualitative studies about the experience of psychotherapists who use EP
- Treatment for trauma in the context of EBP
- Treatment for trauma in the context of integrative psychotherapy within a humanistic and psychodynamic framework
- Influences on the lifespan development of psychotherapists
- The incorporation of spiritual practice into psychotherapeutic approaches

2.1 Overview of EP

EP is a family of mind/body therapies that integrate established psychotherapeutic principles, such as exposure and restructuring of core beliefs, with philosophies borrowed from Eastern systems for healing (Gallo, 2000; Mollon, 2008). The fundamental theory underpinning EP posits that psychological and physiological distress is linked with disruptions in the energy system of the body, or what Eastern philosophies identify as the meridians (Sohn, 1996). Releasing these disruptions leads to therapeutic shifts in emotions, cognitions, and behaviours. In 1999 the Association for Comprehensive Energy Psychology (ACEP) was founded to certify practitioners and to explore, develop, promote, and research EP methods. Membership includes licensed mental health professionals and allied health practitioners. In 2012, the APA approved ACEP to provide continuing education credits for psychologists who avail of professional training programs in EP (ACEP, n.d.).

There are commonalities across all EP approaches. The practitioner asks clients to attune to the issue to be resolved by bringing it into awareness and then shows the client which acupoints to stimulate. The techniques are easy to learn and clients are

encouraged to self-administer the protocols between sessions. The practitioner only lays hands on the client if the client is unable to follow the protocol due to disability or age. Some approaches rely on manual stimulation alone, while others use cognitive interventions, or borrow elements from contemplative aspects of spiritual practices. Table 1 summarizes the characteristics of three commonly used EP approaches: Thought Field Therapy (TFT), Emotional Freedom Technique (EFT), and Tapas Acupressure Technique (TAT).

Table 1. Comparison of TFT, EFT, and TAT

Characteristics of EP Approaches	TFT	EFT	TAT
The client taps or holds acupoints in a specific sequence	Yes	Yes	No
Different sequences of acupoints are used for different problems	Yes	No	No
The client holds a specific set of acupoints for the duration of the treatment	No	No	Yes
The practitioner leads the client in a set of cognitive statements related to the issue	No	Yes	Yes
Secularized elements borrowed from spiritual practice	No	No	Yes

2.1.1. An Uneasy Alliance between Ancient Wisdom and Western Psychology

EP treatments are new, but ‘energy’ is part of the healing lore in Brazil, Africa, Inuit, Egypt, India, Japan, and China. The meridian system of TCM is the most widely recognised and researched ‘energy system’ due to the popularity and acceptance of acupuncture. TCM is based on a belief that ‘energy’, called qi, circulates in the body through a system of pathways called meridians (Sohn, 1996). Physical and emotional disease results when blockages prevent the flow of energy. The earliest surviving Chinese medical text, translated into English as ‘The Yellow Emperor’s Classic of Internal Medicine’ (Ti, 1995), dates back to 200-400 BCE, but evidence of tattoos on mummified bodies indicates that maps of the energy system were developed at least 2000 years earlier (Dorfer et al., 1999).

Based on a systematic review of evidence the World Health Organisation (WHO) designates acupuncture as a treatment for a range of physical and psychological disorders including depression and schizophrenia (2013). Another recent review reported efficacy for depression, PTSD, and anxiety (Kawakita & Okada, 2014). The classically trained

psychiatrist Leon Hammer, who uses TCM in his practice, believes ‘Chinese medicine has a profound effect on emotion, mental states, cognition, and personality’ (2005, p. 15).

TCM is integrated into the national health policy in China and practiced alongside Western medicine (Qi, Liming, & van Lerberghe, 2011). Zhao (2009) describes how a complex mix of cultural and historical issues⁵ means that TCM plays a more significant role in the treatment of psychological issues than Western medicine. Even though treatment involves the prescription of herbs and needles, the role played by the therapist is considered critical to outcome, and Chinese TCM practitioners understand that the processes of examining, understanding, and explaining with empathy and respect contributes significantly to outcome. Practitioners knowingly prescribe placebo herbs and needling in the treatment of psychological distress to good effect. This innate understanding of placebo and expectancy mirrors research that demonstrates the importance of the same factors in psychotherapy (DeFife & Hilsenroth, 2011; Finniss, Kaptchuk, Miller, & Benedetti, 2010; Foot & Ridge, 2012; Frank & Frank, 1993; Tambling, 2012; Wampold, Imel, & Minami, 2007; Wampold, Minami, Tierney, Baskin, & Bhati, 2005) leading Wampold et al to conclude that ‘properly designed psychological placebos are as effective as accepted psychotherapies’ (2005, p. 1).

EP is a hybrid of Western interpretations of TCM combined with elements that owe as much to new age philosophies as they do to psychology. There is little recognition of the nuanced understanding of placebo and expectancy inherent in Chinese approaches to medicine. The rationale for EP is often articulated in terms of simplistic understandings of TCM, but some researchers theorize more scientifically based explanations. These include: 1) the therapies work on the principles of brief psychological exposure combined with distraction (Feinstein, 2012; Karatzias et al., 2011); 2) stimulating acupoints deactivates arousal triggered in the amygdala by traumatic memories (Feinstein, 2009), based on studies that demonstrate the effect of acupuncture on the limbic system (Dhond, Kettner, & Napadow, 2007; Hui et al., 2000, 2005), and on serotonin levels (Cabýoglu, Ergene, & Tan, 2006); 3) tapping induces a trance state, making individuals more susceptible to suggestion (Brattberg, 2008); 4) tapping increases serotonin levels

⁵ Zhao (2009) lists the following reasons for why TCM is often used instead of Western psychological approaches in the treatment of mental health issues: stigma about mental illness, cultural differences between ethnic groups, gap between service provision and demand, outlawing of psychology during the cultural revolution, cultural dynamics of healing relationships, and the lack of systematic theories of psychiatry and psychology in Chinese culture.

(Ruden, 2005); and 5) sensory stimulation combined with interpersonal contact facilitates the release of oxytocin (Uvnäs-Moberg, 1997). Table 2 summarizes these mechanisms in the context of TFT, EFT, and TAT.

Table 2. Summary of currently theorized active mechanisms in EP

Active Mechanisms in EP	TFT	EFT	TAT
Cognitive restructuring	No	Yes	Yes
Exposure	Yes	Yes	Yes
De-sensitization	Yes	Yes	Yes
Distraction	Yes	Yes	Yes
Release of serotonin due to tapping	Yes	Yes	No
Release of oxytocin	Yes	Yes	Yes
Placebo	Yes	Yes	Yes
Expectancy	Yes	Yes	Yes

2.1.2. Research on EP

Studies on Efficacy

Randomized Controlled Trials (RCT) support the efficacy of EP for a variety of conditions: depression (Brooks, 2012); phobias (Baker & Siegel, 2005; Salas, Brooks, & Rowe, 2011); fibromyalgia (Brattberg, 2008); test anxiety (Sezgin & Özcan, 2004); public speaking anxiety (Boath, 2012); and food cravings (Stapleton, Sheldon, Porter, & Whitty, 2011). In a review of efficacy studies on EP, Feinstein (2012) finds that in 15 out of 16 the effect size⁶ was large ($d \geq 0.8$) and one was medium ($0.5 \leq d \leq 0.8$). In the context of psychotherapy where the effect size is considered to be in the range $0.4 \leq d \leq 0.8$ (Lambert, 2013) EP can be considered a highly effective approach.

A significant body of the EP research has focused on the treatment of severe and complex trauma in populations that are typically understudied due to complexities in treatment including: war veterans (Church & Brooks, 2014; Church, 2010; Church et al., 2013; Church, Geronilla, & Dinter, 2009), victims of genocide (Connolly & Sakai, 2011; Sakai, Connolly, & Oas, 2010; Stone, Leyden, & Fellows, 2009, 2010), disaster sites

⁶ Cohen's *d* expresses the efficacy of a treatment through determining the effect size of a treatment. It measures the level of difference between two groups for some variable, such as scores on specific psychological instruments, between a treatment group and a control group. A value of 0.2 is considered small, 0.5 is considered medium, and 0.8 is considered large.

(Asukai, Saito, Tsuruta, Kishimoto, & Nishikawa, 2010; Gurret, Caufour, Palmer-Hoffman, & Church, 2012), and CSA (Church, Piña, Reategui, & Brooks, 2012). One of the key features of EP is the speed with which it reduces symptoms of PTSD to a sub clinical level. While a number of trials use a six-session protocol for PTSD (Church et al., 2009), statistically significant improvements have been found after just one session (Church et al., 2012; Connolly & Sakai, 2011).

Critics challenge the quality of the early studies on the efficacy of EP (McCaslin, 2009; Pignotti & Thyer, 2009; Pignotti, 2005). Devilly designates EP as a ‘power therapy’ believing it lacks any valid scientific basis and has the characteristics of pseudoscience i.e. mimicking the style of science while lacking its substance. McCaslin contends that the proponents of EP’s ‘disguise the therapies as ‘ancient medicine’ (2009, p. 254), and concludes that psychologists should educate the public about the ‘ill effects of therapies that advertise miraculous claims’ (p. 249).

As the quality of efficacy studies has improved detractors point out that there is no proven active component, indicating that the reported efficacy is due to elements shared with CBT (Devilly, 2005; McCaslin, 2009). One study attempted to determine if tapping acupoints is an active component of EFT by randomizing university students with self-reported phobias into four groups: standard EFT; placebo EFT where participants tapped on the arm at places other than the prescribed acupoints; model EFT where participants tapped on a doll; and a control where participants constructed a paper toy (Waite & Holder, 2003). There were statistically significant improvements in all three tapping groups when compared to the control group. The researchers concluded that there was no evidence to support that the improvements related to the tapping of meridians, and argued that systematic desensitization or distraction provide a more plausible explanation for the results (p 24).

Studies on the Experience of Psychotherapists who use EP

A US based internet survey used empirical techniques to examine the practices and attitudes of licensed psychotherapists who use EP (Gaudiano et al., 2012). Of 149 respondents 42.3% reported that they frequently use or plan to use EP, showing that there is significant uptake of EP. The researchers applied a number of measures to determine the characteristics and attitudes of EP therapists. They found that therapists who use EP rely on personal intuition in decision making; use a wide variety of

theoretical orientations; endorse more magical beliefs about health that are not supported by scientific evidence; have more positive attitudes towards complementary medicine; and score significantly lower on a measure of critical thinking abilities. They conjecture that psychotherapists are using EP due to a lack of understanding or interest in a scientific basis for their work and propose the incorporation of critical thinking training into educational workshops to help psychotherapists differentiate scientific from pseudoscientific claims (p. 653). Interestingly they found no difference in attitudes towards ESTs between EP and non-EP therapists indicating that EP therapists are no less concerned about EBP than non-EP therapists.

Schulz (2007) used constant comparison to examine the experience of 12 therapists who integrated EP into traditional methods of therapy for CSA. Anxiety and trauma was perceived by the therapists to be effectively treated with EP ‘in a non-invasive way’ (2007, p. 18) and client improvements in interpersonal and intrapersonal relating were attributed to EP. All participants reported that EP had been transformational in their lives.

Mason (2012) used IPA to explore how EP impacts psychotherapy practice. Participants believed that EP was more effective and facilitated change with greater speed and ease than ‘talk therapy’ alone (p. 4). Change was linked to ‘shifts’ on a physiological and emotional level, which preceded changes in cognitions and insight. Participants reported that EP helped them connect with clients on ‘a spiritual level, which they felt enabled deeper healing’ (p. 6).

2.2 Psychotherapy for Trauma

2.2.1. Research on Efficacy

PTSD is a chronic and debilitating condition, associated with a low quality of life, and considered difficult to treat (Committee on Treatment of Posttraumatic Stress Disorder, Institute of Medicine (US), 2008). Some clinicians and researchers argue that specific trauma focused approaches are required in the treatment of PTSD. This viewpoint is situated in a wider debate about the effectiveness of psychotherapy, which centres around two opposing propositions: 1) specific treatments are more effective than others for particular conditions (Chambless, 2002; Hunsley & Di Giulio, 2002; Siev, Huppert, & Chambless, 2009); 2) effectiveness can be attributed to a number of factors common to all psychotherapies such as therapeutic alliance, empathy, client factors, and expectancy

and placebo (Ahn & Wampold, 2001; Crits-Christoph et al., 1991; Luborsky & Singer, 1975; Luborsky et al., 2002).

The view that specific trauma focused treatments are more effective in the treatment of PTSD is supported by a number of meta-analyses. Bisson et al argue that trauma focused therapies are more effective than non-trauma focused treatments in reducing PTSD symptoms (Bisson & Andrew, 2005; Bisson et al., 2007). Exposure-based CBT has the strongest evidence base and is the only form of therapy recommended by the US Institute of Medicine study on the treatment of PTSD (2008). However the high level data from clinical trials does not tell the whole story; dropout rates in trials for trauma are significant and non response rates can be as high as 50% (Kar, 2011; Schottenbauer, Glass, Arnkoff, Tendick, & Hafter Gray, 2008).

Researcher allegiance is found to be a significant predictor of outcome in comparative studies of trauma focused treatments, and a systematic review of treatments for PTSD concludes there are limitations in the evidence base for trauma focused treatments for three reasons: 1) lack of an active placebo or bona fide therapy in the control treatment; 2) lack of differentiation in efficacy for specific groups; and 3) risk of adverse effects for most treatments (Jonas et al., 2013; Munder, Flückiger, Gerger, Wampold, & Barth, 2012). A meta-analysis of treatments for PTSD, examining only those that make direct comparisons between bona fide treatments found no difference in effect sizes concluding that trauma-focused treatments are not superior to treatments that do not specifically focus on trauma (Benish, Imel, & Wampold, 2008). In a response to criticism (Ehlers et al., 2010) the authors argue that non-specific factors related to the treatment of trauma are likely to be responsible for effectiveness (Wampold et al., 2010).

There is only one RCT comparing EP to a bona fide therapy (Karatzias et al., 2011). When EFT was compared to EMDR, both treatments showed significant therapeutic gains post treatment, with a large effect size of $d = 0.9$, though a slightly higher proportion of EMDR participants achieved clinically significant reductions. Gains were maintained at three-month follow up. Another RCT (Zhang, Feng, Xie, Xu, & Chen, 2011) investigated treatment for PTSD related to an earthquake, comparing CBT to CBT that was augmented with electrical stimulation of acupoints. Treatment that included acupoint stimulation was more effective than CBT alone, indicating that acupoint stimulation may have a direct impact on PTSD symptoms.

Criticism of the marketing of EP and the quality of EP studies has validity. However it is interesting to note that many of the same authors who are critical of EP continue to challenge EMDR using the terms ‘power therapy’ and ‘pseudoscience’ (Gaudiano & Dalrymple, 2005; Herbert et al., 2000; Lilienfeld, 2008). EMDR has significant empirical support, notwithstanding seemingly bizarre ingredients, such as eye rolling and bilateral tapping⁷. Clinical trials have demonstrated the efficacy of EMDR for PTSD, and it has been recognised as an EST by a number of organisations defining national guidelines (American Psychiatric Association, 2006; Australian Centre for Posttraumatic Mental Health, 2007; Edwards, 2010; Foa, Keane, Friedman, & Cohen, 2008; National Institute for Clinical Excellence, 2005; US Department of Veteran Affairs, 2010). Examining this controversy in the context of ongoing debates on ESTs and EBP is helpful. Supporters of specific ESTs tend to challenge all psychotherapies that do not have equivalent levels of empirical support. Others argue that researcher allegiance strongly predicts outcomes and point out that efficacy in a controlled environment is not the same as effectiveness in a clinical environment (Laska, Smith, Wislocki, Minami, & Wampold, 2013; Miller, 2011; Thyer & Pignotti, 2011).

RCTs typically do not address client satisfaction, therapist burden, or reasons for drop-out (Mills & Hulbert-Williams, 2012), and empirical evidence supported by process and relational studies may provide a better foundation for EBP (Fairfax, 2008; Mollon, 2010; Thyer & Pignotti, 2011). Exposure based therapies have the largest empirical support, particularly trauma-focused cognitive therapies (TFCT), but qualitative research offers a more nuanced understanding of effectiveness in a clinical environment. Exposure through reliving the trauma in an ‘imaginal’⁸ sense is a core aspect of TFCT (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005), but clinicians trained in these approaches have concerns about exposure fearing that it leads to re-traumatization, increased symptomology, a high drop out rate. They also express concerns about using exposure

⁷ EMDR is an integrative approach that combines somatic elements including eye rolling and bilateral tapping. The underlying model is closer to a standard behavioural model than the TCM based model of EP (Shapiro, 2002). Throughout this study it becomes apparent that the participants see similarities between EMDR and EP but as EMDR is not an EP it is only examined in this study where the participants make direct comparisons that serve to elucidate EP in some way.

⁸ Imaginal exposure uses visualisation techniques to help the client vividly imagine the feared object or situation, as opposed to in vivo approaches, where the client is exposed to the actual objects or situations they fear.

when co-morbid disorders such as dissociative disorders (DD), borderline personality disorder (BPD), and substance abuse are present (Becker, Zayfert, & Anderson, 2004).

A qualitative study found that clients fear reliving trauma (Shearing, Lee, & Clohessy, 2011, p. 462). The clients emphasised the importance of personal determination and strength in approaching reliving and described how the experience of reliving felt as though the trauma was happening again. They felt that reliving took over their lives (p. 464). Asylum seekers described the experience of reliving as physically draining and anxiety provoking (Vincent, Jenkins, Larkin, & Clohessy, 2013, p. 11). EMDR and EP do not require the client to talk about or relive the trauma, so within an EBP context it may be ethical to offer them as a clinical approach, even if alternative treatments with stronger evidence of efficacy are available (Mills & Hulbert-Williams, 2012).

2.2.2. A Humanistic and Integrative Context

Humanistic psychotherapy has a holistic focus on the self, experience, and growth through the actualizing tendency, and psychodynamic psychotherapy rests on a theory that all symptoms and problems have their genesis in the early attachment bond between the mother and infant. In an integrative framework humanistic and psychodynamic therapy align on the importance of a supportive, holding relationship between the therapist and client (Gomez, 1997; Kahn, 1997; Rowan & Jacobs, 2002), adopting from the humanistic tradition an emphasis on empathy, congruence, and therapist presence (Mearns & Thorne, 2000), while maintaining a commitment to containment and holding from the psychodynamic tradition (Jacobs, 2012). While humanistic psychotherapy does not have a wide empirical research base, a common factors understanding confirms its effectiveness based on the importance of empathy and therapeutic alliance (Cooper, 2008; Messer & Wampold, 2002; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006).

Empathy and therapeutic alliance have been extensively studied, but the concept of presence is harder to define and measure, and is not accepted as a common factor. Many authors in the humanistic tradition see presence as a relational process which promotes healing in the client (Bugental, 1978; Gendlin, 1998; May, 1995; Mearns & Cooper, 2005; Mearns & Thorne, 2000; Rogers, 2004; Thorne, 2002; Yalom, 1980). Healing is understood to occur on two dimensions. Therapist presence creates an attuned awareness that allows the therapist to respond empathetically to the client (Greenberg & Geller, 2001; Mearns & Thorne, 2000), and facilitates moments of relational depth where

‘meeting’ between the client and therapist has an intrinsic healing quality (Mearns & Cooper, 2005).

Presence has been identified as an important factor in healthcare (Breggin, 2006; Finfgeld-Connett, 2006; Hickman, 2013). It contributes to better health outcomes for patients while facilitating improved mental well being among nurses (Finfgeld-Connett, 2008). One conceptualisation of presence in nursing describes four levels of presence: presence, partial presence, full presence, and transcendent presence (Osterman & Schwartz-Barcott, 1996). This sense of a spiritual aspect to presence mirrors understandings of presence described by transpersonal psychotherapist Rowan (2005). It also reflects the conclusions of a panel of senior therapists that integrated spiritual practice and belief supports the development of a healing presence (Phelon, 2004, p. 351).

Integrative approaches based on humanistic and psychodynamic theories do not specifically address trauma. The focus is on interpersonal relating, and the relationship between the therapist and the client is seen as the main conduit of healing. Talking and insight based therapies that focus exclusively on the relationship have been criticised in the treatment of trauma (van der Kolk & Najavits, 2013). Some clinicians believe that talking about trauma contributes to flooding, abreaction, decompensation, and re-traumatisation due to the level of dysregulation and overwhelming affect experienced by traumatised individuals (Browne, 2009; Levine, 1997, 2010; Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, McFarlane, & van der Hart, 1996). There is growing recognition based on research from neuroscience that it is difficult to integrate memories, thoughts and feelings, or split off aspects of the personality, when an individual moves into a state of autonomic dysregulation due to the activation of traumatic memories (Siegel, 2007; Wallin, 2007).

2.3 The Lifespan Development of Therapists

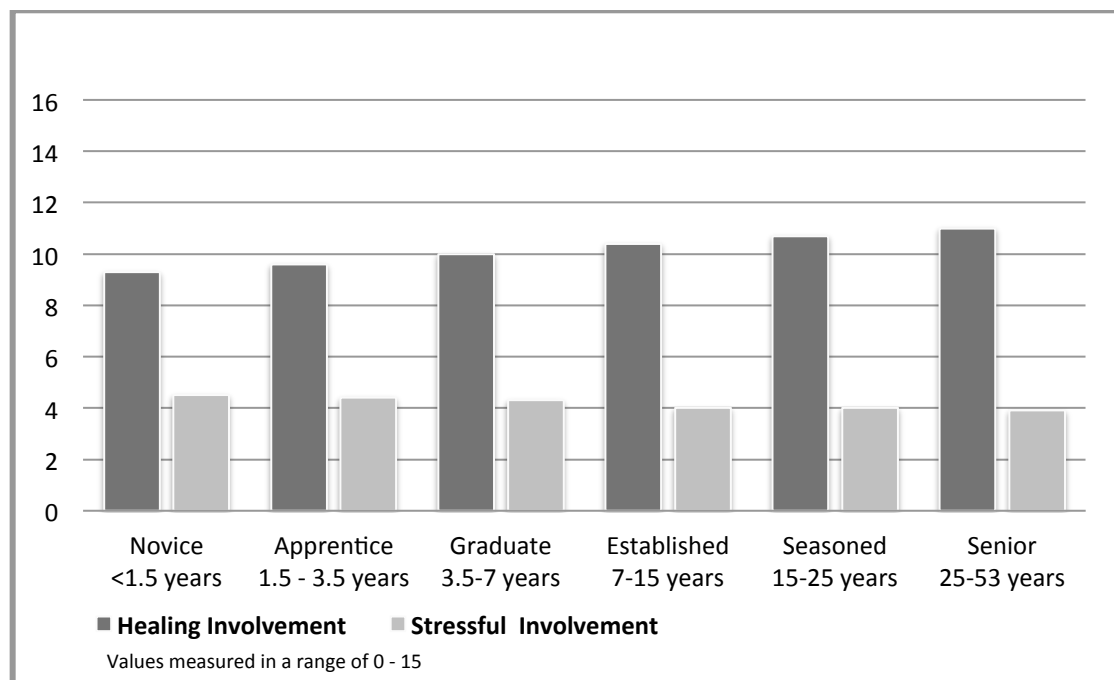
The personal and professional development of therapists impact each other in a complex reciprocal relationship (Skovholt & Rønnestad, 1995) and the boundary between personal and professional development is unclear and shifting (Wilkins, 1996). Two significant studies chart the lifespan development of psychotherapists (Orlinsky et al., 2005b; Rønnestad & Skovholt, 2012). Skovholt and Rønnestad (1992) used qualitative techniques to study 100 therapists and counsellors at five stages of career development,

from first year of graduate school to 40 years of practice. Beginning therapists often experience anxiety about their effectiveness, whereas senior practitioners go through a 'major shift' over the span of their development (p. 510), evidenced in a significant reduction in anxiety as they increasingly make use of 'accumulated wisdom' (p. 512), reaching a place of quiet confidence in their work. The process of development is 'long, slow, and erratic' (p. 511), and shifts related to transformative events in personal life (Rønnestad & Skovholt, 2001), or critical incidents in professional life (Skovholt & McCarthy, 1988), are identified retrospectively.

An extensive quantitative study was carried out, capturing the experience of 5000 therapists at all career levels, professions, and theoretical orientations (Orlinsky et al., 2005b). The authors theorised two constructs⁹, 'healing involvement' and 'stressful involvement', to describe how therapists experience professional practice. Therapists may experience both conditions at the same time therefore levels of professional engagement are defined by a combined measurement of both constructs. Therapists in the earlier stages of career development experience insecurity in their work, feeling awkward and anxious. They describe lower levels of healing involvement, and higher levels of stressful involvement. Across cohorts levels of healing involvement increase in a linear progression while stressful involvement decreases marginally (summarized in Figure 1).

⁹ Healing involvement is a 'mode of participation in which therapists experience themselves as personally committed and affirming in relating to patients, engaging at a high level of basic empathic and communication skills, conscious of flow-type feelings during sessions, having a sense of efficacy in general, and dealing constructively with difficulties encountered if problems in treatment arose'. Stressful involvement is a 'pattern of therapist experience characterized by frequent difficulties in practice, unconstructive efforts to deal with those difficulties by avoiding therapeutic engagement, and feelings of boredom and anxiety during sessions' (Orlinsky et al., 2005b) [kindle edition, no page numbers available].

Figure 1. Healing involvement vs. stressful involvement over lifetime span



Both studies showed that senior therapists experienced significant personal and professional growth, and cited three important influences: learning through client work, clinical supervision, and engaging in personal therapy. As many as 90% of therapists report personal therapy is helpful, easing psychological distress, improving behavioural symptoms, and increasing insight (Orlinsky, Norcross, Rønnestad, & Wiseman, 2005a, p. 215). Therapists, when asked of their own experiences as clients agree that ‘change is gradual and painful’ (Norcross et al., 1992) as cited in (Norcross, 2002, p. 222).

Spirituality and religion¹⁰ are not addressed in the studies on the development of psychotherapists (Orlinsky et al., 2005b; Rønnestad & Skovholt, 2012). While it is true that mental health professionals have less religious and spiritual involvement than the general population the few studies that investigate psychotherapists’ attitudes to spirituality show considerable levels of spiritual involvement. In the US 85% of the general population say that religion is very or fairly important in their lives while a survey

¹⁰ Religion is defined as outward involvement in formal rituals and observances, proscribed by an institution, and performed in community with others, whereas spirituality is defined as an inward involvement in a personal relationship with the divine - subjective and individualistic in nature. Spirituality can derive from religious practice, or be outside of religion, and in some cases, divorced from the divine, when described in terms of an existential search for meaning. Definitions synthesized from the following sources: (Aldridge, 2000; Hill & Pargament, 2008; Koenig, King, & Carson, 2012; Paloutzian & Park, 2005; Wulff, 1997).

of APA psychologists found that 48% report that religion was unimportant in their lives, yet 81% indicated that they had prayed in the previous year and 80% reported that spirituality was very or fairly important in their lives (Delaney, Miller, & Bisonó, 2013). A study of 975 therapists from New Zealand, Canada, and the US found that while 71% of psychotherapists do not appear religious in an overt sense 51% could be defined as having a personal spirituality and 27% a religious spirituality (Smith & Orlinsky, 2004).

2.4 Spiritual Practice and Psychotherapy

There is a significant body of research showing that people involved in religious and/or spiritual practice are on average physically healthier and emotionally happier, with positive impacts demonstrated in improved endocrine, cardiac and immune function, and a lower incidence of depression and anxiety (Koenig, King, & Carson, 2012). Spiritual involvement is associated with serenity (Roberts & Cunningham, 1990) and a sense of flourishing (Koenig et al., 2012; McEntee, Dy-Liacco, & Haskins, 2013; McEntee et al., 2013).

Interest in the positive impacts of spiritual and religious involvement has contributed to the development of psychotherapeutic approaches based on meditative and contemplative practices and positive effects have been demonstrated even when overtly spiritual aspects are elided to secularize the approaches¹¹. Meditation and mindfulness based psychotherapy interventions are considered effective across a range of issues including anxiety and depression (Brown, Marquis, & Guiffreda, 2013; Chiesa & Serretti, 2011; Davis & Hayes, 2011). A meta-analysis of research on meditation calculates the effect size is medium with $d = 0.58$ (Sedlmeier et al., 2012). Meditation is demonstrated to have a positive impact on the capacity to regulate emotions (Hart, Ivztan, & Hart, 2013) and fMRI studies show that meditation directly effects areas of the brain that are involved in the regulation of emotion and stress, leading to the conclusion that these approaches support autonomic regulation (Hanson & Siegel, 2009).

Western forms of contemplative prayer have been correlated with a sense of existential well-being (Poloma & Pendleton, 1989, 1991) and shown to have positive impacts on physiological measures (Stanley, 2009). Siegel (2007) believes that a variety of practices,

¹¹ Secular approaches include: Mindfulness Based Stress Reduction (Newton, 2014), Mindfulness Based Cognitive Therapy (Crane, 2009) Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2011), Naikan (Krech, 2006), Dialectical Behavioral Therapy (Dimeff & Koerner, 2007).

whether Eastern based spiritual practices such as mindfulness meditation, yoga, or tai chi, or Western forms of contemplative prayer, support the development of meta-cognitive awareness of awareness. Nonetheless some authors caution that meditation and spirituality is pervasively used to avoid dealing with the pain of unmet developmental needs in a phenomenon referred to as ‘spiritual bypassing’¹² (Masters, 2010; Welwood, 2002) where ‘people borrow the clothing of spiritual truths’ as a form of psychological defence mechanism (Caplan, 2009, p. 119).

¹² The phrase ‘spiritual bypassing’ was first coined in 1986 by John Welwood, a psychotherapist who integrates western psychology with eastern spiritual wisdom (Welwood, 2002)

Chapter 3: Methodology

3.1 Overview

This chapter presents the rationale for the chosen research method and makes a case for the specific choice of IPA in this study. It examines the use of semi-structured interviews in data collection. A quality plan for the research is presented in the context of ongoing debates about quality in qualitative research. The design of the study is detailed, outlining the approach to sampling, data collection, data analysis, and ethical considerations.

3.1 Rationale for a Qualitative Approach

Qualitative research is relevant to clinical practice, enhancing knowledge about the process and outcome of psychotherapy, through rich descriptions of individual experiences (Silverstein, Auerbach, & Levant, 2006). It focuses on understanding the meanings people attribute to their actions and aims to build theory through examining and interpreting personal experiences of the phenomena under study (Dallois & Vetere, 2005, pp. 49–50). Through detailed interviewing and observation a qualitative approach gets close to the participants' perspective, gathering data that is 'detailed and personal' (McLeod, 2013, p. 74), contributing to rich understandings of phenomena about which little is known.

3.1.1. Research Strategy: Interpretive Phenomenological Analysis

IPA is concerned with the participants' personal perceptions, experience, and accounts, exploring the meanings they attribute to their lived experiences (Smith & Osborn, 2007). It is idiographic meaning that 'the focus is on individuals' cognitive, linguistic, affective, and physical being' (Finlay & Ballinger, 2006, p. 260). A detailed phenomenological account of the participants' experience is recorded from which the researcher develops an interpretative account that explores and communicates the participants' experience through the lens of the research question.

IPA recognises the central role of the researcher in the analysis (Smith, 2004). The double hermeneutic of IPA understands that there are two contexts that interact and co-

inform each other; the context of the participant and the meaning they make of their experience, and the context of the researcher and the meaning they bring to the inquiry (Brogden, 2010).

IPA was indicated for this study by existing qualitative research into EP, which found that EP generated potent shifts in emotions, cognitions, behaviours and physiology and was transformative in the lives of psychotherapists.

3.1.2. Semi-Structured Interviews

A semi-structured interview (Dalloos & Vetere, 2005, p. 182; Kvale, 2008, pp. 51–53; Smith & Osborn, 2007, p. 57) was chosen for data collection because it is open and adaptive, and creates space to explore unanticipated themes that emerge during the interaction between the researcher and the participant. The flexibility of the interview facilitates rapport, encouraging the participant to provide rich descriptions of their experience, while the structure creates a framework that ensures that the underlying research question is addressed in every interview.

3.1.3. Reflexivity

According to Finlay (2008, p. 5) reflexivity is a ‘defining feature’ of qualitative research however she cautions that it should be ‘neither an opportunity to wallow in subjectivity nor permission to engage in legitimised emoting’ (1998, p. 455). In presenting the findings the participants’ accounts are explicitly delineated from the researcher’s interpretation (Willig, 2008, p. 64). In addition a short reflexive statement based on Willig’s (2013, p. 10) criteria for personal¹³ and epistemological¹⁴ reflexivity, as recommended by Eatough (personal communication, June 27, 2014), is provided in Appendix B.

3.2 Planning for Quality

The issue of quality and validity in qualitative research has been a subject of some debate (Hoyt & Bhati, 2007; Malterud, 2001; Salmon, 2003). Applying principles of quantitative

¹³ Personal reflexivity encourages examination of how the researchers values, experiences, beliefs, and identity influence and shape the research (Willig, 2013, p. 10).

¹⁴ Epistemological reflexivity engages with how the choice of method, research question, and design of study have shaped and constructed the findings (Willig, 2013, p. 10).

research, which seek to minimise researcher subjectivity and document reproducibility, may constrain the idiographic nature of qualitative research. Nonetheless the researcher must take responsibility for the quality of the research by implementing verification strategies during the process of the inquiry (Morse, Barrett, Mayan, Olson, & Spiers, 2008) and considering specialised guidelines that address the chosen methodological approach (Elliott, Fischer, & Rennie, 1999).

Smith et al. (2009) recommend Yardley's (2000) guidelines for IPA. Yardley covers four principal areas of quality: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. In a later review of IPA studies Smith defined criteria for determining quality (Smith, 2011a, 2011b). Table 3 outlines a quality plan based on these guidelines.

Table 3. Quality Plan

Quality Actions	Reference
<i>Sensitivity to Context</i>	
Engage with research literature	(Yardley, 2000)
Pro-actively seek findings that go against researcher's own views	(Yardley, 2000)
<i>Commitment and Rigour</i>	
Work to ensure 'depth and breadth' in analysis	(Yardley, 2000, p. 219)
Use feedback to improve quality of analysis ensuring that paths taken to arrive at conclusions are understandable: supervisor, peer group, IPA research community	(Flowers, Larkin, & Smith, 2009)
Use criteria for inclusions of themes developed by Smith	(Smith, 2011a, 2011b)
Work to build rapport with participants through respectful engagement prior to interview and during interview to ensure quality of data	(McLeod, 2013)
Invest time in ensuring quality of semi-structured interview through peer review, supervisor input, test interview, and pilot interview	(Flowers et al., 2009, p. 58)
<i>Transparency and Coherence</i>	
Use decision audit trail to expose how decisions were made throughout the research process	(Koch, 2006; Ryan-Nicholls & Will, 2009)
Use research journal throughout analysis to record researcher context and influences	(Brocki & Wearden, 2006; Finlay & Gough, 2008; Jasper, 2005; Lamb, 2013; Patton, 2002)
Use reflexive statement to provide context to reader	(Finlay & Gough, 2008; Pillow, 2003)
<i>Impact and Importance</i>	
Consider quality in terms of producing papers for publication	(Salmon, 2003)
Consider discussion and results in terms of contributions that are useful to psychotherapy or EP	(Finlay & Ballinger, 2006)
Provide thick descriptions of the phenomena so that readers can determine the transferability of the interpretations to their context	(Bogdan & Biklen, 1998; Ponterotto, 2006)

3.2 Research Design

3.2.1. The Sample

The sampling is non-probable and purposeful based on the participants having extensive experience of integrating EP into psychotherapy practice (Smith & Osborn, 2007).

Guidelines for sampling for IPA recommend a homogenous group, with a small sample size of $n = 3$ (Flowers et al., 2009, pp. 48–52). Mason (2012) identified a limitation in her study based on the diversity of EP approaches used by participants. To increase sample-specificity and homogeneity participants were recruited through an international email list for practitioners who have a professional qualification in a specific EP. A call for participation was circulated (Appendix C).

3.2.2. Demographic Questionnaire

Once consent had been obtained (Appendix D) an initial questionnaire was administered to collect background information on the participants' psychotherapeutic approach and EP qualifications (Appendix E). All participants were qualified in psychotherapy to a Masters level and had undertaken a range of continuing professional development trainings in a variety of approaches including ESTs such as EMDR, CBT, and DBT. Table 4 summarizes information relevant to the participants' EP practice and indicates the approaches they use most frequently with trauma.

Table 4. Demographics of the participants

Name Anonymized	Original Training	Years (Since Psychotherapy Licensing)	EP Certifications	Years (Since First EP Certification)	Approaches frequently used with Trauma
Mark	Person Centred Psychocorporal	23	EFT TAT	9	TAT EMDR
Joanna	Psychodynamic Person Centred	27	EFT TAT TFT REMAP	14	EFT TAT TFT EMDR Clinical Hypnosis Ego States Therapy
David	Psychodynamic Person Centred Gestalt	36	EFT TAT TFT BSFF	13	EFT TFT

3.2.3. Pilot Interview

The researcher tested the first draft of the semi-structured interview with a colleague who integrates EP techniques into psychotherapy for a general client population. As a result the questions were refined to be less direct in an attempt to come at the research question ‘sideways’ (Flowers et al., 2009, p. 58).

The second draft of the questionnaire was discussed with a peer research group and the researcher’s academic advisor (Appendix F). This draft was further tested in a pilot interview with a respondent who was interested in participating in the study, but did not meet the criteria for selection¹⁵. No further changes were made to the interview schedule based on the pilot interview.

3.2.4. Data Collection

The participants were recruited internationally and the interviews were conducted through Skype video. Each interview lasted approximately one hour, was taped, and later transcribed verbatim by the researcher. The process of listening to and transcribing the interviews allowed the researcher to ‘temporarily internalise and ‘own’ as much of the data as possible’ (McLeod, 2013, p. 120). Extensive field notes were taken immediately after interview, and after the transcription process to facilitate the development of ‘thick, deep and rich description’ (Patton, 2002, p. 331).

3.2.5. Secondary Research Questions

The researcher maintained a set of secondary research questions that addressed areas of interest related to theory (Flowers et al., 2009, p. 48). These questions were used to inform aspects of the interpretative analysis that engage with theories of psychotherapy and EP (Appendix G).

3.2.6. Data Analysis

The researcher analysed each transcript in turn (Flowers et al., 2009). On the first and subsequent readings, observations, personal reactions, and queries about meaning were noted in the left hand margin. As themes were identified they were noted in the right

¹⁵ The participant in the pilot interview met the criteria for length of time in practice as a psychotherapist, but not the length of time since professional certification in an EP technique

hand margin. Each theme was double checked to ensure that it was grounded in the participants' account.

Upon completion of the analysis of the first transcript the themes were placed in an Excel spread sheet in order of occurrence. The researcher clustered the themes by category, allowing themes that share characteristics to be grouped together, but not exclusively forcing themes to belong to a classification (Jacob, 2004). The categories were selected for their richness and capacity to illuminate the participants' account as a whole. They emerged through considering the themes in relation to the overarching research question and the secondary research topics, or because they captured phenomenon emerging in the participants' accounts.

During analysis of the second and third cases the researcher was mindful of the ways in which interpretation of one transcript might influence her reading of another transcript, and ensured that all themes 'capture most strongly the respondent's concerns on this particular topic' (Smith, Jarman, & Osborn, 1999, p. 223). After completing the analysis common themes were consolidated, but themes that were similar but slightly different were not modified to ensure that the idiographic texture of each case was retained. The theme categories were updated, creating a visual representation of the emerging patterns in the data, showing the prevalence and importance of the themes. Based on considering the research question in the context of the secondary research topics the final themes were selected.

In line with best practice for IPA the stages of analysis for one participant are provided (Eatough, personal communication, June 27, 2014): sample of annotated transcript (Appendix H); emergent themes in chronological order (Appendix I); clustering of themes into categories (Appendix J); and a thematic structure showing how the categories contributed to the final themes (Appendix K).

3.2.7. Ethical Considerations

Prior to agreeing to participate participants were provided with a detailed document addressing the following areas of concern (Kvale & Brinkmann, 2008, pp. 70–73):

- Purpose of the research
- Possible benefits and risks involved in participation

- Rights of the participant to choose what they disclose during the interview and to withdraw from the research at any time
- Strategy for managing participant anonymity
- Dissemination of research

The participants were provided with more detail about the nature of the research and the interview process prior to the interview, and offered an opportunity to raise queries about the research (Kvale, 2008). All data was anonymized, and stored in password-protected files, in line with the Data Protection Act 2003.

Chapter 4: Findings

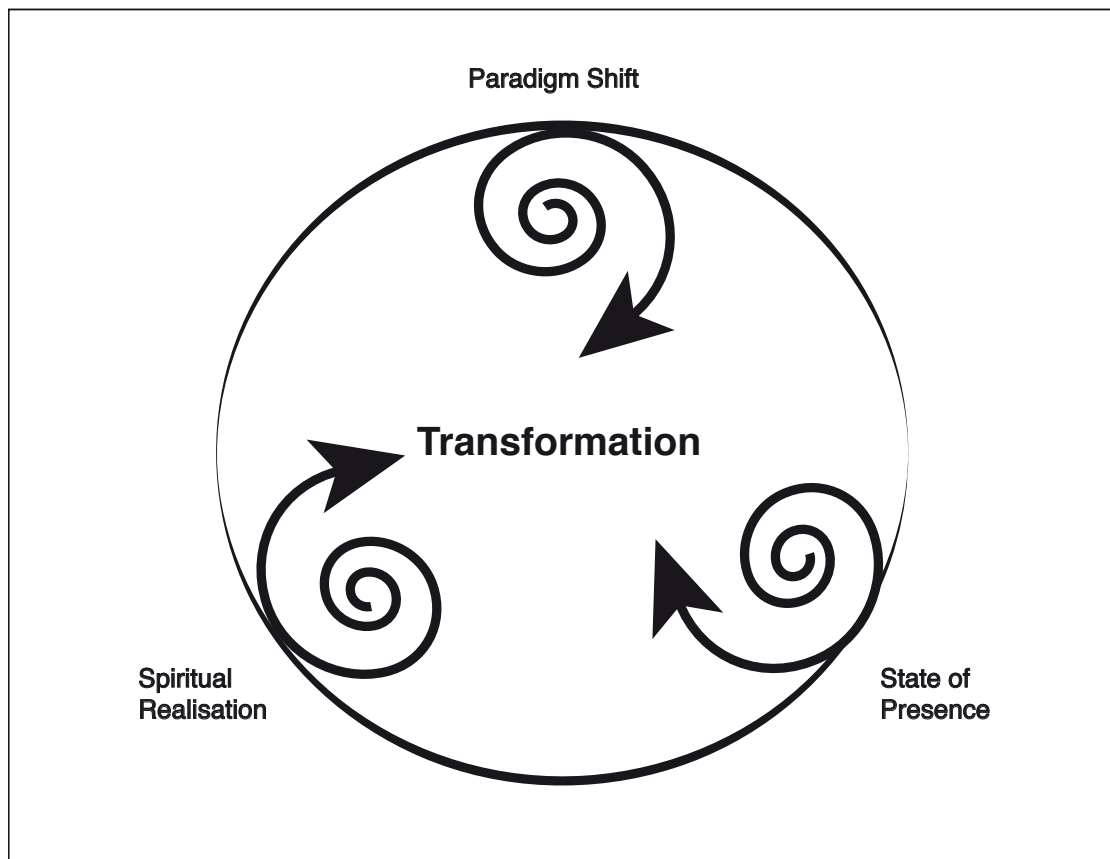
4.1 Introduction

This chapter explores how EP impacted and informed the lives and psychotherapy practice of the participants. A hermeneutics of empathy (Kaplan, 2003) allows the researcher to enter the participants' world (Willig, 2008, p. 63) in order to understand and communicate the participants' experience. The findings are captured in four themes, which are presented in a narrative account that is supported by verbatim quotes from the participants:

- Transformation
- Paradigm shift
- State of presence
- Spiritual realization

The first theme outlines the tentative hypothesis of this study – EP acted like an alchemical reagent catalysing a process of transformation in the lives of the participants. The remaining themes deconstruct the transformational process into three developmental arcs. Figure 2 creates a visual representation of how these developmental arcs interacted in the overall transformational process.

Figure 2. Themes



4.2 Transformation

This theme is presented through a detailed case study of one participant, Mark, a classically trained Rogerian psychotherapist. His narrative illustrates the salient features that appear in the other accounts though each narrative has its own idiosyncratic texture. Focussing exclusively on one account vividly articulates the central hypothesis of this study – that EP can have a dramatic and profound impact on a psychotherapist's professional identity, sense of self, and personal meaning-making, leading to a lived experience of serenity and flourishing.

Mark recounted the story of how he came to be a psychotherapist. He described his feelings of inferiority, stemming from a childhood that left him with a sense that he would never be as good as his father, a physician. We understand how formative this experience was through his use of emphatic repetition:

... [I] had an inferiority complex feeling. I would never be as good as him.
Never be as good as him.

As a young man he reacted against his father but slowly came around to an interest in medicine, choosing to study psychotherapy because he saw it as ‘the best part of medicine’, and we might imagine because he wanted to demonstrate his worth to his father. He chose person-centred psychotherapy, a form of psychotherapy that rejects a medical understanding of psychological distress, hinting at a continuing contrarian stance in relation to his father.

... I went completely the opposite direction from medicine, but little by little became more and more interested, and then became a psychotherapist. For me psychotherapy is the best part of medicine.

Overtime he felt thwarted by what he refers to as ‘talk therapy’ and started to investigate other approaches. He acknowledges that talk therapy supports people in developing insight but overall he experienced anxiety and frustration about the pace and quality of growth. In describing the difference between psychotherapy and EP he tells the story of a colleague, an established and highly respected psychotherapy trainer who continues to seek repair for his early wounds, all the time repeating entrenched patterns of interpersonal relating. Mark suddenly shifts from the third to the first person plural in the middle of a sentence creating a sense that he is recounting his own story, not just the story of his colleague:

... [this colleague is] seeking this eternal love that his father never gave him, and we need to be healed of those wounds, so that we are not reproducing them in professional life. Or even more extensively in romantic life.

Mark sums up the difference between the EP and talk therapy with conscious irony:

... It’s sort of the difference between coping and realising that I have some value, because the therapist has given me so much positive feedback over a couple of years, and finally ... I have got this substitute parent, more or less, who I have been so involved with, and it has been beautiful, and I have been re-re. You know, almost like being reborn in a therapeutic sense, and that’s beautiful [shrugs]. OK. But it’s not healing the wounds that have been specifically caused. [emphatic]

As an established therapist Mark was introduced to EP while training as an EMDR consultant. He experimented with EP on himself and was immediately surprised by the rapid changes he experienced. He first trained in EFT, but it is TAT that has had the most profound impact on him:

... [TAT] is allowing me to make direct experience of who I am, really am, which is not Mark Robbins therapist. It's a space of being, in a form. The form is Mark Robbins born in [place] who lives in [place] and who has done this blah blah blah, but who is not, I can't define myself, nor determine myself, nor you know put myself in that kind of box in reality. I don't know who I am. I don't know what I am going to be doing in an hour. I am just space, open to what happens ... so in reality my real identity is just being present here and now, and TAT has been extremely valuable for me in helping in that way.

His use of language, moving from the first to the third person, emphasised by the use of the gender neutral 'it', indicates a letting go of identification with self. He is no longer defined by his role identity as a therapist. He uses the present tense as he describes who he is, as though making direct experience of himself in TAT has extended to his way of experiencing himself in the present moment. His conception of psychology is radically altered:

...[It] has enormous repercussions in psychology. Because if I just discover who I am, and all the other stuff just sort of dissolves, then the painful psychological elements, which are what we construct ... prevents us from touching who we are. Which is a vulnerable place of being without any particular definite things.

His changing understanding of psychology is linked to a new construction of the role of psychotherapist. A psychotherapist has one function only - to be present - nothing more:

... the art of the therapist, or simply the TAT Professional, is to just allow the patients to be present to his or her experience. Period. Not get involved. Get out of the way, and just allow the process to [pause] to continue by itself.

Mark equates psychotherapists to TAT professionals, an EP certification that requires no specific professional credentials let alone a psychology or psychotherapy background. This is in stark contrast with his original motivation for choosing to train as a psychotherapist, his desire to show his father that he too could be physician.

While the shift in his professional identity is profound Mark retains a commitment to one aspect of his psychotherapy training, a focus on personal development, but he emphasises the use of EP rather than personal therapy in this process. He believes that self-awareness contributes to the creation of safe and boundaried therapeutic relationships. In addition to the changes in his professional identity he describes profound changes in his personal life. He has moved from a place of anxiety to being at

peace in himself. He describes his interpersonal relationships with great pleasure, and a kind of gentle bemusement. It seems that the ‘wounds that have been specifically caused’ are no longer impacting him. Mark sums up the changes he sees in himself, and his use of language, once again, indicates a way of being that is very present to current experiencing:

... a very peaceful, I would say meaning but [pause] not a meaning philosophical. I am not thinking in those terms. A peaceful experience of life. Experiencing life in a much more peaceful way.

... I would never have expected that I would be able to live such a kind of relationship. I just go with it day by day, you know, and it's great.

Ultimately the transformation Mark experienced was multi-faceted. He moved from a place of existential anxiety, and an investment in a particular image of himself as a ‘psychological physician’, to a place of peaceful living, deep spiritual connection, decentring of role identity, and a radically altered understanding of psychology and psychotherapy. Joanna and David offer similar accounts. They use words such as ‘ease’, ‘joy’, ‘peace’, ‘happy’, ‘healthy’ to describe their lived experience. David, who has been practicing psychotherapy for 36 years, and is past retirement age, still has a thriving practice. He says ‘he has been excited by his work’ since he learned EP. Joanna believes that EP ‘saved her marriage’.

4.3 Paradigm Shift

The participants distinguish talk therapy and EP as two separate paradigms. They do not integrate EP into their practice of psychotherapy; rather they now practice EP. We start with Joanna as she describes how her initial trainings in EMDR and EP catalysed a radical alteration in her practice of psychotherapy:

So within a year I did these trainings that kind of turned my whole practice and the way that I viewed people and what was going on for them kind of topsy turvy.

She believes that trauma plays a central role in all psychological distress. Mark articulates the same perspective:

...the problem with psychology is that it did not take into account that most behavioural problems and cognitive problems come from post-traumatic disorder, whether it be an official PTSD or non-official PTSD¹⁶.

The participants make repeated references to trauma as 'stored' or 'stuck' in layers. EP works by clearing these layers, and as one trauma is cleared, another emerges into view. The therapy process is focused on clearing the layers, in discrete EP sessions, rather than in a dialogical therapeutic relationship. David describes it like this:

We clear one trauma away and another one pops up and we clear that.

The participants express a view that talking increases 'identification with' or 'connection to' the trauma, whereas EP clears the connection to the emotional and physiological charge associated with the trauma. Each participant offered examples of a 'shift' followed by an immediate reduction in charged affect, and expressed their initial surprise at this process. Joanna describes how over many years her complex grief worsened, despite deep work in her personal therapy. As she remembers her first experiences of using EP on herself, she speaks in a way that is experience near, as though she still feels the impact of this shift intensely:

... I had a severe complex grief reaction that just got worse and worse over the years. Never got better, just got worse and worse. No matter what I did.

... [EP] helped that just to calm. Right. It went to a place of calm, so I can talk about it. I can be with it.

David gives an example of a significant shift in a client's emotional affect immediately on completion of an EP session that addressed combat trauma:

... when we finished I asked him how he felt, and he said OK, and I said can you go back and look at that event that happened in combat and tell me how you feel, and he said it didn't bother him ... he said 'Really - I don't have any feelings about it'.

EFT and TFT are used to target specific events or memories, but the participants have a preference for TAT because it specifically encourages the client not to think or talk about the trauma during the process. The following extract, where David explains how he sets

¹⁶ Mark went on to explain that when he used the term non-official PTSD he was describing traumatic stress that did not meet the full DSM criteria for a diagnosis of PTSD.

up a TAT session¹⁷ for a specific traumatic event, demonstrates that EP creates a very different way of working with trauma:

[I say to the client] whatever comes up in your mind that you want to work on, let's hold that in your mind and call that 'this', and I didn't have to know what 'this' was, and the beauty of it to me was, like working with rape victims in talk therapy you have got to tell me in detail what happened, and da da da da da, and you have to go through all that misery and fear, and with TAT I could say from the moment you heard that glass break until your sister was with you in the hospital. Let's call that whole experience 'this'.

While each of the participants believe that talking about trauma is not helpful, they acknowledge that sometimes clients need a space to talk about their experience. Clients occasionally experience EP as a 'therapy technique', but overall the participants find that clients chose to work with EP over just 'talking'. The participants noted the importance of respecting clients' preferences and highlighted the necessity of attending to boundaries and issues of power in the therapeutic relationship. They expressed a concern that some EP practitioners may not have the skills required to manage the complex relational dynamics that sometimes emerge in the treatment of trauma, but pointed out that the same is true of some psychotherapists.

Despite the relational orientation of their original trainings they now see the relationship as a context that creates conditions that allow the 'work' of EP to begin. Both David and Mark find that the work of EP can begin quite quickly, in 2 to 5 sessions. Joanna acknowledges that in her work with dissociative disorders and complex PTSD that the process of establishing a secure enough connection takes somewhat longer, none the less she moves towards using EP early in the process. David describes it this way:

... from psychotherapy I think that that connection with you is extremely important before we start doing work. If not I feel like I am discounting the essence of who you are as a person ... to not let them tell their story is real discounting, and I think it is really important. Like I said, the greatest gift you can give another human being is to be present.

¹⁷ TAT consists of three elements: 1) A setup stage where the client chooses the issue they want to work on, and then is supported in disidentifying from the issue through stepping back and referring to everything related to the issue as 'this'. The client can chose not to disclose what 'this' is; 2) A pose where the client places their hands on their head, holding specific acupoints; 3) The active process where the psychotherapist leads the client through a series of cognitive statements. Clients hold the TAT pose for approximately 1 to 2 minutes for each statement, while keeping their attention on the statement, rather than thinking about the issue they chose to work on.

David's description articulates a sense that psychotherapy and EP are distinct. Mark clearly differentiates EP from psychotherapy considering TAT a 'total therapeutic technique'. EP is not integrated into psychotherapy practice, at most psychotherapy practice is understood to provide the basic skills of managing the therapeutic alliance. EP drives the change process.

In moving from psychotherapy to EP, the participants have let go of a role identity as psychotherapist, but have not developed an alternative identity. While they believe EP 'heals' they don't assume the role of 'healer'. As David tries to articulate the difference between psychotherapy and EP he recalls his early experiences of using EP on a particular issue, once again articulating this sense of change preceding insight:

... [the issue] was just gone. I was like some of my clients. It just went away, and I didn't think about it, and so I really realised that was great. So I didn't have to have any insight as to what the issue was that I was dealing with. It just cleared the issue. I think that's the difference between healing and psychotherapy, is that psychotherapy provides insight so as you will know what to do with it. As opposed to healing, it clears the issues.

This sense of sharing a lived experience with their clients, and touching as Mark says, a 'vulnerable place of being', allows the participants to step away from a role identity of expert, fixer, or healer. Mark contends that if we discover who we are 'all the other stuff just sort of dissolves'.

EP has become firmly embedded in their professional lives. They describe how some of their peers were sceptical when they started using EP but that has changed now. Joanna and David see the emerging recognition of the efficacy of EP through referrals from other psychotherapists to consult with clients who are 'stuck' in a current psychotherapy process. All three participants are actively involved in creating professional trainings for psychotherapists interested in EP.

Joanna's closing words, after I asked my final question, wondering if there was anything I had missed in the interview, characterises how each of the participants feels about their work with EP. It is as though the 'advent of Energy Psychology' has heralded a paradigm shift:

I just want to add that I think that the advent of Energy Psychology has enhanced our ability to help people in a way we have never had before and so I am thrilled. I am thrilled that ACEP is getting more recognition, and that there

is more and more research that is coming out about, you know, showing the efficacy of Energy Psychology ... I love it. It helps me to love my work.

4.4 A State of Presence

The participants consistently referred to the importance of therapeutic presence in EP. Their initial training in EP created the first step in the development of presence; they were required to step back and refrain from offering any feedback to clients. This was seen as initially challenging, but ultimately useful. Mark describes the therapeutic stance taken in EP as similar to that in EMDR:

Yes it's quite a change ha ha [hearty laugh] I trained as Rogerian where we listen, listen, listen. We don't intervene very much, and I remember the first shock for me was in EMDR training you weren't even supposed to give a feedback. Because I would always you know feedback 'ah yes you just said to me that', and they told me 'stop the feedback, you don't say anything at all'. So that was a shock. But of course with all the Energy Psychology techniques that would be exactly the same thing. No feedback. No commentaries. No approbation or disapprobation. Just what it is and go on. Go what it is and go on. So that has been quite different, but at the same time very useful.

The role of the therapist is decentred to prioritise the experiencing of the client and the simple discipline of refraining from interpolating has surprising benefits. Joanna describes with some humour how it helped her to give up her position as 'expert':

... you really have to step back. So it was really about retraining to step back and not be so, um, I don't know, pontificating [laughs].

The development of presence was not limited to the process of standing back. Mark attributes the capacity for presence directly to the physical pose used in TAT.

... in TAT it's as if we are in a state of mediation, because my feeling is that the TAT pose, itself, allows oneself to be put into that kind of presence. It facilitates it. It's not an automatic thing, but it certainly facilitates it.

Each of the participants describes how their capacity for presence increased as their underlying fears, anxieties, and neurotic tendencies decreased. Joanna believes that identifying with clients' issues impacts on a therapists' capacity to be present:

... when we resonate with difficulties that other people are experiencing we are going to resonate with whatever's in ourselves. So the more cleared we can make ourselves the better.

Mark relates the capacity to be present to the experience of stripping away the stories of self, and dissolving ‘the painful psychological elements we construct’. Not having to defend a construct of self, or psychotherapist as expert, increases his presence in life as well as in work:

... when you no longer feel that your points of view are essential to justify or defend, you end up getting on with people a lot better ha ha [laughs]. There is nothing to defend.

There is a sense that presence is an individual process of detaching and observing, rather than an interpersonal process between therapist and client. It is as though by being present to self, no longer caught up in identifying with self, the therapist can enter a state of presence. The TAT pose allows the client to enter a similar state of presence, and when the client is in this state of presence healing emerges. The role of the therapist is to stand back and allow healing to happen, not to interfere with the state of presence by ‘pontificating’. When Mark was asked how TAT works he responded, and his description once again highlights the decentring of the therapist and the importance of the client’s presence to self:

Mm. Being present. The presence. The observation ... the witnessing attitude, the witnessing state or the way we are. Whether it be the therapist or the patient. Just being in the pose, hearing or reading the intention, and then just allowing, seeing what comes. That's for me, that is the healing aspect.

4.5 Spiritual Realization

Mark, Joanna, and David described a deepening spirituality that foregrounded a sense of the mystical in their lives. They characterise the change as experiencing spirituality rather than believing in some spiritual construct or philosophy. They each espouse different forms of spirituality: David is a Christian and always held Christian beliefs; Mark explored Eastern forms of meditation in his adolescence as part of his reaction against his father, but consciously moved back towards the scientific when he decided to study psychotherapy; Joanna does not define her spirituality in terms of any specific religious or spiritual philosophy.

While the participants attributed their experiences of clearing trauma and developing presence to their work with a variety of EP techniques, they ascribed their deepening sense of spirituality to TAT. Mark describes TAT as more than just an EP technique:

TAT is so precious to me now, and why I prefer it to any other approach ... it is more a spiritual realization approach.

The sense of deepening spirituality is associated with a letting go of a need for certainty, a shift from a rational and scientific frame to a place of greater comfort with unknowns. Joanna is very clear that in the past she liked to have answers, to be sure of results. Prior to training as a psychotherapist she worked in a quasi-medical profession, unrelated to mental health, where outcomes were definable:

[clients] left better in an hour. So right, so it was very satisfying to have someone come in and be better an hour later.

She believes that it was because of this stance that she originally gravitated towards EP. She was not searching for an approach for spiritual realization; she was looking for an effective psychotherapeutic approach. She now experiences TAT as 'almost a prayer'. When asked if TAT is doing the healing she says no, and starts by saying that the individual is doing the healing, but as she struggles to describe how this happens she uses 'energetic' as a noun. It seems that the 'energetic' is something that she experiences but cannot name or fully articulate. As she tries to find words, her normally fast speaking slows, and she is very present to her sense of not knowing, not having a concrete or scientific answer to offer.

... I think because there is an energetic, that we don't understand. Certainly not 100%, but is out there, we are connected to ... and that's what is doing the healing.

[long pause while she appears very engaged in her inner experiencing]

I mean I don't know for sure. [pause] That's how I understand it.

Psychotherapy is David's second career; his first profession was not health-related and had a basis in maths. Like Joanna, he too investigated a variety of approaches earlier in his psychotherapy career as he searched for approaches that provide results. He says that many clients come in looking 'to fix an it', and the sense is that he wanted to be able to provide such a fix, while also looking to find a fix for himself. That has changed now and what he likes about TAT is that it resolves issues, but it does much more. It is:

... more spiritually oriented, it's moving people towards wholeness rather than resolving issues.

And ultimately the place it has brought him to – and in telling me this he uses my name, as though to underscore the personal significance – is a living experience of ‘spirit’ and ‘energy’. His use of the present tense mirrors the sense of present experiencing in the earlier extract from Mark (see fourth extract in ‘Theme 1’). David has moved from having spiritual beliefs to having direct experience of what Joanna referred to as the ‘energetic’, and Mark called ‘a vulnerable place of being without any particular definite things’:

... it's like spirit equals energy, so Iseult, it is not a belief system. It is a living reality. It's almost a mystical approach ... You have a living experience of the energy, and not just a belief about the energy. There is a big difference there.

Chapter 5: Discussion

5.1 Introduction

The tension between Ricoeur's hermeneutics of empathy and hermeneutics of suspicion (Kaplan, 2003) allows the researcher to extend beyond the participants' accounts creating a fuller understanding of the question under research. This chapter, while remaining grounded in the participants' worlds, incorporates theoretical concepts from the outside to examine the participants' accounts through a lens of questioning (Flowers et al., 2009). The findings are examined under the following headings:

- Research on EP
- Trauma
- Transformation
- Presence
- Paradigm Shift

5.2 Research on EP

This study is consistent with previous qualitative studies of EP, but there is divergence in some important areas (Mason, 2012; Schulz, 2007). Table 5 compares and contrasts the findings from each study. EP is seen as safe and effective, producing 'shifts' that lead to a reduction in traumatic symptoms and improvements in interpersonal relating. There was agreement that EP causes more rapid change than 'talk therapy' alone, though not as rapid as the hype about EP would suggest. David quantifies the difference estimating that prior to EP he has spent up to 4 years working with CSA but finds that similar work can be completed in 6 months with EP. The participants question the likelihood of completing trauma treatment with the ease and speed claimed by some people in the EP community, other than in occasional cases where PTSD is related to an isolated incident such as a road traffic accident, but they confirm that they do see significant and holistic changes in their clients immediately they start working with EP.

Table 5. Analysis of qualitative studies on therapists' experience of EP

Characteristics of EP	Mason (2012)	Schulz (2007)	Current Study
General Findings about EP			
EP creates significant 'shifts' and transformational change	Yes	Yes	Yes
EP is highly effective, but not as effective as some of the EP 'hype' suggests	Yes	Yes	Yes
Significant changes in mood or affect are observed immediately on completion of an EP protocol	Yes	Yes	Yes
EP leads to improvements in interpersonal relating	Yes	Yes	Yes
Therapists use multiple EP protocols	Yes	Yes	Yes
EP is easily self-administered and can be used by clients between sessions	Yes	Yes	Yes
Proper training in EP should be required before using the protocols with clients	NA*	Yes	Yes
EP contributes to a capacity for self-regulation	Yes	Yes	Yes
EP contributes to therapist presence	Yes	NA	Yes
Clients can experience EP as a technique	Yes	NA	Yes
Sometimes clients just need to talk about their experience rather than using EP	Yes	Yes	Yes
Findings Related to Trauma (Mason study did not address trauma)			
EP facilitates desensitisation to trauma without the need for reliving or talking about traumatic experience	NA	Yes	Yes
EP has a very low incidence of decompensation or abreaction when working with traumatic material	NA	Yes	Yes
EP works well with dissociation	NA	Yes	Yes
Areas of Significant Divergence			
EP must be introduced carefully to clients because it represents new paradigm in healing	Yes	Yes	No
Therapists use EP in a relational frame	Yes	Yes	No
EP leads to spiritual realisation	No	No	Yes
* Not addressed in this study			

The participants in this study did not experience any challenges around the introduction of EP to their clients. This may be related to the emerging research on efficacy and growing popularity of EP, or it could be related to the comfort senior therapists feel in their professional identity and choice of techniques (Orlinsky et al., 2005b; Rønnestad & Skovholt, 2001). The other studies do not highlight spiritual involvement, but their focus was on psychotherapy practice, so impacts on personal growth might not have emerged. The previous studies indicate that EP was integrated in a relational frame, but the participants in this study see EP as a distinct therapeutic approach. This is discussed in detail in section 5.4.

An empirical study on the attitudes of psychotherapists who use EP conjecture that they are not interested in working within a scientific model and propose that training in critical thinking might encourage psychotherapists to make more ‘scientific’ choices (Gaudiano et al., 2012). The current study suggests a more nuanced understanding of why therapists chose EP. The participants investigated EP after discussion with colleagues and they experimented on themselves prior to using EP with clients. This mirrors research that shows that interpersonal encounters are perceived as more influential than the impersonal data of clinical research (Orlinsky et al., 2005b, p. 512), and that theoretical orientations are influenced by: experience in personal therapy; clinical experience with clients; engagement with colleagues and supervisors; personal philosophy; personality type; learning style; professional seminars; and reading (Heffler & Sandell, 2009; Norcross & Prochaska, 1983; Orlinsky et al., 2005b; Rosin & Knudson, 1986; Skovholt & Rønnestad, 1995; Vasco & Dryden, 1994). The participants currently work within an EBP framework, using ESTs within the complex context of clinical experience, ethical considerations, and client preferences (Rønnestad & Skovholt, 2012, p. 96). As senior therapists they operate at Belenky’s (1986) highest level of ‘constructed knowledge’ as cited in (Skovholt & Rønnestad, 1992, p. 510), within a complex framework of personally developed theoretical constructs, against which they balance received wisdom from experts espousing specific approaches.

It is possible to understand the account in Gaudiano et al’s study as a product of a specific ‘epistemological knowledge culture’, that of applied psychologists working within a behavioural framework, applying the ‘scientific’ principles of behaviourism to psychotherapy. Cetina argues that science is not unitary, rather it is a disunity of different epistemological knowledge cultures, each with its own biases, and culturally defined strategies and policies for collecting knowledge or defining ‘*how [they] know what [they] know*’ [emphasis in original] (Cetina, 2009, p. 1). Within the knowledge culture from which Gaudiano et al’s study derives, EP and EMDR are defined as ‘pseudoscience’, and therefore do not require investigation (Gaudiano & Dalrymple, 2005; Gaudiano & Herbert, 2000; Herbert & Gaudiano, 2001; Herbert et al., 2000). Clinicians, however, are working in a different context, informed by clinical experience and influenced by the needs, preferences, and characteristics of clients (Rønnestad & Skovholt, 2012, p. 96).

David, in his work with combat veterans¹⁸, responds to the sociocultural context of his clients by not demanding that the psychotherapeutic process force them to disclose and articulate their most shameful moments lived in the complexity of combat – the terror and desperation, the allure and elation – eloquently described by Powers (2014) in his poetry about combat and the challenges of living with PTSD. EP returns some agency to these individuals, and perhaps opens life up to being more than ‘just a catalog of methods, every word of it an effort to stay sane’¹⁹. A six session EFT protocol with combat veterans reduced anxiety, depression, and pain as well as PTSD symptoms, and improvements were maintained at follow up (Church & Brooks, 2014). Studies like this confirm the conclusion reached by Mills and Williams’ (2012); approaches like EP should be studied for what they are and what they offer, in the context of their popularity with practitioners and clients, while maintaining a critical curiosity (p. 325).

5.3 Trauma

5.3.1. EP and Autonomic Dysregulation

Recent understandings contend that trauma is a disorder of autonomic dysregulation and the focus of treatment should be on reducing levels of arousal so that traumatic experience can be integrated into the personal narrative of the survivor (Levine, 1997, 2010; Ogden et al., 2006; Rothschild, 2000; Schore, 2009; Siegel, 2010; van der Kolk et al., 1996; van der Kolk, 2003). This is particularly important in working with severe trauma, where dysregulation is at the core of co-morbid problems such as substance abuse, BPD, and DD (Chu, 2011; van der Kolk & Najavits, 2013). Feinstein theorizes that acupoint stimulation calms dysregulation thereby explaining EP’s efficacy with trauma (Feinstein, 2012).

The descriptions in the participants’ accounts offer another plausible explanation for EP’s impact on dysregulation. The participants variously referred to their experience of EP as form of prayer or meditation. Contemplative prayer and meditative practices have been shown to contribute to physical and emotional well being, increased awareness, and

¹⁸ He finds TFT, which requires no talking at all, particularly useful with this client group. He says ‘I found TFT was much better. I don’t know how the men are in Ireland but over here the men are pretty rigid, like I had one emotion in 1980, and I have never had another one, and so with TFT it would help them clear stuff’.

¹⁹ Powers describes the inadequacy of being taught a variety of techniques to manage the lived experience of PTSD in the poem ‘After Leaving McGuire Veterans’ Hospital for the Last Time’ (2014, p. 41).

de-centering of self (Hart et al., 2013; Josefsson, Lindwall, & Broberg, 2014; Poloma & Pendleton, 1989, 1991; Sedlmeier et al., 2012; Siegel, 2010; Stanley, 2009; Wallin, 2007), through an increased capacity to self-regulate (Sedlmeier et al., 2012; Siegel, 2010; Stanley, 2009; Wallin, 2007). Aspects of EP that are common to spiritual practices may offer an alternative explanation for active mechanisms in EP.

This proposed mechanism has further implications for a phased approach to working with trauma, where the first phase concentrates on building safety and a capacity to self-regulate, prior to working on the integration of trauma in the second phase (Chu, 2011; Herman, 1997; Ogden et al., 2006). Interventions such as EMDR, exposure, and mindfulness are often found to be problematic in the first phase, due to the risk of decompensation (Becker et al., 2004; Germer, Siegel, & Fulton, 2013; Shapiro, 2002). The participants in this study use EMDR but find that it occasionally leads to an abreaction. They believe the TAT pose has an immediate calming effect on dysregulation and use the TAT pose when they are concerned about levels of hyperarousal. They contend that TAT is a safe and effective approach for working with dissociative disorders, combat-related trauma, and CSA. EP, particularly TAT, may be a safer intervention than exposure, EMDR, or mindfulness in trauma informed treatment where dissociation and dysregulation need to be prioritised over the reintegration of traumatic material.

5.3.2. A Common Factors Context

Wampold et al (2010) propose a number of factors that are likely to be common in effective treatment of trauma. Table 6 analyses the participants' accounts in terms of these factors, suggesting that common factors provide a plausible explanation for efficacy²⁰. EP particularly addresses two of these factors, offering clients agency and self-efficacy, by providing techniques that can be self-administered between sessions. It is possible that this feature of EP contributes to the faster treatment timeframes reported by the participants.

²⁰ This analysis is based on a close reading of the participants' accounts. As the interview did not seek information about a common factors approach no inference can be drawn about a lack of evidence of any of these factors. It is interesting to note how many of the common factors were present in the accounts.

Table 6. *Non-specific factors that contribute to treatment of PTSD*

Possible Factors Important to Successful Treatments of PTSD Suggested by (Wampold et al., 2010)	Evident in accounts
Cogent psychological rationale that is acceptable to patient	Yes
Systematic set of treatment actions consistent with the rationale	Yes
Development and monitoring of a safe, respectful, and trusting therapeutic relationship	Yes
Collaborative agreement about tasks and goals of therapy	Yes
Psychoeducation about PTSD	Yes
Opportunity to talk about trauma	Yes
Ensuring the patient's safety, especially if the patient has been victimised as in the case of domestic violence, neighbourhood violence, or abuse	Yes
Helping patients learn how to avoid revictimisation	No
Identifying patient resources, strengths, survival skills and intra and interpersonal resources and building resilience	Yes
Examination of behavioural chain of events	No
Exposure	Yes
Making sense of traumatic event and patient's reaction to event	Yes
Encouragement to generate and use social supports	No
Teaching coping skills	Yes
Relapse prevention	Yes
Factors Particularly Emphasised by EP	
Nurturing hope and creating a sense of self-efficacy	Yes
Patient attribution of change to his or her own efforts	Yes

5.4 Presence

Therapeutic presence is considered an essential aspect of the therapist's contribution to therapeutic alliance by many writers in the humanistic traditions (Bugental, 1978; Cornell, 2013; Gendlin, 1998; May, 1995; Mearns & Cooper, 2005; Thorne & Sanders, 2012; Thorne, 2002; Yalom, 2003). The participants' accounts do not fit clearly within the humanistic account of how presence contributes to psychotherapy. EP training requires the therapist to stand back, decentering the therapist to prioritise clients' present moment experience. This contrasts with a common perception in humanistic and integrative psychotherapy that presence cannot be taught; rather it emerges as a phenomena of increasing personal awareness (Rowan & Jacobs, 2002). It is possible that training in person-centred and humanistic psychotherapy deconstructs the philosophy of Rogers (2004) into atomic techniques, such as reflective listening, paraphrasing, and summarising, which paradoxically reduces therapist presence by fostering a concentration

on technique. In essence this is what Mark suggests when he contrasts his experience of learning EP to the Rogerian approach of his original training.

In the participants' accounts presence, spirituality, and transcendence emerge as intertwined phenomena that contribute to the participants' experience of healing. This is mirrored in the experience of three out of five therapists in Mason's study (2012), who believed that energy work helped them connect with clients on a spiritual level, enabling deeper healing (p. 6). A similar motif is found in two qualitative studies of psychotherapists who place importance on presence: 'integrated spiritual practice' (Phelon, 2004, p. 352), and daily meditation practice (Geller, 2002) are considered supportive to the development of presence.

Therapeutic presence is more widely studied in nursing. Osterman and Schwartz-Barcott (1996) describe four levels of presence in nursing: presence, partial presence, full presence, and transcendent presence. It is this last category that accords some understanding of presence as it is experienced by Mark, David, and Joanna.

Transcendent presence is described as going beyond physical and psychological presence into a metaphysical presence, drawing from universal energy; role free, moving beyond the constraints of professional relating. This description of transcendent presence appears to operationalize Rogers' writing about his experience of therapeutic presence:

... in a slightly altered state of consciousness, then whatever I do seems to be full of healing. Then simply my presence is releasing and helpful to the other. There is nothing I can do to force this experience, but when I can relax and be close to the transcendental core of me ... it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present. (Rogers, 1996, p. 129)

Rogers' experience of a 'transcendental core' and 'energy' is reminiscent of Mark's 'vulnerable place of being', David's 'spirit equals energy', and Joanna's 'energetic'. Like Rogers, most humanistic writers place an emphasis on the relationship, believing that healing emerges when the therapist and client meet at 'relational depth', facilitated through the empathy and presence of the psychotherapist (Mearns & Cooper, 2005). The words 'spiritual' or 'magical' are attributed to moments of relational depth by participants in a qualitative study on psychotherapy process (Wiggins, Elliott, & Cooper, 2012, p. 120).

The participants in the current study do not believe the relationship is the main conduit; rather they see basic human connection as a context for healing, a necessary, but certainly not sufficient condition. The client's work with EP is the primary mechanism of change. EP facilitates healing through fostering the client's presence to his or herself. The a priori assumption that therapeutic presence creates healing may be a constructed concept within the epistemological knowledge culture of humanistic psychotherapy, one that is not supported by psychotherapy research. Process research shows that the client's experience of the therapeutic alliance is more important than the therapist's experience in determining outcome (Greenberg, Watson, Elliot, & Bohart, 2001; Hannan et al., 2005; Horvath & Bedi, 2002), and a study that attempted to measure the impact of therapist presence on the relationship, found that clients' reports of therapists' presence showed a significant predictive relationship with clients' ratings of therapeutic alliance; however, therapists' ratings of self-reported presence were not predictive of clients' ratings of therapeutic alliance (Geller, Greenberg, & Watson, 2010).

The importance of the client's perspective and contribution to successful outcomes is supported by earlier humanistic process research, which showed that clients who had the capacity to contact an inner 'felt sense' experienced most change in psychotherapy. Clients who could not access the 'felt sense' failed to change even when therapeutic alliance was good (Gendlin, 1982, 1998). Gendlin's research led to the development of the focusing process, which forms the basis for a number of somatic approaches to working with trauma (Levine, 2010; Ogden et al., 2006). Cornell (2013) articulates the process of focusing as a kind of 'self-listening', where the client is encouraged to disidentify from emotional experience, moving into a state of 'self in presence'. The therapist supports the client in 'self-listening' through presence, focusing on the client's experiencing rather than the therapist's interpretation of the client's experiencing. From this space experiential shifts emerge that precede shifts in cognition and insight.

The procedural steps in focusing are very similar to the description of working with TAT. The first instruction David gives to clients is to dis-identify from the emotional experience. Mark believes that the physicality of the TAT pose puts clients into a state of presence, and each participant describes experiential shifts that precede cognitions and insight, a phenomenon that is confirmed in the EP literature (Mason, 2012). This offers an interesting reference point for further research on how EP works, one that is not currently theorised in the EP literature.

While noting these similarities between focusing and EP it is clear that there are also significant differences. Focusing requires a level of somatic awareness that is typically not available in the dysregulated states associated with trauma. Ogden (2006, p. 210) acknowledges that clients with complex trauma can be ‘easily triggered by interventions that access the body too quickly’, and trauma approaches based on focusing proceed slowly until somatic security and awareness are developed. EP may provide a manual technique that calms dysregulation (see Table 2) while facilitating contact with a felt sense. While these ideas about the relationship with focusing are very speculative they offer an interesting alternative to explanations that rely solely on an acupoint and TCM based understanding of EP.

5.5 Transformation

The overarching theme that emerged in the findings was that EP contributed to an experience of transformation in the participants’ personal and professional lives. This transformation arose in the context of their commitment to continued personal and professional development, combined with a reflective stance regarding significant events and issues in their lives. None the less they attribute much of their experience of personal growth to EP. Their accounts both converge and diverge with the typical lifespan developmental arc of psychotherapists (Orlinsky et al., 2005b; Rønnestad & Skovholt, 2012).

Like many senior therapists, Mark, Joanna, and David express a sense of vitality and joy about their professional work, feel confident about their capacity to help clients, and no longer experience the anxieties associated with earlier stages in career development. Their accounts mirror the language of the senior therapists in Rønnestad and Skovholt’s study:

[EP is] another tool in your tool box and it’s not the answer it’s just one of the answers and I think it’s good that people have a variety of answers, a variety of modalities that they can use working with people ... I [don’t] have any anxiety about my work anymore .. I have been excited by my work for a number of years [David]

With diminishing anxiety, I became less and less afraid of my client and with that came an ease for me in using my own wide repertoire of skills and procedures. They became more available to me when I needed them. ... This brought a sense of intense pleasure to me. [Senior Therapist] (Rønnestad & Skovholt, 2003, pp. 26–27)

On initial consideration the developmental arc of the participants appears to converge with previous studies, but there are also interesting points of divergence. The first area of divergence is around the role of personal psychotherapy in the development and growth of psychotherapists. Orlinsky et al believe that all therapists have at their centre a 'patient vector' (Whitaker, Malone; 1954) as cited in (Orlinsky et al., 2005a), which they must understand and manage in their role as therapist, and suggest that this is one of the main functions of personal therapy. When therapists describe their experience of therapy as clients they conclude that 'psychotherapy could be effective and that change is possible, albeit gradual' (Geller, Norcross, & Orlinsky, 2005, p. 222) and the process of personal and professional growth is seen as 'long, slow, and erratic' (Skovholt & Rønnestad, 1992, p. 511).

The participants in this study expressed the view that a focus on personal development is vital, and agree that gradual change is possible through psychotherapy, but they also believe that the change is incomplete or partial leading to insight rather than deep change. With EP they experienced rapid and dramatic shifts mirroring descriptions in other qualitative studies of EP (Mason, 2012; Schulz, 2007). This differentiates the process of change in EP from the common understanding of change in psychotherapy, where clients make conscious changes based on acquiring new insights, changing negative thinking patterns, or learning new ways of relating through the reparative experience of the therapeutic relationship. The participants in the current study believe that EP supports and heals their 'patient vector' in a way that traditional forms of psychotherapy do not and question the received wisdom of psychotherapy that personal growth is inevitably long, slow and painful.

Spirituality stands out as a significant differentiator between the experience of the participants in this study and the research on the lifespan development of therapists. Studies show that spirituality is important in the lives of many psychotherapists (Delaney et al., 2013) and many psychotherapists adopt a personal spirituality that is 'outwardly secular, but inwardly religious' (Smith & Orlinsky, 2004). Of the participants in this study, only David expressed a specific religious affiliation, whereas Joanna and Mark fit the description of a personal spirituality. All three describe an inward involvement in a personal relationship with the mysteries of existence, which is subjective and individualistic in nature, and can be understood as mystical; mysticism is an experiential aspect of spirituality that contributes to the development of new perspectives by moving

beyond the immediate context of the self (Aldridge & Fachner, 2005). As the participants describe their deepening spirituality they communicate a sense of awe and mystery about this way of experiencing themselves, and search to find the words to describe their felt experience, coalescing with Gorsuch and Miller's (1999) description of mystical experience as at once, profound, transcendent, and difficult to articulate.

It is possible that their deepening spirituality is part of a general developmental process where spirituality is foregrounded in later life, after a focus on self development (Irving & Williams, 2001; Maslow, Maslow, & Lowry, 1998), none the less it arose in the context of their personal work with TAT. Their experience of transcendence, of moving outside the context of a limited self, went hand in hand with a continuing process of addressing their personal wounds. There is no evidence that they used transcendence to rise above the messiness of human existence; they seem to have made peace with their inadequacies, wounds, and personal sorrows avoiding the escape of 'spiritual bypassing'²¹ (Caplan, 2009; Masters, 2010; Welwood, 2002). A concurrent process of decentering in their professional identity is seen in their move from psychotherapist as expert who 'pontificates', heroic in the process of psychotherapy, to a position where the client, and possibly, some hard to define quality related to 'energy', is the hero. It is possible that their phenomenological experience – just like that of Rogers – leads them to the same intuitions about life force and energy that inform Eastern understandings of 'Qi' (Sohn, 1996).

This study offers an alternative account for why some senior therapists experience a 'realignment from self as powerful' in the therapeutic relationship (Rønnestad & Skovholt, 2012, p. 159). Rønnestad and Skovholt suggest that decentering occurs through a 'series of humiliations' where failures with clients are integrated in the therapists self experience, but for Mark, Joanna, and David, the juxtaposition of mystical experience with touching into places of core vulnerability seems to have been more potent. Their experience that EP provides easy to learn techniques, which require no expertise in mental health or acceptance of arcane spiritual philosophies, may also democratise the practitioner/client dyad in their eyes. The practitioner takes on the role of witness, not expert, mentor, or guru.

²¹ Using spirituality and spiritual practice to avoid dealing with the pain of unmet developmental needs.

Each of the participants described their personal mysticism using language that was unique, expressing their spiritual involvement through different concepts and philosophies, suggesting that their experience is deeply felt and ideographic, rather than a wisdom or philosophy given through the dogmas of a religion, or the pressures to take on the beliefs or philosophies of a spiritual group or set of teachings. When questioned about how their clients perceive the spiritual aspects of TAT they noted that TAT can be used equally effectively in a secular or spiritual format, and that different clients resonate with one or the other based on individual preference. The participant's description confirms research that shows that spiritual practices remain effective even when spiritual elements are secularised (Siegel, 2010).

David, Mark, and Joanna describe their current way of experiencing the world variously using the adjectives 'ease', 'peace', 'joy', 'happiness', 'health', 'spiritual', 'mystical'. While serenity is not a word they use, Roberts and Cunningham's (1990) concept analysis of serenity, which defines serenity as 'a spiritual experience of inner peace, trust and connectedness' (p. 582), captures the overall sense their descriptions create. Their descriptions fit with Maslow's concept of plateau experience, a sustained and calm response to the mystical, in contrast to the intense and high emotions of a peak experience (1994). The sense of flourishing described by the participants is consistent with research that shows that people involved in religious and/or spiritual practice are on average physically healthier and emotionally happier (Koenig et al., 2012; McEntee et al., 2013, 2013). Spiritual involvement may explain why this particular sample of senior therapists expressed such consistently high levels of vitality and engagement in their lives and work, unlike other senior therapists whose reports 'vary in positive and negative tone' (Rønnestad & Skovholt, 2012, p. 122). It also offers an explanation for why the participants' accounts indicate a more significant increase in healing involvement and greater reduction in stressful involvement than is indicated by the linear progression outlined in Figure 1.

5.6 Paradigm Shift

The double hermeneutic of IPA requires the researcher to make sense of the ways in which the participants make sense of EP. In considering how the participants express the differences between EP and psychotherapy the researcher concluded they see EP as a significant shift in paradigm. Rather than integrating EP into psychotherapy practice they now practice EP. Nonetheless their descriptions do not offer a clear rationale or

cogent theoretical definition of EP, they base their rationale on the phenomenology of their own personal growth through EP combined with their clinical experience with clients.

Yet for research purposes an understanding of EP within the context of traditional formulations of psychotherapy remains an interesting question. EP appears to be a hybrid of behavioural psychology, spiritual practice, and somatic elements. Attending to the language in the participants' accounts hints at the ideas that are driving this paradigm shift. It is as though new metaphors related to the treatment of trauma are tentatively emerging; traumas are 'stuck' or 'stored', and EP 'clears' what is stuck causing 'shifts'. Listening to these accounts the researcher is reminded of Merleau-Ponty's phenomenology of embodied understanding, where experience has a felt quality, out of which understanding emerges (2002). The participants felt experience of EP is captured in the language they chose.

Gadamer describes 'horizons of understanding' shifting and extending to create space for new protean understandings to find voice when we listen to the other as though they could be right (Gadamer & Linge, 2008). Placing the participants' accounts in the context of the language used by other trauma clinicians hints at common perspectives. Levine describes trauma as 'locked' in the body so that the traumatised individual is frozen in an 'unfinished' state. Browne agrees with Levine, but describes traumas as being cut off from experience and memory remaining 'frozen' or 'suspended' (Browne, 2009, p. 285). Van der Kolk (2009) believes that 'PTSD causes memory to be stored at a sensory level' in the body (p. 12).

On one level this idea of the need to process or clear trauma is similar to the CBT model, which contends that trauma symptoms persist because the traumatised individual avoids stimuli that remind them of trauma, interrupting adaptive processing that would naturally lead to a reduction in anxiety (Abramowitz et al., 2012, p. 240). Treatment involves engaging with trauma-related stimuli until the event is processed. EP appears to work differently, calming the hyperarousal of trauma, while methodically working through layers of trauma in the order they emerge. As a trauma is cleared the individual no longer needs to avoid stimuli related to that trauma. While this difference might appear semantic, leading to the conclusion that EP is working through standard behavioural mechanisms (Waite & Holder, 2003), there are differences that have very real implications for how treatment is experienced by clients.

A client in Schulz's study reported a sense of not being impacted by events any more after working with EP, describing the trauma of CSA as 'it has floated away' (Schulz, 2007, p. 18), evoking the same sense as David's combat veteran, who noted that charged feelings about a combat experience were gone upon completion of an EP session. Contrast these reports with the experience of clients who fear exposure (Shearing et al., 2011) finding it 'exceedingly difficult, anxiety provoking and physically draining' (Vincent et al., 2013, p. 11). Psychotherapists avoid using exposure therapy with clients, due to a perception of re-traumatization, increased symptomology, and high drop out rates (Becker et al., 2004), yet it is not clear what alternative they offer their clients.

The humanistic and psychodynamic approaches focus on provision of a reparative experience through the therapeutic relationship. While there is no demand that the client relives the trauma there is an emphasis on symbolising traumatic material in speech so that it can be reintegrated into the client's narrative. There are fundamental flaws in this approach; trauma defies linear narrative, makes a mockery of chronology, tests the expressive capacity of language, and engenders a wide variety of defensive reactions in therapists (Laub, 1992; Rothschild, 2000; Terr, 1995). At the heart of severe and complicated trauma is an experience of powerlessness through injury by another human, but traditional forms of psychotherapy have failed to theorise the power dynamics of the therapist/client dyad (Proctor, 2002), or address the myriad ways that the therapeutic relationship triggers affective memories of relational trauma (van der Kolk & Najavits, 2013).

EP offers the possibility of a different account of the therapeutic relationship; one that decenters the role of the therapist while focussing on the client's experiencing. It gives clients choice and flexibility in how they heal from trauma, providing relief from PTSD symptomology with no requirement to relive or speak about the trauma, while also providing space to address the existential issues that are at the core of traumatic experience. While EP appears to represent a paradigm shift – recognising trauma as a primary cause of psychological distress but understanding that the resolution of trauma requires interventions that directly address the physiology of traumatic stress – it can also be contextualized in a much wider paradigm shift that is emerging in psychotherapy. A number of researchers and practitioners advocate moving the practice of psychotherapy beyond the epistemological knowledge cultures of specific therapeutic approaches, privileging the client rather than the therapist as heroic in the therapeutic relationship

(Duncan, Miller, & Sparks, 2004), and recognising the importance of respecting clients' preferences over therapists' allegiances (McLeod & Cooper, 2012).

While this study has theorised two mechanisms for how EP contributes to the treatment of trauma, future efficacy research that compares EP to other therapeutic approaches may conclude that efficacy is based on common factors found in many forms of psychotherapy. But there is a possibility that research may also confirm that simple manual techniques like tapping can have a powerful effect on neurophysiology. Regardless of what conclusions emerge it is clear that EP has had a profound impact on Mark, Joanna, and David, utterly changing their understanding of psychotherapy and contributing to a lived experience of flourishing and serenity. Mark and David agree with Joanna – EP helps them to love their work.

Chapter 6: Conclusion

The participants in the current study concluded that EP supports and heals their ‘patient vector’ in a way that traditional forms of psychotherapy do not. This process of personal growth was linked in a complex, reciprocal relationship with spiritual realization and the development of therapeutic presence. The profound changes reported by the participants inform the central hypothesis of this study, which is that EP catalysed transformation in the participants’ personal and professional lives, leading to a lived experience of serenity and flourishing.

The pilot interview provides further support for this hypothesis. Mary, the therapist in the pilot interview, is in the ‘established’ stage of development (7 – 14 years), and has been using EP for a number of years, but does not meet the inclusion criteria for length of time since professional certification in EP. Her interview provides a single data point that supports the hypothesis, which in quantitative terms is meaningless, but within the idiographic framework of IPA adds texture to the findings of this study. In her case, the changes cannot be understood as a result of the overall development process of a senior therapist. The following quotes illustrate the themes of transformation, state of presence, and spiritual realisation:

[EP] has definitely impacted my spirituality, I always was an agnostic ... but now there are times I have these really deep experiences of God being present, not all the time ... I wouldn’t say it has made me a more religious person, but it has deepened my spirituality.

[EP] helps me be more present.

Further conclusions are that EP has characteristics in common with contemplative prayer and meditation that may contribute to an increased capacity to self-regulate. Phenomenological descriptions of EP share some similarities with the process of focusing, which forms the basis for a number of treatment approaches to trauma. Based on these findings Table 8 updates the list of proposed active mechanisms in EP.

Table 7. Active Mechanisms in EP, including findings from this study

Active Mechanisms in EP	TFT	EFT	TAT
<i>Mechanisms proposed in existing literature</i>			
Cognitive restructuring	No	Yes	Yes
Exposure	Yes	Yes	Yes
De-sensitization	Yes	Yes	Yes
Distraction	Yes	Yes	Yes
Release of serotonin due to tapping	Yes	Yes	No
Release of oxytocin	Yes	Yes	Yes
Placebo	Yes	Yes	Yes
Expectancy	Yes	Yes	Yes
<i>Additional mechanisms proposed by this study</i>			
Mechanisms derived from spiritual practices			
Acceptance	No	Yes	Yes
Forgiveness	No	No	Yes
Directed attention	Yes	Yes	Yes
Self-compassion	No	Yes	Yes
Dis-identification from self	Yes	Yes	Yes
Mechanisms related to ‘focusing’ (Cornell, 2013)			
Dis-identification from emotional issues	Yes	Yes	Yes
State of ‘self in presence’	Yes	Yes	Yes
Contacting a ‘felt sense’	Yes	Yes	Yes

Further conclusions include:

- EP shares non-specific factors common to other forms of therapy that also contribute to its effectiveness
- The spiritual development experienced by the participants suggests that EP may also address the existential meaning making aspects of the experience of trauma.
- EP can be considered in EBP for trauma for clinicians and clients who do not favour ‘reliving’ experiences
- EP fits with new approaches to psychotherapy that privilege the client, rather than the therapist, as heroic in the therapeutic relationship.

6.1.1. Limitations

As in all qualitative research the findings are influenced by the subjectivity of the researcher and offer a particular interpretation of the data that might not be reproducible by another researcher.

The participants' accounts do not represent the whole picture with regard to their practice of psychotherapy as the research question was aimed at understanding the impact of EP, nor does it address the experience of their clients, whose voices are only reported.

While the participants use a number of EP approaches in their clinical practice, they each reported a personal preference for TAT. Therefore some of the findings may be specific to TAT rather than EP as a whole. TAT is not supported by empirical research; there is only one RCT for TAT investigating weight loss relapse prevention, and no positive effect was found (Zange, 2013).

The participants were senior therapists and some of the findings might relate to their developmental stage and life experience rather than to the impact of EP.

6.1.2. Strengths

This study was rigorous, carried out in the context of a well-defined quality plan. Large quantities of data are synthesised in easy to understand tables and figures, allowing the reader to consider findings in light of existing research. The study develops new theories about the active mechanisms in EP, and makes findings that are useful to clinicians who treat trauma. It highlights gaps in existing research on the lifespan development of psychotherapists, and suggests that rather than comparing EP to traditional forms of psychotherapy, EP should be considered with critical curiosity for what it offers to psychotherapists and clients.

6.1.3. Suggestions for Further Research

The tentative suggestion that EP catalysed a transformation in the lives of the participants merits further research using a sampling technique that allows comparisons between therapists at different stages of development.

The interesting data generated by this study highlights the usefulness of examining the impact of working with specific therapeutic approaches. Comparative studies between

EP therapists and therapists using other approaches might identify meaningful differences between approaches.

The apparent similarities between EP and EMDR, and their efficacy for trauma, suggest that a comparative qualitative study between these approaches might provide interesting findings about the treatment of trauma.

Further topics that merit research include:

- Studying the phenomenology of ‘shifts’ and ‘clearing’ ascribed to EP and comparing them to phenomenological accounts of how change is experienced in other forms of therapy
- The impact of spiritual involvement on the development of therapists, and on the therapeutic relationship
- A comparison of the phenomenology of the state of ‘self in presence’ from focusing, states of mindfulness, and the state facilitated by the manual techniques of EP
- Investigating EP using measures and approaches that have been used in the investigation of meditation
- Qualitative studies on the clients’ experience of EP

6.1.4. Implications for Clinical Practice

- Clinicians can consider EP in EBP for clients who do not favour reliving or exposure experiences in the treatment of trauma.
- EP is indicated in the treatment of severe trauma based on the following characteristics: positive impacts on autonomic dysregulation, low chance of abreaction, and capacity to self-administer allowing clients to manage intrusive symptoms between sessions. It can be integrated in a phased approach to the treatment of trauma in phase 1) to increase client’s experience of physical safety through calming dysregulation, and in phase 2) to address the integration of traumatic material while minimising abreaction and decompensation.
- The impact on spirituality and development of therapeutic presence indicate EP may fit in a humanistic and integrative framework.

6.1.5. Implications for Training and Development of Psychotherapists

The central hypothesis of this thesis, that EP catalysed a transformative developmental process, combined with reports about the effectiveness of EP and the suitability for self-administration, suggest that EP could be used as a tool for personal development during psychotherapy training and in continuing professional development.

The suggestion that presence can be taught through a process of the therapist standing back and de-centering suggests that similar techniques could be integrated into general psychotherapy training.

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Appendix A. Glossary

ACEP	Association for Comprehensive Energy Psychology
APA	American Psychological Association
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CSA	Child Sexual Abuse
DD	Dissociative Disorders
DID	Dissociative Identity Disorder
EFT	Emotional Freedom Technique
EMDR	Eye Movement Desensitization Reprocessing
EP	Energy Psychology
EST	Empirically Supported Treatment
EBP	Evidence Based Practice
IPA	Interpretative Phenomenological Analysis
PTSD	Post Traumatic Stress Disorder
RCT	Randomized Controlled Trial
TAT	Tapas Acupressure Technique
TCM	Traditional Chinese Medicine
TFCT	Trauma Focussed Cognitive Therapy
TFT	Thought Field Therapy
WHO	World Health Organisation

Appendix B. Reflexive Statement

Personal Reflexivity

I have experienced a number of approaches to psychotherapy as a client. Based on these experiences I concluded that psychotherapy has limited efficacy in the treatment of PTSD. I used EP as a self-administered tool, learned from the Internet, and found that it was highly effective in the resolution PTSD symptoms. Subsequently I trained as an EP practitioner but found myself concerned about efficacy claims and the suggestion that practitioners untrained in psychology or psychotherapy might ethically treat complex mental health conditions. I believe that the understanding of trauma within traditional forms of psychotherapy is simplistic, failing to address traumatic stress or consider how power is constructed in therapist/client dyads. Equally I believe that some of the newer somatic approaches to trauma neglect existential and relational aspects of the experience of trauma. This research has not changed these opinions, but it has given me a much broader understanding of how each approach constructs trauma, and how clients and therapists experience the treatment of trauma.

I was surprised by a number of things during this study:

- I had expected the participants to use EP within an integrative psychotherapy framework, possibly because that is the framework within which my psychotherapy training is conceived, and was surprised that they see EP and psychotherapy as quite distinct.
- The way the participants foregrounded the clients experience with EP rather than the psychotherapeutic relationship as the main factor in relieving psychological distress.
- The importance the participants accorded to EP in their experience of a deepening spirituality. I noted in myself an initial reluctance to develop this theme, due to an internal sense that discussing spirituality might allow both the participants experience and my research to be dismissed as somehow ‘unscientific’.
- The participants made no mention of vicarious trauma, or compassion fatigue. On researching this area further I found that many psychotherapists do not experience vicarious trauma, particularly more experienced psychotherapists, like the sample in this study.

Epistemological Reflexivity

- The use of IPA influenced the final research question contributing to the decision to inquire into the impact of EP on the participants’ personal lives. This highlighted the role of spirituality in a way that a different research method may not have done. It also resulted in the participants giving rich descriptions of their personal client experiences with EP providing unexpected insight into the client experience of EP.
- The decision to introduce homogeneity in the sample by ensuring that all participants shared experience of at least one EP method may have resulted in foregrounding a particular set of experiences that are not generalizable to EP as a whole.
- Examining EP in the context of integrative psychotherapy within a humanistic and psychodynamic framework leads to a particular set of findings concerning presence and therapeutic relationship which might not have been considered if the data was looked at through a different lens.

Appendix C. Participant Information Sheet

Research Study: An exploration of the Integration of Energy Psychology into Psychotherapy Practice with Trauma Clients

PARTICIPANT INFORMATION SHEET

Introduction

My name is Iseult White and I am a studying for an MA in Psychotherapy in Dublin Business School. I am researching the integration of Energy Psychology into psychotherapy practice. I am particularly interested in psychotherapy for trauma.

I am inviting experienced psychotherapists, who use Energy Psychology techniques in their work with trauma, to participate in this study by agreeing to a 45-60 minute taped interview.

If you would like to participate please read the detailed information provided below.

Who is organizing this study?

This study is part of a Masters Degree in Psychotherapy being undertaken at Dublin Business School, Dublin, Ireland.

What is the purpose of the study?

The purpose of this study is to understand how the integration of Energy Psychology techniques into psychotherapy practice impacts and informs the work and life of experienced psychotherapists.

What are the criteria for participation in the study?

Participants in this study must be experienced psychotherapists, currently licensed and practicing, and must have a recognized Energy Psychology qualification. Further details of criteria are listed below:

Psychotherapy Experience	7 years post qualification/accreditation
EP Training	Practitioner level accreditation at in at least one EP approach such as DEHP, TFT, EFT, TAT, or AIT
EP Experience	3 years post practitioner qualification/accreditation such as DCEP, TAT, EFT, TAT, AIT
Other Criteria	Currently working with EP in clinical practice Uses EP in work with clients who experienced trauma

What is involved in participation?

If you choose to contribute to this study, you will be invited to take part in a face-to-face interview over Skype. The interview will take approximately 45 - 60 minutes and will seek to understand your experience of using Energy Psychology. The interview will be taped and later transcribed by the researcher.

Are there any risks/benefits?

There are no known risks to you from taking part in this research. The results of the study will be made known to you and may benefit you in your work.

Will my identity be protected?

Your identity will be protected and known only to the researcher. All identifying information will be removed during transcription to protect your anonymity. Notes about the research will be stored in a locked file. Each person who participates in the research will be given a code number so that the researcher will be the only person who can identify the participant. The key to the code numbers will be kept in a separate locked file. The audio recordings of the sessions will only be accessible to the researcher and will be destroyed once transcripts have been made of the sessions.

Can I withdraw from the study?

If you initially decide to take part you can subsequently change your mind. You can request to have your data removed from the study. Additionally, under the Freedom of Information Act (1997) you have the right of access to information concerning you, which you may request from the researcher in writing.

How can I get further information?

For additional information please contact:

Researcher:	Ms Iseult White	iseult.white@gmail.com http://iseultwhite.com/about/
Research Supervisor:	Ms Siobáin O'Donnell	siobain.odonnell@dbs.ie

<http://www.dbs.ie/psychotherapy-ma>

DBS School of Arts,
13-14 Aungier Street, Dublin 2.



Appendix D. Email with Consent Statement

Thank you for agreeing to participate in the **Research Study: An Exploration of the Integration of Energy Psychology into Psychotherapy Practice with Trauma Clients**.

The next steps are:

1. Send a confirmation email stating that you have read the Participant Information Sheet (attached to this email), and formally give consent to your participation. The consent statement at the end of this email provides a sample statement of consent.
2. Arrange a time for the interview.
3. One week prior to the interview I will ask you to fill out a short demographic questionnaire that seeks information about your qualifications and theoretical orientation. This should take approximately 5 minutes to complete. The purpose of the demographic questionnaire is to gather general information so we can make the best use of the interview time.

If you have any questions please don't hesitate to contact me.

Regards
Iseult

CONSENT STATEMENT

I have read the document Participant Information Sheet.pdf. I give my informed consent to participate in this study and agree that my contribution can be included in this research thesis, academic reports and publications. I understand my right to anonymity and I understand that I can withdraw my participation from this study any time prior to completion of the final draft on May 1st, 2014.

Appendix E. Demographic Questionnaire

6/5/2014

EP Research Study - Google Forms

EP Research Study

This form gathers some basic demographic information. Please remember to press SUBMIT at the end of the form.

1. **How many years have you been practising as a licensed psychotherapist?**

.....

2. **What level of psychotherapy qualification do you hold?**

Select any that apply

Check all that apply.

- ☐ Diploma
- ☐ Undergraduate degree
- ☐ Masters level degree
- ☐ Doctorate level degree
- ☐ Other:

3. **What theoretical orientation best describes your original training?**

Select any that apply

Check all that apply.

- ☐ Integrative
- ☐ Counseling Psychology
- ☐ CBT
- ☐ Psychodynamic
- ☐ Person centered
- ☐ Gestalt
- ☐ Jungian
- ☐ Psychoanalytic
- ☐ Other:

4. **Please list any post qualification psychotherapy trainings that you use frequently in your practice?**

For example: EMDR, DBT etc ...

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.....

5. Please list any EP qualifications you hold at a practitioner level.

Include the year that you got the qualification e.g. EFT - 2001, TAT - 2005

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.....

6. What percentage of your client base is trauma related?*Mark only one oval.*

- ☐ 0 - 15%
- ☐ 16 - 30%
- ☐ 31 - 50%
- ☐ 50 - 100%
- ☐ Other:

7. Are there particular categories of trauma that you specialise in?*Check all that apply.*

- ☐ Combat veterans
- ☐ Childhood sexual abuse
- ☐ Domestic violence
- ☐ Natural disasters
- ☐ Victims of crime
- ☐ None: I work with all trauma
- ☐ Other:

8. Please select the trauma interventions that you frequently use in your practice

Select any categories that apply

Check all that apply.

- ☐ EMDR
- ☐ EFT
- ☐ Hypnotherapy
- ☐ TAT
- ☐ Trauma focussed CBT
- ☐ TFT
- ☐ Somatic Experiencing
- ☐ Sensimotor
- ☐ None
- ☐ Other:

9. Please select the trauma interventions that your clients frequently request?

Select any categories that apply

Check all that apply.

- ☐ EMDR
- ☐ EFT
- ☐ Hypnotherapy
- ☐ TAT
- ☐ Trauma focussed CBT
- ☐ TFT
- ☐ Somatic Experiencing
- ☐ Sensiormotor
- ☐ None - My clients don't request an intervention
- ☐ Other:

10. Please add any background information that you feel might be relevant, but is not covered by this questionnaire.

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Appendix F. Semi-Structured Interview

1. I'd like to start by hearing about what brought you into psychotherapy work?
2. And similarly, what brought you into working with trauma?
3. What led to your interest in EP?
4. How do you feel when you are working with EP?
Prompt: physically, emotionally, spiritually
5. If you remember back to how you felt in your work prior to the integration of EP, can you describe any differences between how you feel in your work now and how you felt in your work then?
6. Can you describe any differences in how you think about your work now, and how you used to think about your work prior to the integration of EP?
7. Do you imagine there are differences for clients in their experience of psychotherapy with EP and without EP?
8. Can you tell me any things that you believe would be useful to share with a psychotherapist who is planning to integrate EP into psychotherapy work?
9. Likewise, are there things that you believe might be useful to share with a practitioner who is trained only in EP techniques?
10. If you remember yourself as an individual before you started working with EP, and consider yourself now, can you describe any impacts that you believe EP has had on you as a person?
11. Can you describe any ways that integrating EP into your work has impacted your relationships with other psychotherapy colleagues?
12. If you have been a therapy client (or supervisee) do you imagine that working with EP has changed what you might look for as a therapy client (or supervisee)?
13. Is there anything else you would like to add, or any questions you wish I had asked?

Appendix G. Secondary Research Questions

Characteristics of EP

- What are possible active components of EP?
- Is EP seen as a somatic intervention?
- Are there particular aspects of EP that address trauma?
- Does the speed with which these techniques are reported to work have an impact on the therapeutic process?

EP in an Integrative Framework

- How does working with EP alter concepts of the development and treatment of psychological distress?
- How does EP fit in a common factors model of psychotherapy?
- How does EP fit in a humanistic and Integrative framework?
- What influences psychotherapists in their choice of EP?
- What model of integration do psychotherapists use with EP?
- On what basis do psychotherapists determine if a technique is effective i.e. supported empirically, intuitive decision?

Appendix H. Sample from Transcript

<p>At peace = at ease with self – not worried about what others think</p> <p>A change in the last 10 years.</p> <p>Shift in way of being – from self-conscious and concerned about other's views – is this related to TAT and EP?</p> <p>Some of the change in how he works now is due to underlying shifts in his own way of being in the world</p> <p>Contraindications for EMDR, no targets, dissociation, not enough ego strength</p> <p>TAT is main modality he suggests to clients at moment</p> <p>TAT is easy to learn – for clients too, clients use it on self?</p> <p>He feels at peace in himself about proposing TAT – <u>suggests previously not at peace in proposing things to clients: shift in self</u></p> <p>EMDR sometimes causes distress – see contraindications above</p>	<p><i>How do you feel when you are working with energy psychology?</i></p> <p>Well I feel quite at peace today, but if you had asked me how I was 10 years ago maybe it would have been a bit different. Yeah anything which is new when I started new things, of course, you can be a bit worried or concerned that people might not quite understand what your're, you're saying. OK so eh today I feel quite at peace I explain when people come and ask for, basically a lot of people come because I am a consultant in EMDR so they are going to come asking for EMDR but sometimes EMDR might not be the best thing for them when they don't have specific targets, when they are dissociating too much, when they are much too you know not enough psychological stability and equilibrium to really do it so I propose other things as well and mostly right now it's TAT I am proposing and I fell quite at peace about that yeah it's easy to learn, it's, people don't, in EMDR people don't really get distressed often but I would say</p>	<p>Feeling at peace in himself – a shift</p> <p>Greater ease in himself through use of EP</p> <p>Change in self leads to change in practice</p> <p>EP good for dissociation</p> <p>EP good when there is not a lot of psychological stability</p> <p>EMDR can cause distress</p> <p>TAT is easy to learn</p> <p>TAT is preferred approach</p>
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<p>TAT does not cause distress in clients – another reason why they can use it on themselves – don't need the therapist there to handle the distress</p>	<p>that 1 out of 10 people can have some things which are coming up, whereas during TAT it is very very rare to have that kind of thing coming up</p>	
<p>TAT is mystical</p> <p>TAT not an approach based on insight or interpretation – what is the role of the therapist too?</p> <p><i>See it bit by bit</i> – maybe in TAT the change is too rapid sometimes – or is it just the lack of awareness of the change as it happens</p>	<p><i>You mentioned some contraindications for EMDR, would you say there are any specific contraindications for TAT</i></p> <p>The counter indications could be that it's a little bit mystical, that the person doesn't see what is going on, doesn't have any cognitive feedback, or very little, sometimes there are little insights or flashbacks which are going to come up, or my mother all of a sudden, I'm going to see her at one point and we are going to have a conversation, it's not highly nourishing to the intellect or to reason so some people need more, they wanna understand what is going on, see it bit by bit, very often, not always, but often the EMDR can give them sort of an update as they are going on kind of thing whereas very often TAT and EFT will not give them that kind of update</p>	<p>TAT is mystical and may not appeal to some people</p> <p>No contraindications for EP</p>

<p>EP works for everybody – but some may not like the process – or may have some ego investment in something? No contraindications</p>	<p>but it is not a counter indication per se its just a little bit more difficult for those people.</p> <p><i>So it seems that sometimes energy psychology might not suit some clients?</i></p> <p>Doesn't suit there ego ha ha ha but if you can get beyond that it works just as well for them as for anybody else of course</p>	<p>Some people do not like/resonate with EP</p> <p>EP works for everybody</p>
	<p><i>My next question is about any differences related to your work since you have started using energy psychology. If you remember back to how you felt in your work prior to the integration of energy psychology techniques, can you describe any differences between how you feel in your work now and how you felt in your work then?</i></p> <p>A difference in how I feel or a difference in ...</p> <p><i>Yeah a difference in how you feel while you are working with clients or how you feel about your work now eh with energy psychology?</i></p>	

<p>TAT at limit of EP</p> <p>Does not consider TAT an EP technique – so what is it?</p> <p><i>But that's a moot question or one he does not want to answer or ask?</i></p> <p><u>Again – use on self – no longer in same place as 10 years ago – changes include being more at ease with self (see back to 102 – 108)</u></p> <p><i>I am no longer in the same place – shift in identity – seems to be related to usage of TAT</i></p> <p><u>Would have felt more at ease no matter what techniques he was using – not really sure – there is something here that I want to capture – perhaps that the technique has helped him as a therapist – and the ways it has helped him are more important in client work that actually using TAT with clients?</u></p> <p>Again – change in ease within self – not concerned about others opinion etc</p> <p>Changes in self not so much to do with approach but with personal development – but I feel there is some contradiction in here – TAT used on self a lot – would other approaches have worked just as well – <i>and the way it comes at the end after the pause?</i></p>	<p>Yeah as I have been doing eh energy psychology mostly TAT which is at the limit of energy psychology I would personally not even call it an energy psychology technique, but that's a moot question perhaps, since I have been using it a lot on myself, I am no longer in the same place psychologically as I was 10 years ago either, that has a lot to do with it, if I was who I am today 10 years ago even with other approaches I think I would have been more at ease and a lot of questions about what if I make mistakes things that therapists they carry around their own stuff as long as that has not been worked on too much, there is fear of being rejected, fear of not being good enough who am I to ask for money out of these people, I should be doing this for free and all the standard stuff so thats not very prevalent nowadays ehm but I think that's more having to do with the work I have done on myself over the years than the approach per se</p>	<p>TAT is different to other EP approaches</p> <p>EP used by therapist on self EP causes shift in self/identity</p> <p>Greater ease in himself through use of EP on self</p>
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Appendix I. Emergent Themes in Chronological Order

EP tested by use on self	Catharsis does not heal
EP can be self-administered	Conflict in self about medicine/opposite to medicine
Openness to trying new modalities	Psychotherapy is medicine
Rapid change with EP	All psychotherapy is with trauma
Greater ease in himself through use of EP on self	Psychological distress is caused by trauma
TAT is preferred approach	Trauma is stuck
Some people do not like/resonate with EP	Trauma is stored
EP is effective	Psychological distress is caused by identification with the problem
EP used by therapist on self	Psychological distress is caused by identification with self
TAT is tool for spiritual realisation	Trauma memories are stored
Shift in identity - spirituality	EP is a different way of looking at psychological distress (trauma based)
Presence is helpful	Feeling at peace in himself - a shift
TAT has deep personal meaning	Change in self leads to change in practice
EP targets the "problem"	EP good for dissociation
Decenter role of therapist	EP good when there is not a lot of psychological stability
Presence in therapist is important	TAT is easy to learn
Talk therapy does not heal	TAT is mystical and may not appeal to some people
EP heals	No contraindications for EP
Importance of work on self for therapist	EP causes shift in self/identity
EP is not talk therapy	Mystical experience of self
Shift away from traditional psychology/psychotherapy	Letting go of psychological construct of self
Psychotherapy provides boundaries for client/therapist relationship	TAT enables present moment awareness
EP is at the frontier of psychotherapy	TAT is different to other EP approaches
Share knowledge with others	EP approaches target specific issues
Talking about problems does not work	Conflict about spiritual/scientific/psychotherapy
EP had impact on personal relationships	Does not push EP on people
Scientific background of practitioner	TAT is open and non-directive
Clear impetus to personal growth in practitioner	Some clients need a directed approach
Personal experience of the mystical	EP is a therapeutic approach
Willingness to take personal risks	TAT is not talk therapy
Shift in identity – letting go of ego	Psychotherapy does not have scientific basis
Shift in identity - healer	Letting go of identification with the problem
EMDR can cause distress	Therapist experiment with EP
EFT is specific	Shock in change in identity
Learning to be present is part of learning EP	Decentering of therapist is useful
EP and EMDR focus on presence	Presence
Importance of proper training in EP	Therapist has central role in talk therapy
Different understanding of relationship between trauma and psychological distress in EP	Psychology theories get in the way
EP works for everybody	Therapist as objective partner
Eastern understanding of psychology	Therapist as witness not healer
Conflict in identity, psychotherapist/healer	Shift in identity from doctor to witness
Other therapists refer clients when stuck	TAT as meditation
Spirit equals energy	Process of decentering
Desire to clear issues	TAT not well known
Relationship is important in healing	Easy to seupt as EFT practitioner
	Dual attention is active component

Appendix J. Themes Clustered by Category

Themes Clustered by Category

Changing Identity	Code	Trauma	Code	Healing	Code
Openness to trying new modalities	T123	Rapid change with EP	T123	Talk therapy does not heal	T123
Greater ease in himself through use of EP on self	T123	Trauma is stored	T12	EP heals	T123
Shift in identity - spirituality	T123	All psychotherapy is with trauma	T1	Talking about problems does not work	T123
Decenter role of therapist	T123	Psychological distress is caused by trauma	T1	Shift in identity - healer	T123
Share knowledge with others	T123	Trauma is stuck	T1	TAT is tool for spiritual realisation	T123
EP had impact on personal relationships	T123	Trauma memories are stored	T1	Shift in identity - spirituality	T123
Scientific background of practitioner	T123			Learning to be present is part of learning EP	T12
Clear impetus to personal growth in practitioner	T123			Conflict in identity, psychotherapist/healer	T13
Personal experience of the mystical	T123	Characteristics of EP		Desire to clear issues	T23
Willingness to take personal risks	T123	EP tested by use on self	T123	Relationship is important in healing	T23
Shift in identity – letting go of ego	T123	EP can be self-administered	T123	Catharsis does not heal	T23
Shift in identity - healer	T123	Rapid change with EP	T123	Psychology theories get in the way	T1
Conflict in identity, psychotherapist/healer	T13	Some people do not like/resonate with EP	T123		
Desire to clear issues	T23	EP is effective	T123		
Conflict in self about medicine/opposite to medicine	T1	EP targets the "problem"	T123		
Feeling at peace in himself - a shift	T1	EP heals	T123		
Change in self leads to change in practice	T1	Shift away from traditional psychology/psychotherapy	T123		
EP causes shift in self/identity	T1	EP is at the frontier of psychotherapy	T123		
Mystical experience of self	T1	EFT is specific	T12		
Letting go of psychological construct of self	T1	EP and EMDR focus on presence	T12		
Conflict about spiritual/scientific/psychotherapy	T1	EMDR can cause distress	T12		
Shock in change in identity	T1	Importance of proper training in EP	T12		
Decentering of therapist is useful	T1	Different understanding of relationship between trauma and psychological distress in EP	T13		
Therapist as objective partner	T1	EP works for everybody	T13		
Therapist as witness not healer	T1	Desire to clear issues	T23		
Shift in identity from doctor to witness	T1	Catharsis does not heal	T23		
		EP is a different way of looking at psychological distress (trauma based)	T1		
		EP good for dissociation	T1		
		EP good when there is not a lot of psychological stability	T1		
Shift in thinking about psychological distress and therapy		No contraindications for EP	T1		
Talk therapy does not heal	T123	EP causes shift in self/identity	T1		
EP heals	T123	EP approaches target specific issues	T1		
Shift away from traditional psychology/psychotherapy	T123	Does not push EP on people	T1		
Talking about problems does not work	T123	EP is a therapeutic approach	T1		
		Easy to seupt as EFT practitioner	T1		
Different understanding of relationship between trauma and psychological distress in EP	T13	Dual attention is active component	T1		
Eastern understanding of psychology	T13				
All psychotherapy is with trauma	T1				

The Therapist

EP tested by use on self	T123
EP can be self-administered	T123
Openness to trying new modalities	T123
Greater ease in himself through use of EP on self	T123
EP used by therapist on self	T123
Decenter role of therapist	T123
Presence in therapist is important	T123
Share knowledge with others	T123
Shift in identity – letting go of ego	T123
Shift in identity - spirituality	T123
Learning to be present is part of learning EP	T12
Different understanding of relationship between trauma and psychological distress in EP	T13
Other therapists refer clients when stuck	T23
Desire to clear issues	T23
Relationship is important in healing	T23
Change in self leads to change in practice	T1
Does not push EP on people	T1
Decentering of therapist is useful	T1
Therapist as objective partner	T1
Therapist as witness not healer	T1

Themes Clustered by Category

Psychological distress is caused by trauma	T1				
Trauma is stuck	T1	TAT		Therapy	
Trauma is stored	T1	TAT is preferred approach	T123	EP can be self-administered	T123
Psychological distress is caused by identification with the problem	T1	TAT is tool for spiritual realisation	T123	Rapid change with EP	T123
Psychological distress is caused by identification with self	T1	TAT has deep personal meaning	T123	EP is effective	T123
Trauma memories are stored	T1	TAT is easy to learn	T1	Presence is helpful	T123
EP is a different way of looking at psychological distress (trauma based)	T1	TAT is mystical and may not appeal to some people	T1	EP targets the "problem"	T123
Trauma memories are stored	T1	TAT enables present moment awareness	T1	Decenter role of therapist	T123
		TAT is different to other EP approaches	T1	Talk therapy does not heal	T123
		TAT is open and non-directive	T1	Psychotherapy provides boundaries for client/therapist relationship	T123
Clients		TAT is not talk therapy	T1	EP is at the frontier of psychotherapy	T123
EP can be self-administered	T123	TAT as meditation	T1	Talking about problems does not work	T123
Some people do not like/resonate with EP	T123	TAT not well known	T1	Other therapists refer clients when stuck	T23
Presence is helpful	T123	TAT is calming	T2	Relationship is important in healing	T23
Talking about problems does not work	T123	EP creates space for healing	T2	Catharsis does not heal	T23
Other therapists refer clients when stuck	T23	TAT is broad	T2	Psychotherapy is medicine	T1
Relationship is important in healing	T23	Use TAT in personal process with therapist	T2	All psychotherapy is with trauma	T1
Catharsis does not heal	T23	TAT encourages client to step back from the issue	T3	EP is a different way of looking at psychological distress (trauma based)	T1
Some clients need a directed approach	T1	TAT clears issues	T3	Some clients need a directed approach	T1
		TAT resonates with spiritually based people	T3	Psychotherapy does not have scientific basis	T1
		The changes are profound and subtle	T3	Decentering of therapist is useful	T1
		Connection is important	T3	Therapist has central role in talk therapy	T1
Presence		Spirituality			
Presence is helpful	T123	TAT is tool for spiritual realisation	T123		
Presence in therapist is important	T123	Shift away from traditional psychology/psychotherapy	T123		
Decenter role of therapist	T123	Personal experience of the mystical	T123		
Shift in identity – letting go of ego	T123	Spirit equals energy	T23		
Learning to be present is part of learning EP	T12	Spiritual level of healing is important	T2		
Decentering of therapist is useful	T1				
Presence	T1				
Therapist has central role in talk therapy	T1				
Psychology theories get in the way	T1				
Process of decentering	T1				

Appendix K. Categories and Themes

