From the Outside In: Incorporating the use of EFT into traditional psychotherapeutic approaches and its impact on therapeutic alliance

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Declaration

I confirm that all names and identifying information has been changed to protect confidentiality.

Abstract

This thesis examines the effect of the use of Emotional Freedom Techniques (EFT) on the therapeutic alliance. Sixteen therapists who had both traditional psychotherapy training and had been trained to use EFT were interviewed in an exploration of their beliefs about whether the use of EFT enhanced, threatened or had any effect on the therapeutic alliance in their work with clients.

There was no existing research in this field and due to the essential nature of the therapeutic alliance in any therapeutic modality (Bordin, 1994; Horvath, 2001; 2018) the necessity for it seemed clear, when thinking about how EFT might be incorporated into traditional psychotherapeutic work. The research arose out of an episode in the researcher's clinical work when the therapeutic alliance appeared to have been ruptured by the introduction of EFT. The methodology used for this qualitative research was Framework Analysis. This allowed the researcher to analyse the results, developing themes that emerged across all participants and simultaneously dissecting some aspects of the interviews in greater depth.

The results indicate that the use of EFT appears to enhance the therapeutic alliance. However, there were also indications that the therapists participating in this study found it difficult to define the term 'therapeutic alliance' and struggled to put their conceptualisation of the phenomenon into words.

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Chapter 1. Introduction

This thesis is an examination of the effect of Emotional Freedom Techniques (EFT) on the therapeutic alliance. The idea for the research arose out of an experience I had in my clinical work. I had been working together with a client for approximately a year using an integrative therapeutic approach, which incorporated psychodynamic ways of working with some elements of Cognitive Behavioural Therapy (CBT) that I believed would be useful for the client. This integrative approach to the therapy involved only talking and did not include any other somatic elements, such as those found in Eye Movement Desensitisation and Reprocessing (EMDR) or EFT.

1.1 What EFT is

EFT falls into the category of energy therapies and combines a somatic approach with the more traditional approach of talking. When a client first arrives for EFT treatment an issue is isolated by the client and therapist working together. Then client and therapist together establish (in the client's words) the best description of the difficulty, and what seems to have the most significant emotional impact for the client (Ortner, 2013). Because of the premise in EFT and many other psychological therapies that mind and body exist as one and therefore work together, it is believed that emotional difficulties can present as physical symptoms and behaviours and have an impact on emotional life (Church, 2013b; Burkitt, 1999). However, EFT can also be used when clients are not experiencing a physical sensation with their emotional difficulties.

It is also sometimes known as 'acupuncture without needles' or referred to as 'tapping therapy' because each round of EFT involves the client tapping on points that are believed to be on an energy meridian system within the body. These are the same points traditionally used in acupuncture (Ortner, 2013).

The tapping sequence is taught to the client and begins on the hand, progresses to six different points on the head, moves to two points on the upper body, and concludes with tapping on points on the hand. Fingertips are used to tap all the points approximately 5-7 times. The client taps on themself, following the movement between points that the therapist leads them through. The therapist also usually taps on themself throughout this process, and both repeat the words of a reminder phrase which client and therapist have determined together

(Dawson, 2014). One point that is apparent in reading EFT manuals is that EFT protocols are inconsistent and vary according to where EFT training is given (Craig, 2011; Ortner, 2013; Dawson, 2014), so although the tapping element is consistent within EFT use, the order and use of all the tapping points varies.

Once a difficulty has been established as clearly as possible, a setup phrase is determined. This is almost always structured as: 'even though I have this [difficulty], I honour and accept myself' (Dawson, 2014). The set-up statement names the difficulty and includes a phrase that confirms the sufferer's worth (Church & Brooks, 2014). A reminder phrase is also determined and is usually a very brief statement that reminds the client, while they are tapping, of the difficulty, such as 'this fear in my belly' (Dawson, 2014).

Prior to the commencement of the tapping, the client is asked to estimate their Subjective Units of Disturbance (SUDs) for the difficulty on a scale of 0-10, where 0 is no disturbance and 10 is the highest level of disturbance imaginable to the client. This is important because it helps both client and therapist to understand whether the EFT is having an effect (Dawson, 2014; Ortner, 2013) and whether change, shift and calming are brought about (Stewart, 2014; Dawson, 2014). Determining SUDs is also used in EMDR (Shapiro, 2018)

Between rounds of tapping, the client and therapist pause to determine whether SUDs are changing or if other new thoughts and sensations are emerging or old memories are being touched on. Sometimes the shifts are subtle and difficult to quantify, so even though a client may be aware that something feels different after tapping, occasionally they are unable to say what feels different, or they are able to say only that things feel 'better' (Bach, et al, 2019). There are other specialised tapping routines that therapist and client may consider using, although the 'basic recipe' described above is sufficient (Stewart, 2014).

1.2 The experience from my clinical work

After a year of weekly appointments, my client and I reached a point where the therapy felt stuck and we could not seem to move forward. After discussing this phenomenon over three or four sessions with the client, in which he agreed he was also feeling as though the therapy had stagnated, I introduced the idea of using EFT. I encouraged him to explore what was available to read about this modality on the internet and to consider this option. After a week of thinking it

over, he returned to therapy and reported that he was eager to give it a try and so we began using it in that and two subsequent sessions.

Throughout the three sessions in which EFT was used, it seemed that the client was able to move again. We discovered previously undiscussed memories and he began to make links to these and his current behaviour, outlook and day-to-day mood. The EFT appeared to be having a beneficial effect both on the therapy and for the client. However, in the fourth session, he entered the room and told me that he no longer wished to use EFT. I was curious to understand why this was given the apparent improvement that we both had seen. I asked him why he no longer wanted to use it, and he was either unable to articulate his reasons or did not want to tell me. It was clear that something had changed and it seemed that it was likely to have been something that happened with the use of EFT.

We returned to talking therapy and the previous integrative stance. I was left with the nagging question of what had happened for him with EFT use. I began to think that perhaps it had interfered with a vital element of the therapy for him, which I had not anticipated. At that time, I attributed this to some effect that the EFT use had had on the therapeutic alliance, though I never felt certain about this conclusion. Thus, the research question was established.

1.3 Background of Emotional Freedom Techniques

According to Church (2013a), Emotional Freedom Techniques (EFT) as a modality is becoming more popular amongst people seeking psychological therapeutic support internationally, particularly in the United States (US). He cites the international online traffic from unique visitors searching for information about EFT and instructional videos teaching its use from zero in 1990 when EFT was first developed and marketed, increasing to 2 million in 2013. That there is interest in the general population seems clear; what is less clear is what purpose the people who are searching for EFT online have for their search. Reasons could range from simple curiosity all the way through to seeking amelioration of serious mental health difficulties.

This rise in perceived popularity is not reflected in the number of therapists who incorporate EFT into their practice in the UK. The United Kingdom Council for Psychotherapy (UKCP) claims membership of 8,000 (UKCP, 2019), and the British Association for Counselling and Psychotherapy (BACP) has membership

of 45,000 (BACP, 2019) while EFT International has membership of just 1,344 (EFT International, 2019). Psychologists, psychiatrists, psychotherapists, researchers and NICE, all working within the field of psychological therapy have been sceptical of EFT as a way of working that offers genuine help to people seeking psychological support (Bakker, 2013; Devilly, 2005; Lillienfeld, 2011; Goldacre, 2007). It has been seen as an ineffective distraction to therapy that has no efficacy and in one contribution, the opinion was expressed that no further research resources should be allocated to EFT (Bakker, 2013).

EFT has thus far failed to gain endorsement from the National Institute of Health and Care Excellence (NICE) in the UK as a treatment for psychological distress, although there is a growing body of evidence to support its efficacy (Nelms & Castel, 2016). EFT has been approved by the National Registry of Evidence-based Programs and Practices (NREPP), a division of the Substance Abuse and Mental Health Services Administration (SAMSHA) in the US. More recently, EFT has been approved by the Veterans' Administration (VA) in the US as a treatment for Post-Traumatic Stress Disorder (PTSD) after an article in the *Kaiser Permanente Journal* (Church, Stern, & Boath, 2017) was published reviewing studies of EFT's efficacy, and recommending treatment guidelines. While this may be an indication that, in the US, more time and resources have been devoted to researching EFT, the results of the US research are available to NICE in their considerations around whether to endorse it.

With this background, therefore, there are difficulties encountered in thinking about how to incorporate EFT into more mainstream psychological support approaches. If the method is not widely endorsed nor seen as an effective modality, then thinking about how to incorporate it in therapy remains unclear if the opinions about whether to use it at all cannot be resolved. This may be one reason why very little evidence of the impact of EFT's use on the therapeutic alliance is available.

EFT is a manualised therapy with clear protocols that has met with much support, largely from the complementary and alternative medicine (CAM) community (Church, 2013a; Feinstein, 2016). Like EMDR, EFT is an energy therapy which uses a somatic element (Shapiro, 2018): the tapping on the points by the patient in treatment and a cognitive element. Proponents of EFT claim that it is effective in helping clients with their bodily- or physically-felt sense of experience and

trauma, and using a cognitive element to re-structure thinking around traumatic events or difficult experiences (Church & Brooks, 2010).

Two features of EFT use that are supported by clinical trials which conclude that it is an effective therapeutic approach are that it is cost-effective, and that changes brought about by its use are either long-lasting or permanent (Stewart, et al, 2013; Kalla, et al 2017; Stapleton, et al, 2017; Church, et al, 2017; Bach et al, 2019;). The research on EFT seems to support the supposition that it is cost-effective because of the speed with which it works. Research into client changes or shifts that occur through EFT use indicate that they are at least longer-lasting than changes brought about through the more traditional psychodynamic psychotherapies or the family of Cognitive Behavioural Therapies (CBT), if not permanent (Stapleton, et al., 2017; Stewart et al., 2013; Bach et al 2019).

Therapeutic alliance has long been regarded as potentially the most important healing or effective element of most talking therapies (Clarkson, 2003; Gelso & Carter, 1994; Bordin E., 1979; Meissner, 1996; Wampold & Imel, 2015; Luborsky, et al., 1980; Kern, et al. 2009; Horvath, 2001). It has also been very widely researched in many different contexts. This is important because it has an effect on the question of whether psychotherapeutic orientation and ways of working or the modalities employed in therapy are the effective elements (Cooper, 2008), or whether the focus of efficacy should be on the relationship and alliance between client and therapist.

That EFT is a significant alteration with its physical tapping and call-and-response format from the talking of more traditional therapy, be that with a psychodynamic or a CBT approach, seems clear. It is, however, very unclear whether the tapping or call-and-response format affects the therapeutic alliance. When EFT is effective for client growth, it is not known whether that is because of the beneficial positive impact of a strong working alliance or the modality, or some combination of the two. Equally, when EFT is ineffective, it is unclear whether this is as a result of its activities (tapping), some kind of failure in the therapeutic alliance (a failure to form, to be maintained, or an incomplete repair to a rupture in the alliance) or some combination of these elements.

1.4 Definition of therapeutic alliance

It was important to clarify my own thinking around what the therapeutic alliance is as that has an impact on all elements of this research and was fundamental to the research, and to the reflexive inquiry.

For further clarity, I make a distinction between therapeutic alliance and transference and while I see both as elements of the therapeutic relationship, it is my belief that neither is the entirety of the relationship. There are overlaps between therapeutic alliance, transference and the therapeutic relationship, but for the purposes of this exploration, I am looking at therapeutic alliance alone. To more clearly understand this distinction, I have followed Fuertes et al.'s 2013 study in which the theory was advanced of the real relationship between therapist and client, an idea they took from Gelso and Carter's 1994 research and Gelso and Samstag's 2008 work. In Fuertes et al.'s results (2013) three distinct elements of relationship are named between client and therapist: the real relationship, the transference relationship and the therapeutic alliance. They found that the real relationship and the therapeutic alliance increase together, but that when transference or countertransference distortions are greater, the real relationship is weakened. Although they do not explicitly say that the real relationship is what I am naming the therapeutic relationship, it does appear to be so. I conceptualise the therapeutic relationship as a whole, which exists whether transference or countertransference is active, and encompasses the transference and countertransference and the therapeutic alliance. My exploration of the therapeutic alliance is of an element of the therapeutic or real relationship, not its entirety. It also leaves the question of transference and countertransference unexplored, though does make note that it can have an impact on the therapeutic alliance. Although his work conceptualising the therapeutic alliance was not the first, Bordin (1979), from whose work much subsequent research and contribution has stemmed, proposed that the therapeutic alliance is a pan-theoretical concept and is composed of an at least tacit agreement between client and therapist on three elements: a bond between them, a goal for the therapy and the tasks of therapy. This definition at first appears very clear because it breaks down the therapeutic alliance into constituent elements. What it lacks is a sense of the whole alliance and how these three elements might combine in practice, and more importantly to the sense that

the therapist (for the purposes of this research) experiences an alliance within the therapeutic dyad.

The therapeutic alliance is widely regarded as crucial to therapy (Horvath, 2018) and has been studied from the client's perspective with respect to its outcome on the effectiveness of therapy. Bordin's definition, whilst clarifying its elements and providing a vocabulary with which to discuss it, lacks a description of what it is as a whole and whether it is effective, although his work implies that it is essential.

Ackerman and Hilsenroth (2003) argue that an alliance must already exist to allow for agreement about the tasks of therapy. Indeed, if a client approaches a therapist for assistance, and the therapist agrees to offer it, then some level of agreement is already in place when the client arrives for their first session. If this is the case, then the alliance is something other, or something greater, than the constituent parts that Bordin (1979) identified. From Ackerman and Hilsenroth's perspective, the tasks of therapy are not a part of the alliance; rather the focus would be placed more accurately on the agreement and, though important, less on what the agreement is about.

In an online blog for therapists, Tyrrell (2018) cites the values of warmth, trust, therapist openness to the client and therapist genuineness with the client as crucial to forming the therapeutic relationship of which the therapeutic alliance is a part. Once the therapist and the client are able to bring these qualities to the encounter, the framework within which the therapist and client work is established, and the work can begin. In other words, the relationship, and with it the alliance, must be established before any work can be done. Tyrrell is not discussing the alliance, but the wider context of the relationship as a whole. These qualities appear to be what leads to an alliance and are also part of the alliance. The difficulty around this is that warmth, trust, openness and genuineness vary widely from one therapist to another. For example, some therapists will not reveal anything about themselves to a client, while other therapists sometimes do, and here I am thinking of moment-to-moment disclosures that are used to help the client understand the effect of what they are saying on someone else and not therapist disclosure of personal details: however, openness is difficult to define. This also raises many issues about what effect the therapist-perceived openness has on clients. For the purposes of this definition, I have considered openness to mean a therapist's receptiveness to the

client, whatever form that may take. This has implications too, for the other qualities of trust, genuineness, warmth.

Clarkson's (2003) discussion of the therapeutic alliance in her book, *The Therapeutic Relationship,* acknowledges that it is an idea that has emerged from psychoanalysis and while Clarkson was primarily working from a humanistic orientation, she makes the case that the therapeutic alliance is essential for all psychotherapeutic work, whatever the modality. She draws on Bordin's (1979) conceptualisation of the alliance, but her thinking encompasses a felt sense of the presence of the alliance in addition to the elements of which it is made up. Of interest to my definition is her assertion that the therapeutic alliance is difficult to define when it is present and is more noticeable by its absence; however, that still does not define what it is.

No questions were posed in this research that explored the idea of transference in the working relationship and its impact on the therapeutic alliance. However, transference is a vital part of the working relationship, particularly for psychodynamic and psychoanalytic clinicians (Lister, 2017) and has an effect on the therapeutic alliance. Gelso and Carter (1994) see transference and the therapeutic relationship as different elements of a therapy, though they do affect each other. They point out a paradox within the therapeutic relationship that resistance to greater self-knowledge by the client, expressed through negative transference, can later foster a positive transference which in turn aids a greater therapeutic alliance, though negative transference itself is usually seen as a resistance to the therapy. They stipulate that therapeutic approaches require a therapeutic alliance that covers more than transference to allow for the transference to be analysed.

In her research into the different approaches to therapy by humanistic and psychoanalytic therapists, Lister (2017) seems to express her surprise at their different understandings of the therapeutic alliance and concludes that it is a fluid concept that for psychoanalysts involves an element of transference and for humanistic therapists has little relationship to transference. For me, the latter orientation to the fluidity of the therapeutic alliance and the perception of it having a lesser relationship to transference is most true. It is the quality of being aligned, or in agreement in some way, with a client, and how that takes place that I was seeking to understand. This varies from Zetzel's (1956) conceptualisation of a

healthy transference that is necessary within an alliance to allow work to proceed and transference neurosis which precludes psychoanalytic work. This may be an indication that, in the main, it is humanistic counsellors who are drawn to the use of EFT, as Lister found (2017). What is important about this is that therapeutic relationships involve both therapeutic alliance and transference, and in my view, therapeutic alliance can exist when transference, particularly negative transference, is enacted.

Meissner (1996) discusses Goldberg's (1978) idea of *negotiation* between client and therapist as a component of the alliance, in which negotiation does not include any indoctrination, compliance or submission on the part of either, and out of which comes empathy and engagement from both sides of the relationship. Part of the thinking that Meissner (1996) then further explores is that the therapist must hold the client (and presumably themself) responsible for their role in this process. Although he incorporates the idea of negotiation in his conceptualisation, he does not name the elements of the relationship that are negotiated. His thinking could mean that the elements that Bordin named of agreement on the goals, tasks and bonds of therapy are what is negotiated. Negotiation on these elements does imply that some form of agreement between client and therapist must exist prior to negotiations being undertaken; there is no point in entering into negotiations if there is no intention to continue to work together.

Phelan (2008) studied adults working with troubled youths and the connections that must be established for this work to be successful. He described three different levels of connection that appear to be about the therapeutic alliance. He does not use the term 'therapeutic alliance'; but rather describes the three levels as initially establishing trusting connections, building on this initial connection to establish ecological connections in which the adult counsellor is a support to the youth both outside and inside the youth's world, and finally what he names the deeper alliance. It is at the deeper alliance level that, whilst maintaining a detached presence, the therapist must also be able to share experience and to a certain, limited extent identify with the youth. Whilst all elements of his description of these connections are a part of my conception of the therapeutic alliance, the third level is perhaps the most similar.

In their review of psychotherapeutic evidence, Roth and Fonagy (2005) stated that the therapeutic alliance makes a small but significant and consistent contribution to the effectiveness of therapy, whatever the treatment modality used. However, they do not see it as a causal element in client change, but rather as a moderating element that assists in the effectiveness of the work. This view shifts the emphasis away from the alliance as the effective element of therapy and onto the alliance with the other elements as variables in the relationship as a whole that determine the effectiveness of therapy. In this review then, the therapeutic alliance would need to be established either through the use of EFT or prior to it, and then EFT along with the alliance would be seen as the effective elements of a successful therapy.

There is another element of the therapeutic alliance that does not come across as clearly in any of the contributions yet cited in this definition, and that is the sense of collaboration between client and therapist. The use of the word alliance seems to imply collaboration; yet it has felt possible to have an alliance – for me a sense of joining together with the client, the bond in Bordin's conceptualisation – without a sense of collaboration. This would include times when agreement on both the tasks and goals of therapy appears to exist and the client and therapist have formed a bond, yet the work sometimes does not seem possible. For example, in work with a particular client once, there were times when she was actively subverting the gains of therapy. We had explicit agreement that the work of the therapy was pursued to help her feel better and function more fully in her daily life; however, when small gains would occur, gains we both agreed were helpful toward this goal, she would often purposefully work against them, at the time or later. With this particular client I believe there were other factors complicating the work; however, the phenomenon did occur. It could be argued that if the client and therapist are not working together, using the tasks to achieve the goals, there may be subconscious disagreement from either or the bond does not exist, despite a sense of it in the therapy. However, I believe that there is a further sense that is best captured by the use of the word collaboration, an idea explored by Berdondini et al. (2012), in which they name collaboration as an essential element for the alliance in experiential therapies. The concept of collaboration is seen as involving an element of commitment and responsibility from both client and therapist, elements that are essential precursors to the formation of an effective therapeutic alliance. Collaboration, therefore, may not

be part of the alliance itself but must be established before the alliance can exist and is therefore crucial. Freud (1937, cited in Saketopoulou, 1999), too, seems to regard the alliance as a collaboration of effort between the therapist and client against the client's neurosis. There is a sense of coming together, however that may be achieved, of client and therapist in response to an unwanted element (Saketopoulou, 1999).

Kern et al. (2009) suggested that the therapist's role in the alliance is perhaps more important than the client's in facilitating the therapy itself by decreasing attrition and may, through the building of the alliance, increase the effectiveness of treatment. They outline an intervention they call Therapeutic Alliance Building Early Recollection (TABER) for use in therapy and indicate that it not only builds alliance but may reveal the way of working that the client finds most suitable (Kern, et al., 2009). There was also a meta-analysis published in 2012 that outlined the significance of the therapist's role in the formation of the alliance and highlighted the importance of the alliance itself in bringing about change for the client (Del Re, et al., 2012). For the purposes of this research, what is interesting here is the emphasis on the therapist's role in the formation of the alliance and the idea that different modalities appeal to different clients and if matched correctly, seem to enhance both alliance and treatment outcomes. This slight shift in focus again suggests that it is therapist qualities that allow for the establishment and subsequent building of the therapeutic alliance, but they do not deal with what the alliance is. However, the suggestion that selecting the appropriate way of working with the client has a beneficial influence on the alliance is significant. Because EFT is an unusual way of working and is far enough outside the mainstream of therapeutic interventions, both client and therapist may be self-selecting through use of the modality. This, in turn, may facilitate the alliance to form more quickly, or more substantially, from the outset of the work.

When the alliance begins to build is also unclear. In a pilot study of 50 patients and 33 therapists (some therapists had more than one patient) Dolinsky et al. (1998) found that it was often the fantasied match that served as the basis for a referral to a particular therapist, though they do not say whether this referral originates within the dyad or outside of it. This is evidence that the alliance is forming before the patient and therapist physically meet.

Recently, Horvath (2018) has reopened the question of the alliance. In a review paper, he aims to quantify the challenges facing research into the alliance. He remarks that the definition of what the alliance is has become unclear despite research attempts to clarify it and that for research into the alliance to be helpful, a better definition of what it is must be established. In some senses, this echoes Clarkson's (2003) assertion that awareness of it is most clearly known by its absence. What it actually is, however, remains difficult to define. Horvath also echoes Lister's findings (2017) that the alliance is a fluid factor which indicates that it can change and that it is conceived differently depending on the orientation of the therapist.

In discussing the modern developments of the alliance, Horvath relies on Luborsky et al.'s (1980) and Bordin's (1979) definitions which emerged within a year of each other and have been widely relied on ever since. Luborsky et al.'s (1980) contribution to thinking about the alliance was broken down into two categories which work sequentially. Initially, the emphasis is on the therapist to provide support and help and then the emphasis moves to both client and therapist working collaboratively together to form the alliance. Bordin's (1979) contribution was his conceptualisation of the alliance being formed out of an agreement between client and clinician on the bonds, tasks and goals of the therapy. Horvath notes that both definitions are narrative and concentrate on how the alliance is achieved, how it works in practice and what it does. Neither involves a description of the substance of the alliance itself.

Horvath also says that the alliance is one of the common factors of the therapeutic relationship and not something that emerges from other common factors, such as those cited by Tyrrell (2018) in his discussion of the therapeutic relationship. Previously, common factors in the relationship have been regarded as those that lead to alliance-building (Gelso & Carter, 1994; Wampold & Imel, 2015; Kern, et al., 2009; Norcross & Lambert, 2011). The common factors must exist before an alliance can be formed. Horvath's (2018) assertion that the alliance is, in fact, one of the common factors itself within the therapy relationship suggests that the emphasis on the alliance's role as a single aspect in helping clients may be less important than previously believed. It also suggests that the focus of research into determining what is helpful to clients should be the working relationship, with

all of its elements, though he retains his emphasis on the alliance within the relationship.

While it is helpful in defining the difficulty in studying the alliance and defining the alliance itself, Horvath's (2018) paper raises a series of queries. The most important of these were: what the alliance actually is as opposed to what it does; from which elements it is constructed; and how therapists contribute to forming it with their clients.

The conceptualisation of the alliance from which this study was conducted implies a large measure of not only cooperation but also a commitment to and responsibility for the therapy by each member of the dyad for the therapy to be effective. It is also seen as separate from transference, perhaps not as significant when a healthy, adult transference is operating but certainly from a transference neurosis. It was also defined as more of a felt sense, more noticeable in its absence than in its presence. It was seen as both a process because it changes over the course of therapy, and simultaneously possessing a polarity: does it exist or does it not.

Primarily, the sense of collaboration and responsibility between client and therapist is the quality that stands out most strongly for me. The Oxford English Dictionary (2019) defines collaboration as 'the action of working with someone to produce something' and as 'traitorous cooperation with an enemy'. In both definitions, a sense of cooperation is implied or stated. While I am thinking of the therapeutic alliance more in the sense of the first definition, that a collaboration between therapist and client produce healing or movement for the client, the second definition could also apply in the sense of its element of cooperation. Both include a sense of individual responsibility for each contribution to the collaboration. Whilst this is not a semantic exploration, the need to turn to the OED for a definition rather emphasises the slipperiness of the concept.

What is important in my definition of the therapeutic alliance is the sense that alliance, whatever the modality chosen, is a cooperation and collaboration between therapist and client. It seems to be established before the work of therapy can begin even if it later changes, and transference plays a lesser role within alliance than other clinicians (Lister, 2017) have previously argued. It is a difficult element of a therapy to define and is perhaps more noticeable by its

absence than by its presence. Whether it is helpful to the therapy, or indeed is the thing that assists the client the most is of less importance in this definition although the assistance to the client is a crucial element of the therapeutic relationship.

I have also distinguished therapeutic alliance from the concept of the negative therapeutic reaction (Freud, Strachey, & Gay, 1960) in which the client ultimately remains unable to be helped by therapy due to their unconscious guilt. Spillius (2007) attributes this phenomenon to envy and narcissism (p.138). What is of interest with the negative therapeutic reaction for this research is more the inability to form a therapeutic alliance that arises out of it, rather than its origins. On the surface, the negative therapeutic reaction by a client suggests that there is no therapeutic alliance as I have defined it. On closer inspection, however, the negative therapeutic reaction must to a degree be dependent on some form of alliance between client and therapist: the therapist must be making helpful interventions in the chosen modality for the client to retreat into their unconscious guilt and self-punishment and thus show the unconscious negative therapeutic reaction

There are times in my experience when engagement, cooperation and collaboration from both therapist and client have seemed to exist and I have simultaneously believed that the client and I were not wholly in alliance – that we differed implicitly on some aspect of the work, though explicitly we were in agreement. Because I have on occasion introduced EFT into a talking therapy, I wondered whether, because an element of the therapy had changed and the protocols around EFT are so different to those around talking therapy, it had affected either my own or the client's contribution to the alliance.

1.5 Research aim and research questions

The aim of this research is to establish as a groundwork the understanding that therapists who use EFT see as the impact on the therapeutic alliance of EFT. To do this, a secondary aim of the research was also to establish how therapists who use EFT conceptualise the therapeutic alliance. In line with my initial clinical concern combined with the explanation of therapeutic alliance definition in section 1.2, the research questions are as follows:

- How do EFT therapists understand the therapeutic alliance?

- How do EFT therapists know when the therapeutic alliance exists?
- How does EFT use affect the therapeutic alliance?
- Does the therapeutic alliance change when EFT work is brought into the therapy?
- When EFT work is brought into therapy and the therapeutic alliance changes as a result of this, how does it change?

Chapter 2. Literature review

This literature review provides the rationale for research into the ways in which psychotherapists, psychologists and qualified mental health counsellors who choose to use EFT, incorporate it into their clinical work. It focuses on and explores the effect that the use of EFT has on the therapeutic alliance and its definition. It also highlights the gap in existing knowledge in this area.

The literature review is a narrative one. I attempted a systematic literature review and found only one piece of research that looked, briefly, at the effect on the therapeutic alliance of the use of EFT (Mason, 2012). It was therefore prudent to search more widely and look for research, articles and interviews into how energy psychology generally, and EFT specifically, is incorporated into psychotherapeutic practice and from that to extrapolate whether there is a significant effect on the therapeutic alliance.

2.1 Establishment of a question and the parameters for the literature review

The central question was whether the use of EFT had an effect on the therapeutic alliance. It was clear from the literature review submitted with the proposal for this study that EFT practitioners may not use the word alliance when they describe this element of the working relationship between themselves and their clients. A list of synonyms for therapeutic alliance, and particularly ‘alliance’, was therefore developed for use in the literature review. These were:

- bond;
- co-operation;
- connection;
- closeness;
- association;
- pact;
- relationship;
- affinity;
- cohesion;
- agreement;
- collaboration
- partnership; and

- teamwork.

2.2 Inclusion and exclusion criteria for the literature review

The inclusion and exclusion criteria for the literature review are summarised in Table 1. This includes all the papers that were found using the alternative search terms listed above. Criteria for inclusion were that the sources must have been written after 1990, as that was the year that EFT was first developed by Craig from Thought Field Therapy (TFT) and the method first marketed. It was also the year that the term 'energy psychology' was first coined, and EFT is one of the group of energy psychology methods. Studies written after 1990 about the use of TFT were sought due to the small number of studies about the inclusion of EFT within psychotherapeutic practice. Other studies that examined the use of some of the Complementary and Alternative Medicine (CAM) approaches to therapy and their use in psychotherapy were excluded because the number of variations between the protocols of each therapy and EFT was too high to make comparisons valuable. Any conclusions drawn from the examination of these studies would not make a valuable contribution to the level of knowledge that existed about the impact on the therapeutic alliance of EFT. The literature review also included only studies published in English.

Table 1. Inclusion and exclusion criteria for the literature review

Inclusions	Exclusions
Papers published in English	Papers published in any language other than English
Papers published between 1990-2018	Papers published at any time prior to 1990 or after 2018
Papers written between 1990 and 2018 about the impact of TFT on therapeutic alliance	Papers published 1990-2018 about the impact of CAM therapies on therapeutic alliance
Papers cautioning against the use of EFT if they examined the effects of EFT on the therapeutic alliance	Papers published that examined the efficacy of EFT as a modality, without mention of therapeutic alliance
Papers about the use of energy psychology that included an examination of an impact on therapeutic alliance	Papers that examined the conceptualisation of the therapeutic alliance without the use of EFT

Studies that examined the efficacy of EFT were also excluded, because this research did not consider whether EFT is effective in addressing specific mental health distresses, without consideration of the therapeutic alliance. It was assumed that participants in my research use EFT in their work with clients because they believe it is an effective intervention. Criteria for participation in this

study were that participants had to have a basic level of EFT training in addition to training in counselling, psychotherapy or psychology. The literature review focus, therefore, was what outcome the use of EFT had, if any, on the therapeutic alliance.

Papers about the conceptualisation of the therapeutic alliance, with or without EFT use, were not considered as part of the literature review. They were, however, consulted in the formulation of a definition of the therapeutic alliance (see Section 1.4) in order that the themes emerging from the results could be more clearly understood against this definition.

Articles cautioning against the use of EFT were also sought if they included concerns about what might happen to the therapeutic alliance when EFT was used. EFT practitioners often note (and did so in this research) that there is a bias against the use of EFT among practitioners of established mental health therapies (Minewiser, 2014). Feinstein (2009), an American psychologist and enthusiastic proponent of EFT, referred to this directly in his summation of the process of acceptance of EFT by individual clinicians. He concludes that there is an ever-increasing gulf between those who use EFT and those who do not. However, he does not link this to any concurrent changes in the therapeutic alliance. Indeed, the fact that *Energy Psychology: Theory, Research and Treatment*, a peer-reviewed journal, does not appear on any of the major databases I explored in the literature review may be an indication of bias. The existence of a perceived bias indicated to me that there might have been some literature that existed in this area about the use of EFT and possibly its negative effect on the therapeutic alliance, so I considered articles that researched or examined the lack of efficacy of the method. I was not, however, looking for evidence of EFT's inefficacy; rather research that might indicate what effect the use of EFT has on the therapeutic alliance.

Studies that looked at therapy modalities referred to as 'energy psychology' and their relationship to the therapeutic alliance were also initially sought, as EFT is within this grouping. Some of the CAM therapies are also considered energy psychology approaches, so although I did include energy psychology approaches, I excluded CAM therapies that do not fall under the umbrella of energy psychologies, which are described as 'the branch of psychology that studies the effects of energy systems on emotion and behaviour' (Gallo, 1999).

There were no studies that examined the effects on the therapeutic alliance of an energy psychology. Although I did search for such articles, had there been any, it would have been impossible to determine which elements of those approaches were affecting the therapeutic alliance, because EFT has specific protocols and it would be difficult to know which element of EFT or the energy psychology in consideration, might be having the greatest effect on the therapeutic alliance, or whether it was the modality in its entirety.

2.3 Methodology of the literature review

This literature review was initially conducted using PubMed, PsycINFO, PEP-Web and AMED. I also searched through EthOS for dissertations and theses that might be useful. Finally, because of the paucity of results returned while searching these databases, much of my research was conducted online from widely placed sources such as recorded interviews emanating from energy psychology-based websites and membership groups of energy psychologists.

I searched the back catalogue of *Energy Psychology, Theory, Research and Treatment,* a peer-reviewed journal in publication since 2009 that did not appear on any of the databases already searched. I also put out a request via email to colleagues who use EFT in their work for anything they might have known about or written that would be helpful.

What is clear from the attempt at a systematic literature review, and then the results of the narrative literature review which followed, is that there is very little written about the impact of the use of EFT on therapeutic alliance. Applying the Critical Appraisal Skills Programme (CASP, 2018) criteria (see Appendix 1) to the results of the literature review, most of the documents retrieved were not of high quality. The advantage of using a CASP checklist for this literature review is that it allowed me to apply methodological criteria to evaluation of the studies included. What CASP does not allow for is determination of bias of any of the studies considered (unisa.edu.au, n.d.) The research that directly addressed the effect of EFT on the therapeutic alliance were small and addressed the question as part of a study focused on the use of EFT generally. Therefore, the consideration of whether the use of EFT had an impact on therapeutic alliance was brief and not fully explored.

2.4 Results of the literature review

In total, 13 sources, including papers, research, journal articles, theses and dissertations were included in the review but only one looked briefly at the impact of EFT on the therapeutic alliance (Mason, 2012). There were two other studies, one completed for an MSc and one completed for an MA that looked at the use of EFT by experienced practitioners, but which did not delve deeply into its effect on the therapeutic alliance. However, they did mention the effect on the alliance, and this gave some insight into current understanding of the subject. The other papers provided a more generalised look at the incorporation of new therapy modalities into an existing therapy, though none specifically addressed the question of the alliance. They did, however, provide some insight into the participants' (therapists') ways of being which has an impact on any alliance that will be formed.

2.4.1 Work that specifically addressed EFT and the therapeutic alliance

Mason (2012) found two themes in her small study of five therapists who use energy psychologies in their practice, that are of interest here. The first is the impact of energy psychology on the therapeutic alliance. She cites two different therapists (of the five interviewed) who said they did not engage in energy psychology use with some clients because the need for a reparative relationship was too great. This suggests that the use of energy psychology does not allow for, or impedes the formation of, a reparative relationship. One of Mason's participants said that the use of energy techniques helped her mirror her client more effectively within the therapy, and mirroring is an important part of building the therapeutic alliance (Stern, 1985). However, beyond this statement, there was no further reflection or commentary on this point.

Mason's second theme that is of interest here, though only briefly explored in her paper, also notes that a relatively high percentage of the clients of her respondents either did not wish to take up energy psychology work or were not offered it. Her results indicate that it is not helpful to use EFT for clients with a need for control. She also briefly says that some of her respondents believed transference issues within the alliance and working relationship need to be worked through before energy psychology work can safely begin. Mason makes note of how the use of EFT in the therapeutic dyad can empower clients, and that this was something her respondents liked. This suggests that even for clients who

have a need for control in the therapeutic endeavour, energy psychology may help build or form an alliance, despite client hesitancy. This would then open questions about how to introduce energy psychology work, and indeed whether this introduction to energy psychology might impact any alliance. Frustratingly, Mason doesn't offer any further thinking on exactly how energy psychology affects the alliance, simply that it does.

Although Mason's work is a valuable contribution to thinking about EFT when in use by qualified clinicians, it is not sufficiently focused enough on the effect on the therapeutic alliance for it to make a large contribution to knowledge in this area. It is also a very small study, limited to 5 participants and therefore it is hard to know how generalisable her results are.

Another MSc dissertation (Bennett, 2016) examined therapists' use of EFT as a self-care tool. Of note in Bennett's study and directly applicable to my work, is the greater clarity that therapists' who use EFT report feeling around client material; whether the feelings that therapists experience during client sessions are their own or residual feelings picked up from the client (Bennett, 2016). This is an element of countertransference and is a common occurrence within the working alliance. Bennett, like White, notes that use of EP (in this case EFT specifically) allows the therapist to get out of the way of the therapeutic process for the client, and this is achieved by gaining clarity through EFT use. In turn, the therapy provided becomes more effective, in Bennett's respondents' perceptions. This underscores the emphasis on the necessity of the detached involvement of the therapist stance, rather than on the therapeutic intervention.

2.4.2 Work that addresses therapeutic alliance with other methodologies

In a 2014 Master's dissertation that examined how therapists who work with trauma sufferers use energy psychology (EP) for themselves, White quotes several therapists who indicated that the common factor of therapist presence that aids in the formation of the psychotherapeutic working alliance is greatly assisted by the use of EP. White's participants noted this both in the work they did with their clients, and in the EP work that they had done on themselves (White, 2014). White's dissertation did not specifically examine the impact of EP on the therapeutic alliance; however, some of her participants mentioned these common factors that, significantly for my work, develop into a theme in her dissertation. White discusses in somewhat greater detail the element of therapist presence.

Presence is an essential element in the formation of therapeutic alliance and is noted as such by many contributions to psychotherapeutic thinking, particularly those from the humanistic, person-centred schools (Cornell, 2013; Gendlin, 1998; Mearns & Cooper, 2005; Thorne & Sanders, 2012; Yalom, 2003; Lister, 2017). However, although all of White's participants endorse the use of EP both with clients and on their own, they note that it is primarily because it allows them to get out of the way of the client's experience and enable healing to take place. This seems at first reading to contradict what White says about presence; however, is possible to be present and yet to remain clear of client experience. Although she did not use this term in her study, White appears to be referring to the concept of a stance of detached involvement from the therapist. Lingiardi (2013) outlined this concept as being one of the most effective in any successful therapy and says that the stance is more effective than any specific intervention. It is also echoed in Bennett's work, outlined above.

There is an interesting paradox that seems to emerge in this understanding of EP work, and it is that the client comes to the therapist for assistance with a trauma, so the therapist has to be present, in all senses of the word, for that. The therapist has also to be present for the alliance to form. However, the therapist's EP modality allows them to get out of the way to enable what the client needs to happen. White (2014) says her research does not fit with earlier findings on therapist presence. Additionally, it has to be noted that White was considering not only EFT, but also other EP methods and primarily her respondents seemed to endorse Tapas Acupressure Technique (TAT) which, while bearing some similarities to EFT, has some differences. White's study was also relatively small. She drew on semi-structured interviews from three respondents only, and thus her results are not necessarily generalisable. Her research methodology was Interpretative Phenomenological Analysis (IPA) and was therefore very helpful to compare with this study because IPA might have been an appropriate methodology for this work. Because her research was a more generalised approach to EP overall and embraced many aspects of energy psychology that were not applicable to this study, including a section on the efficacy of EP, it was not directly comparable.

Research indicates that the formation of a therapeutic alliance is crucial to client healing (Bordin, Theory and Research on the Therapeutic Working Alliance: new

directions., 1994; Gold, Hilsenroth, Kuutmann, & Owen, 2014; Wong & Pos, 2014). This is not a new idea; however, this research also indicates that therapists and clients form alliances that arise out of the specific modalities within which they work. However, like Mason's work, none of these papers suggests what the differing qualities of these alliances might be; they simply note that the alliances vary in different modalities. It is therefore difficult to draw any conclusions from these papers. Bennett and White provide some greater illumination on what happens in the therapeutic alliance when EP and specifically EFT are in use but do not go on to examine this any further. Lingiardi (2013) maintains that the alliance must be formed before any intervention can be used.

Although there is little research about how the incorporation of EFT into the practice of clinicians occurs, there is much helpful information to be found in Mollon's 2008 work, Psychoanalytic Energy Psychology (PEP). PEP is a creation of Mollon's own and explains his understanding of energy psychologies and how they are effective, although he does not limit himself to the use of EFT. Rather, he draws on several different EP modalities: EFT, Thought Field Therapy (TFT), TAT and his thinking about applied kinesiology. Mollon explains his own steps around using energy psychology within his practice that, until he discovered EFT for himself, was a predominantly psychoanalytic one. He draws strong links between psychoanalysis and energy psychology, arguing that the concept of the libido posited by Freud (1920) is what we refer to today as energy, although he is at pains to point out that PEP is not psychoanalysis. His work describes a way of using the two approaches together to assist those seeking help. He explains how he does this, but not what happens to the relationship between him and the client when he does. Although Mollon enthusiastically endorses the use of energy psychology, he clearly states that at times it simply does not work and he is at a loss to explain why that might be (Mollon, 2008). This raises questions about whether the use of PEP has an adverse effect on the alliance. Mollon's 2008 work is not the result of research, apart from his own personal working life and observations gathered therein. While it is helpful to this study, there are no quantifiable results or analysis that can be reliably drawn upon to either support or to take issue with any of the findings of this work.

Because it is distinct from the traditional talking-only approach to therapy, EFT is also a significant departure for patients who agree to be treated with it, or who

allow some aspect of EFT work to enter into the therapy. In a study of psychotherapists in the US and Canada, Cook et al. (2009) found that the most significant factors governing uptake and continued implementation of new therapeutic tools or modalities was the ability of the new therapy to fit into an existing practice, and this echoes Mollon's (2008) assertions that psychoanalysis and TFT can work in conjunction with each other, but how is left to the individual clinician to assess. Although not stated in the paper (Cook, 2009), this suggests that the introduction of EFT might not have a significant impact, either negatively or positively, on the therapeutic alliance. It may also underline that the practitioner's way of being with clients, and out of this their choice to train to use EFT, would mean that every therapeutic alliance is different, based on both the practitioner's way of being and the client's way of being. Although this is likely the case, it makes it difficult to generalise EFT's impact on therapeutic alliance.

Cook et al. (2009) also found that factors such as the accessibility of training in the new modality and the opinions of respected colleagues were important to psychotherapists. An evidence base for a new modality was interpreted to be less important with regard to its uptake and use by mental health practitioners. These findings were echoed in a 2011 study of psychotherapists in which it was found that an evidence-base was not the deciding factor in the implementation of a new therapy; rather, practitioner intuition about a modality was the more significant element when therapists selected which newer approaches to implement. The paper does not explain what 'intuition' covers, although it could certainly include the impact on the therapeutic alliance of the new modality (Gaudiano, Brown, & Miller, 2011). The lack of clarity around the definition of a therapeutic alliance was something my research underlined, and thus any alliance may be more of a felt, intuitive process for therapists. This also takes into account the wide variance between practitioners and what they bring to a therapy and how that might impact the alliance in any way of working but does not say anything about the impact of EFT on a therapeutic alliance.

In his 1992 work, Lambert identifies key findings that suggest that 30% of the improvements for psychotherapeutic clients can be attributed to the relationship between client and therapist, and 15% could be attributable to the method chosen. He argues that the remainder of client improvements can be attributed to the client individually, and particularly to aspects of external change in the

client's life (Lambert, 1992). In his 1994 work, Bordin also concludes that the therapeutic working alliance is the factor that provides the healing in any psychological therapy, with a lesser emphasis on the working method. This indicates that the client-therapist relationship has a greater impact on the effectiveness of the treatment than does the modality. The impact on the therapeutic alliance of EFT, particularly in light of its claims to bring about more rapid change for the client, then becomes of great interest. This could suggest that the impact of EFT on the therapeutic alliance might be beneficial.

Fife et al. (2014) stipulated that there is a pyramid of emphasis on the development of healing for clients. The foundation of the pyramid is the therapist's way of being which they define as somewhere on the spectrum of a caring, open attitude to the humanity of the client at one extreme, through to impersonal objectifying of the client at the other. This is the foundation on which the therapeutic alliance – the second level of the pyramid – rests. Atop the pyramid, and thus the element with the least impact, sit the skills and techniques that the therapist employs to help the client facilitate change. This suggests that the therapeutic alliance is more important than the technique in facilitating client change, which dovetails with Lambert's findings in 1992, but it remains unclear how specifically EFT's use might impact the therapeutic alliance and indeed whether those therapists that choose to use EFT practise a particular way of being, or if their way of being is changed through the use of EFT (Fife, et al., 2014; Bennett, 2016; White, 2014). It also raises questions about whether there is some fundamental quality that therapists who choose to use EFT share, and particular ways of being that the therapists who do not use it, do not share.

In a study examining the use of complementary therapies (CT) in counselling, Nichols (2015) refers to what she terms cohesion with clients, which she says goes on to help the therapeutic alliance form. She does not address the therapeutic alliance further but says that use of CT with clients helps counsellors form a deeper, different bond with their clients than what would presumably be normally available to them through counselling alone. This was reflected in what some of the participants in this study said, but is nonetheless vague. Additionally, cohesion, whilst possibly a synonym for alliance, could also mean collusion, in some circumstances, between therapist and client which can be a negative element in the therapeutic relationship. Nichols definition of cohesion seems to

suggest a coming together and a closeness which is part of the therapeutic alliance at times. However, it is not clear enough, nor is there a sufficiently distinct definition of the term, for this to be helpful when looking at EFT's impact on therapeutic alliance.

There was one short case study that attempted to describe the process of the use of Thought Field Therapy (TFT), Roger Callahan's therapeutic approach and the precursor from which EFT emerged (Callahan, 2001). It was a description and analysis of what occurred in one session between a healer and a client which delved into what I believe is the therapeutic alliance without ever using those words to describe it (Williams, Dutton, & Burgess, 2010). It draws on ideas about intersubjectivity and co-proprioception from Merleau-Ponty (1962) and Csordas (1997). Of interest to this study is the phenomenological description of a session between the healer and one of the clients. The procedure for the session included a description of how the healer listens to the client's difficulty, and then begins to build rapport before introducing either EFT or TFT – both methods the healer uses in the session. Both listening and building rapport with a client could be building blocks for the therapeutic alliance; therefore, to place them in sequential order would be incorrect in thinking about the formation of the therapeutic alliance. If both are part of the formation of the alliance, then the question becomes one of when the alliance begins to form, a query Williams et al. were not addressing. The establishment of rapport between client and healer was essential to the healing process in this paper and occurred before either TFT or EFT treatment began. Williams et al. do not return to the idea of rapport or alliance in the paper; however, that they describe it as part of the session on which they conducted their phenomenological enquiry suggests how important it is.

In a survey of the membership of the Association for Comprehensive Energy Psychology (ACEP) in which 294 members completed a written questionnaire detailing their ways of working and their views about energy psychology (not limited to EFT) 92% of respondents reported used energy psychology as an adjunct to their existing psychotherapeutic approaches, not as their foremost or main modality (Feinstein, 2016). The remaining 8% were not using it in a therapeutic context. This raises the question of why this is so, particularly from members of an energy psychology group. Of the respondents, 59% identified themselves as mental health professionals. This seems to suggest that energy

psychologies are not appropriate for every client, nor every sort of distress they may experience. Feinstein goes on to say that energy psychologies can be either a standalone approach and this he bases on descriptions of energy psychology use from manuals explaining protocols, which seems weak evidence on which to base this assertion. His research indeed indicates that many therapists do not use one energy psychology approach as their primary modality but incorporate it into their existing work. This is interesting because it reflects the practices of the UK respondents in this work, but it makes no mention of the therapeutic alliance in the work of the ACEP members surveyed (Feinstein, 2016). It does throw up the question of why this is the case. If EP methods are powerful and helpful to clients, the evidence here suggests that for an unquantified or poorly understood reason, it is not used by professionals in all of their work with clients and this, in turn, will have an impact on the therapeutic alliance. The choice of whether to use it, taking into account that the therapist believes it is generally a powerful and helpful intervention, is an outcome of the therapist's thinking about the client and that will have an impact on therapeutic alliance.

Gaudiano et al. (2012) studied the personal characteristics of psychotherapists who choose to use energy meridian therapies (EMTs) with their clients. Although they do not address the therapeutic alliance, they state that psychotherapists who choose to use EMTs tend to be more open to non-evidence-based approaches to work. They also state that previous research has indicated that intuitive practitioners, the classification in which they place therapists who use EMT approaches, are less able to perform critical thinking (Gaudiano, Brown, & Miller, 2012). It is hard to know what this might mean with respect to the formation of the therapeutic alliance of which the therapist is an integral part. The article says nothing about whether these practitioners are able to assist their clients and appears to have a bias against EMTs which might mean that there also exists a bias against the practitioners who choose to use EMTs. The article was published in *Research on Social Work Practice*, and it is unclear whether there was also some confusion about the different roles of social worker and psychotherapist.

In an article that appeared in the BACP *Private Practice* publication, Fogel (2014), a psychotherapist and EFT enthusiast, describes a case study of EFT use. The client was in extreme physical pain due to previous trauma and Fogel was able to significantly ameliorate its effects with the use of EFT. Fogel says in her article

that she does not see EFT as a replacement for therapy, nor, importantly for this research, as a replacement for the therapeutic dyad, but does not explain why she views EFT in this way. A comment from the patient in the case study is also interesting; she says that the EFT helped, but she had experienced previous talking therapy as well and did not know how much of her improvement she could attribute to the EFT alone, although it had a marked effect. This raises the question of whether the talking therapy before the EFT was an important element and, if so, in what way. While the article does not explore this assertion any further, it is interesting that Fogel feels the need to point this out. It suggests that something is happening within the therapeutic dyad that does not occur when EFT alone is used. (Fogel, 2014).

In an interview recorded in 2014 for *The Tapping World Summit,* an annual online EFT event hosted by Nick Ortner and aimed at anyone with an interest in EFT, American clinical psychologist Dr Erin Shannon remarked that she had initial reservations about incorporating EFT into her clinical practice, but that when she did so, she found that it integrated very well and now she cannot imagine not using it. She does not discuss anything to do with its effect on therapeutic alliance; however, her stance is that her work with clients is more powerful with EFT than it would be without (Shannon, 2014), and may suggest that EFT is perhaps playing some role in the therapeutic alliance, if that is indeed the healing element of any therapy (Bordin, 1994). It must be borne in mind, however, that Shannon's audience was likely to have had a very wide range of professional backgrounds and would also have included non-professionals who simply had an interest in the subject. It is also noteworthy that the interviewer (Jessica Ortner) is not a mental health professional and appears in the interview to have been somewhat awed that a clinical psychologist had incorporated EFT use into her practice.

Despite the lack of research into the effect of EFT on the therapeutic alliance, an element that comes across clearly in all the articles cited is that EFT does not appear to be used as a standalone modality. It is being incorporated into already existing practices and practice guidelines by the sources in the literature review and indeed by the respondents in this research. The majority of participants in this research expressed the opinion that EFT was not a standalone therapy as

they saw it. This, in turn, raises queries about the alliance in both talking only therapies and in EFT and when both are used together.

2.5 Conclusions

Because there was only one small scale study found which directly, although briefly and only partially, addressed the effect of EFT use on the therapeutic alliance, the search necessarily widened to other sources that either did not specifically address the use of EFT and its impact on therapeutic alliance, or did not address the therapeutic alliance specifically within EFT use. A lack of clarity emerged when considering different studies' semantics in defining what happens in therapy and the therapeutic alliance when a new way of working is introduced.

All of the studies named elements of the therapeutic relationship that could be a part of the therapeutic alliance, according to my definition of it (see section 1.4). They stipulated that the use of common elements of the therapeutic alliance were present in the modalities they considered. All concluded that these common elements beneficially impacted the therapy as a whole. None of the studies, apart from Mason's (2012) looked directly at the concept of therapeutic alliance, however the authors might have defined it. The impact on the therapeutic alliance therefore was extrapolated from their discussions of the use of common elements

There is a great deal published about the efficacy of EFT; however, this was not the topic of this study and therefore research into this area was necessarily ruled out. There is thus a clear gap in the knowledge about using EFT within a therapy and what effect that has on the therapeutic alliance, whether alone or in conjunction with more traditional approaches. It is that gap that this research attempts to fill.

I used the CASP checklist for qualitative studies (2018). There is no formal scoring system and the publisher recommends that one is not used. However, there are 10 questions set for each work considered and they fall into three categories: validity of the study, the results of the study and whether the results are applicable locally. Assessing the articles found against the CASP checklist they fall short of the minimum standard for quality outlined. Particularly this is true on points 8 and 10 of the CASP checklist which address the results and rigorousness of the studies, and the value of the research done. While none of the research used in the literature review directly addresses the question for this

research, and therefore contributes only pieces of the puzzle, much of the research for these articles did not make valuable contributions to theory nor practice more generally. The studies involved very small numbers of participants and the analysis of the data collected was not rigorously performed. They also fell short on their applicability to a wider readership.

2.6 Papers that were excluded from the literature review but were interesting nonetheless

There were three papers that, although they did not fit the criteria of the literature review, were interesting because of their thinking about the impact of non-mainstream therapeutic interventions on the therapeutic alliance. All three of the therapies considered in this group of papers were too far removed from the protocols of EFT to make them a valuable comparison; however, they make a contribution to thinking about therapeutic alliance while lesser-known modalities are in use.

In 2018, Solomonov et al evaluated fluctuations in the therapeutic alliance in a review of psychotherapists using supportive expressive therapy (SET). It was found overall that therapists who use SET were consistent in their use of the modality, but less consistent in use of the factors common to therapy such as therapist warmth, empathy and attentive and active listening.

Watson and Greenberg (2000) wrote about alliance ruptures and repairs during the use of experiential therapies. Their work is interesting because what they call experiential therapy is a talking-only model. It is too far removed from EFT to make valuable comparisons of the methods directly and was therefore excluded from the literature review. However, they highlight the rupture to the therapeutic alliance when the tasks (Bordin, 1979) of therapy prove unexpected to the client.

Brodie (2015) outlined the use of shamanic practices in trauma therapy. She does not make mention of the therapeutic alliance, but quoting Schore (2012), says that the aim is to widen the windows of affect tolerance and that the best way to do that is by the therapist holding a safe place, both physically and emotionally for the client.

None of these papers was a high-quality research contribution based on the CASP criteria (CASP, 2018). They all query the use of more alternative therapies and in some cases, look at the impact of a particular therapy on the therapeutic

alliance. However, Brodie's (2015) paper does not name what she is describing as therapeutic alliance; instead it is talked about in more generalised terms. What they provide is a loose conception of common factors and their role in facilitating work with clients.

The literature review does not provide evidence for the specific question of this research because there was nothing found that examined that question directly, and only very little found that mentioned it in the context of other research pursuits. Rather, it gives a picture of the background against which this research was conducted and to which it contributes.

Chapter 3. Methodology

This chapter presents the rationale for a qualitative research enquiry and specifically for the use of Framework Analysis (FA) as the chosen methodology. The research was in an area that had very few contributions in answer to my specific questions. A qualitative study and approach to analysing the findings was selected because the data collected were not only non-numerical, but also about a phenomenon that is not well-understood (Streefkerk, 2019). This study looks at what happens between therapists and clients, from the therapists' point of view and thus is focused on a micro-level of social interaction and experience, and not large-scale trends that are understandable through the use of numerical data (Thoughtco.com, 2019) and therefore a qualitative approach was determined to be more helpful in beginning to develop themes in this field.

3.1 Rationale for a qualitative approach

Qualitative research can make a vital contribution to knowledge. It provides a greater depth of understanding about the topic under consideration by adding rich, detailed and sometimes colourful knowledge and accounts of experiences (Mason, 2018). Qualitative research increases understanding of a topic to allow the meanings that participants ascribe to phenomena to come to the fore and for the findings to be used in practice in a way that places both members of the therapy dyad at the core (Galvin & Galloway, 2009). It can also begin to generate theories that help shape our understanding of how, in this instance, EFT might affect therapeutic alliance (Silverstein, Auerbach, & Levant, 2006; Spencer, Ritchie, Lewis, & Dillon, 2003). Finally, qualitative research is more able to provide an insight into the shaping of, in this instance, practice guidelines in bringing EFT into a talking therapy. That was not the aim of this thesis but may be a benefit that arises from the research (Johnson & Waterfield, 2004). In this aspect, as so little knowledge currently exists about the impact of EFT on the therapeutic alliance, my research is an initial exploration into this area and therefore was better served by a qualitative approach in helping to identify what the current level of knowledge is in the field. Although I had some pre-conceived opinions about EFT's effect on therapeutic alliance following my work from which the research question emerged, I had very little understanding of what other practitioners' experiences might be. Particularly, therefore, the qualitative

contribution which seeks in part to generate theories played an important role in this study.

Qualitative research focuses on attempting to understand the meanings people give to their experiences and allows observers to have some understanding of how this meaning is derived (McLeod, 2013). Through semi-structured interviews, participants are encouraged to speak freely, with minimal guidance from the interviewer apart from the initial questions and attempts made at clarification (Kvale, 2008; Dallos & Vetere, 2005) Particularly in this study, for an area in which so little pre-existing research has been published, it was helpful to give participants as much freedom as possible to say what they believed was appropriate and reflective of their own experiences and points of view.

3.2 Research strategy: Framework Analysis

Framework Analysis (FA) (Ritchie & Spencer, 1994) is a methodology that has been widely used in applied policy research and was specifically developed for that. In this research, FA was used because there was so little pre-existing data available, the generation of themes around this topic was an important consideration. Ritchie and Spencer outlined four categories in which qualitative data can be used in public policy research to meet different needs: contextual, diagnostic, evaluative and strategic. This study sits within their diagnostic category because it evaluates how clinicians use EFT within therapeutic offerings now and its subsequent effect on the therapeutic alliance. It seeks to understand the current state of thinking that clinicians who use it have about EFT's impact on therapeutic alliance. It may also, to a lesser extent, fit into Ritchie and Spencer's (1994) strategic category because the results may have some influence on thinking about the incorporation of EFT into more mainstream therapy. This strategic aim, however, was not the purpose of the study but was one of the themes that developed out of the data and from the researcher's reflective and reflexive thinking.

Ritchie and Spencer describe the aim of public policy research: 'output from research needs to be appropriately targeted towards providing "answers", in the form of greater illumination or understanding of the issues being addressed' (Ritchie & Spencer, 1994, p. 175). They also assert that Framework Analysis with its strong structure provides clearer insight and visibility of the analysis which offers readers greater confidence in the results obtained. The clarity of the

method offered much to this study as well. EFT as a modality has been on the fringes of mainstream psychotherapy since its inception in 1990. Indeed, it was not originally developed as a therapeutic approach. There has been a great deal of suspicion about the method from many sources (Bakker, 2013; Feinstein, 2016). Its efficacy has been supported by studies which suggest it is effective and there are psychological health practitioners who do use and endorse it. This study's purpose was not to assert the efficacy of EFT; rather, in its assertions about what EFT's impact on therapeutic working alliance is, it offers a view of one way in which EFT use could affect therapeutic work.

Framework Analysis has been more recently adopted by researchers in psychology and health sciences (Parkinson, et al., 2016; Hill, Gingras, & Gucciardi, 2013). It was chosen as a methodology for this study because, although in Parkinson et al.'s study FA was used because it was a good approach for a group of researchers, it was also chosen because it provides a structured approach to the data for inexperienced researchers. This was important to my study, because of my lack of experience as a researcher.

In Hill, Gingras, & Gucciardi (2013), Hill, an inexperienced researcher, initiated the research idea and led the focus groups used for data analysis. Her study was similar to my work because the question being researched was the experiences of Canadian university students with a diagnosis of diabetes when they attended university. Hill herself has diabetes and therefore had a high level of both interest in, and experience and bias around, the question being researched. Her co-authors played a more supervisory role in the research and provided a more experienced and less biased view which would have been useful in ensuring the quality of the research. This is a role that in my study has been filled by my academic supervisors and my fellow students as peer reviewers.

Framework Analysis also allows data to be extracted from interviews whilst simultaneously keeping it linked to its source (Gale, et al., 2013). Gale et al. stress the ability the methodology offers to organise larger sets of data into a 'descriptive, holistic overview'. My data set was not large, but the amount of material I gleaned from the research was significant and colourful. Due to the lack of existing knowledge in the area, it was important to draw out themes that were important to all or many of the participants. From there, further and more detailed research into particular areas of the topic can be conducted. Framework Analysis

fitted with this aim very well as it is one approach that uses a basis of thematic analysis.

Finally, Gale et al. (2013) make the point that FA has no allegiance to either inductive nor reductive thematic analysis; rather, it can be used in either way and particularly for the main research question in this study it seemed appropriate to use it in an inductive way, to allow for open coding and for unanticipated themes to emerge from the data, and because an inductive approach more easily allows for the exploration of anomalies in the data. I also used it in a reductive way to allow me to stand back from the individual contributions and gain an overview of participants' views and outline broader themes.

Some of the cautions around the method that Gale et al. (2013) cite are that it is difficult to use when data is heterogeneous, and they advise that Framework Analysis works best when data covers key issues or similar topics. In my data, all participants were asked the same set of questions and although encouraged to speak freely in answer, the number of questions that I used was relatively high for a semi-structured interview. This served the purpose of ensuring that all participants spoke about the key issues and the same topics, although of course their answers varied, in some cases widely so.

Interpretative Phenomenological Analysis (IPA) might have been another suitable approach for this study, because of its recognition of the central role that a researcher plays in the research process and the double hermeneutic that emerges in any research process (Smith, Flowers, & Larkin, 2009). However, FA was chosen over IPA as the latter would not have allowed for an adequately in-depth analysis of each of the 16 interviews while simultaneously allowing for a more removed overview within the confines of this thesis. Most of the interviews were approximately an hour in length, and so much information was gleaned from each that to adequately represent all of the contributions I had to stand back and look at broader emerging themes. IPA studies generally have fewer participants (Smith, Flowers, & Larkin, 2009) for a project of this length and I sought to gain a greater breadth than I would have been able to use IPA with my results. The data I had was rich and widely varied and I wanted to include as much of the detail as I could, whilst organising it so that within the confines of this work as much of it as possible could be used. In this way, I simultaneously used it in both a reductive and an inductive way: inductively to include the many anomalies that cropped up,

and reductively to gain an overview of the whole picture and how all the pieces fit together.

Framework Analysis fits broadly within the thematic analysis family of methodologies and is also phenomenological (Gale, et al., 2013). Therefore, it allows for thematic exploration of participants' individual accounts whilst allowing the researcher to step back from the individual contributions and see themes that are more widely shared within the group of contributors.

3.3 Epistemological stance of this research

As the researcher, I would have been an ideal participant for this study, as was the case in the Hill et al (Hill, Gingras, & Gucciardi, 2013) research: : I fitted all the criteria I sought in my participants and the research question arose out of an experience I had in my private clinical work. Coding for reflexive observations both in myself and remarks participants made was also achieved through the use of FA. Here again, I used both an inductive and a reductive approach simultaneously, as I sought broader themes and general understandings whilst also sifting through the data for the *a priori* themes and their finer nuances within the context of individual interviews. At the conclusion of the study, for example, it was the broader theme of an inherent desire to prove the value of EFT that seemed to pervade all of the contributions made and to colour my own thinking to an extent.

This research was conducted from an hermeneutic epistemological stance therefore, following the guidelines laid out in Dieleman's paper of 2017. Dieleman discusses the role of hermeneutics in transdisciplinary studies. While my work is not a transdisciplinary study – the field is limited to psychology and psychotherapy – there is a trans-disciplinary aspect to it through the examination of EFT, often seen as a therapy that exists outside psychotherapy. Direct mention of this was made by several contributors, but generally only once the formal part of the interviews had concluded and I asked respondents whether they had any questions they wished to ask me. This was an important part of the analysis that will be discussed in the reflexive observations chapter.

3.4 Study design and methodology

In this study, I was the only researcher and my credentials for performing the research were made clear to all participants through the use of an information

and consent form (see appendix 2)) and at the outset of each interview. I asked all participants to sign and return a copy of the form prior to the interview. Once I had received the signed form back from a participant, I scheduled the interview. At the beginning of every Skype interview, I re-confirmed with each participant that they met the criteria for inclusion and that they understood my purpose of the research, and who I was. Although I knew some of the participants prior to conducting the research, I did not know any of them well and have never worked alongside them. The respondents I previously knew were people I had met on various training events in EFT and through seminars and workshops and were colleagues in a looser sense: that we were practising psychotherapists or counsellors who use EFT. Two of them were leaders of workshops that I had attended. I had no involvement in their personal lives, nor they in mine and we had limited involvement in each other's professional lives, as described above. Some participants' names emerged from interviews with other participants from snowball sampling, and thus, those who came out of this group may have been told something about me of which I was unaware and that would be difficult to ascertain.

3.4.1 Participant selection

Participant selection was purposive initially and the criteria for inclusion were specific: participants had to have a degree or qualification in psychotherapy, counselling or psychology; participants also had to have had formal training in the use of EFT; and they had to be actively working with clients and using EFT at least sometimes in that work. Additionally, I sought participants who were UK based; however, because it seemed at different times in the process as if it might not be possible to find sufficient numbers of participants for a valuable study, the location criterion was dropped.

Of the 16 participants, 13 were in private practice, one was employed by a private therapeutic agency in North America, and two were employed by the NHS. That the participant group was overwhelmingly in private practice may be a reflection of the lack of NICE support for EFT use in the NHS. Two of the participants were from outside the UK so could not have been expected to be employed by the NHS. As far as was possible, homogeneity amongst participants was sought, although clinicians' training and orientations to psychotherapy varied and specific

information about their orientations outside of EFT use was not used. A list of participants, listed by their pseudonyms, appears at Appendix 3.

A request for participation was put out on Facebook on the page run by the Association for the Advancement of Meridian Energy Therapies (AAMET). AAMET (as it was known at the time of this research) is an internationally focused, though largely UK-based, organisation that promotes the use of Energy Psychology (EP) and seeks to advance the use of EP in many different settings, including within therapy. The association changed its name to EFT International in 2019. This produced two potential participants. Sampling then occurred through both continued purposive efforts and snowballing as these two participants also had suggestions for potential participants and these names emerged in the course of discussion both by email and telephone between the existing participants and me.

I then contacted my clinical supervisor and my academic supervisor in a bid to find further participants, and from these conversations, another 15 potential participants emerged. I wrote to all of them individually by email, seeking their participation and of these 15, 11 both fitted the criteria for inclusion and agreed to take part. One of this second set offered to circulate my email to colleagues of hers who fitted the criteria for participation and from that, another participant was identified. Ultimately, of the 11 identified and contacted, 10 participated in the study.

Finally, during data gathering, one of the participants who had a mailing list of EFT practitioners from his website offered to circulate my initial email in his newsletter and from this, 6 more potential participants identified themselves and 5 met the criteria and were included.

3.4.2 Setting

Semi-structured interviews conducted over Skype were used as the main vehicle for data collection. The reasoning for this was to allow participants to say whatever they felt was appropriate in response to the queries posed and to allow for flexibility from the researcher to enable this process while also ensuring that the main research questions were put to every participant. Unlike the use of the telephone, Skype interviewing involves a visual element and allows for a more natural exchange between researcher and participant. There are some visual

cues that are picked up from Skype that might have been difficult or impossible to notice in a telephone interview, such as facial expression. Because of the higher number of visual impressions that the researcher is able to gather over Skype, it also allows for a greater rapport to develop between the two (Irvine, Drew, & Sainsbury, 2012). The interview with Ava was particularly difficult as the Skype connection on the appointed day was very poor. We decided to stop the interview and agreed to meet again the next week to conclude it. When we re-convened the following week, the Skype connection was again very poor, so we turned off the video element and continued with just the audio. This made her interview very similar to a telephone interview; however, we had established some rapport from the parts of the interview where we had achieved both audio and video elements of Skype.

Skype interviews were conducted for all of the data collection. One important element in the decision to use Skype, apart from those mentioned above, was to do with the geographical distance between the researcher and some of the contributors. In some cases it was impossible to meet in person as some of the participants were hundreds or thousands of miles away; therefore, to keep as many elements of the interview as possible consistent across participants and meet the homogeneity guideline of Framework Analysis (Gale, et al., 2013), Skype was chosen as the interview means (Opdenakker, 2006).

Each respondent was alone in a room of their choosing and I was alone in my room during interviews. One participant was brought a cup of tea during her interview. Another participant was in a room where a dog and some budgies were also present. This is important because the animals interrupted the interview briefly at several points. They also interfered slightly with the recording, so fragments of sentences were lost behind the noise the animals were making during the interview.

The interviews occurred between August 2017 and February 2018, according to the availability of both participant and researcher. The interviews ranged in time between 35 and 75 minutes, determined by the length of participant answers. It also varied somewhat due to the length of any discussion that occurred after the formal questions and answers of the interview were concluded. Although participants had been offered the opportunity to ask questions at all stages of our contact (at initial email contact, on receipt of their signed information and consent

forms, during email contact in establishing an interview appointment and at the beginning of each recorded interview), it was only when offered the opportunity to ask questions at the end of the interview that many of them took the opportunity to do so.

3.4.3 Data collection

I developed a list of questions for use in the semi-structured interview, following guidelines in *Social Research Methods* (Bryman, 2012). This list of questions was then sent to my academic supervisor and discussed. Questions which began with 'why' were taken out because the use of the word 'why' can sometimes be heard as implying that there is a right or a wrong answer (Bryman, 2012; Knox, 2016).

There were three main questions, which were intended to be put to every participant and 19 that were designed to be used to draw out further thinking if necessary (see Appendix 5). They were grouped into three sections: what participants like and do not like and why they use EFT in their work; how decisions are made about when and how to use EFT and with which clients; and how participants conceive the idea of therapeutic alliance and whether the use of EFT changes the therapeutic alliance. In the first group of questions, there was one question about the therapeutic alliance which was placed in this grouping to get respondents started thinking about the therapeutic alliance (Knox, 2016).

Each respondent was interviewed only once, and each was offered the opportunity to read over the transcript of their interview when it was ready. For those that asked me to send them the transcript, none offered corrections, deletions or changes. Field notes were kept throughout each interview and immediately following it notes were also made. During the familiarisation process of Framework Analysis, further notes were made in the margins of the transcripts on reading them. Notes were also made during re-reading the transcripts whilst simultaneously listening to the interviews from which the transcript was derived.

Data saturation was not discussed with respondents. Due to the uncertainty around the anticipated findings, it was not thought that data saturation would be fully achieved. Although there was partial data saturation on some of the questions to do with what participants liked about EFT and the fact that they believed it either did not harm or strengthened the therapeutic alliance, there was also a lack of clarity amongst many of the participants around what the

therapeutic alliance is as a concept. Therefore, it became difficult to achieve data saturation on the query of EFT's effect on the alliance as the understanding of what the alliance is was unclear. However, what did emerge was some data saturation in the lack of clarity.

3.4.4 Analysis and findings

Coding was performed entirely by me and then checked with colleagues. I engaged in a triangulation process with two other doctoral candidates, the first of whom is also a qualified psychotherapist though not an EFT practitioner. We began the process of reading through each transcript alone, and then meeting for an hour over Skype to discuss them one by one. Triangulation was completed between steps 2 and 3 of the FA process (Gale, et al., 2013) described above. We went through each of the first nine interviews (over 50% of the sample size) line by line discussing potential emerging themes in participants' contributions and in the interaction between me and each participant. Our intention had been to fully discuss all the interviews; however, after we had completed the first nine my colleague was unable to continue.

Following discussion with my supervisor about these events, I contacted another doctoral candidate and psychological therapist working with clients in an NHS service in the Southwest. I sent two of the transcripts from the Skype interviews to her (over 10% of the sample size), for which I had already performed an initial coding. She read through them and made her own notes about the interviews themselves and my coding. We then had an hour's meeting in which we discussed our thinking about the emerging themes. The two interviews I sent to my second colleague had not been discussed with the first. I purposely chose one interview that I thought had been a contextually rich and complex interview, and one interview that I thought had been very different to the first and had seemed difficult for the participant and for me. We then discussed each interview by telephone.

After reading through the transcribed interviews for the first time, some emerging themes were recorded in the margins of the document. Although for an FA methodology analysis it is not necessary to have an absolutely verbatim transcript with each pause and 'um' and 'ah' noted (Gale, et al., 2013), I recorded all of these to help me later when I analysed the transcripts, particularly for reflexive themes. Transcription is the first step of FA (Gale et al., 2013).

I then listened to each interview again with the transcript in front of me, making further notes in the margins, line-by-line. This step of familiarisation with the data is the second step of FA (Gale, et al., 2013; Parkinson, et al., 2016; Ritchie & Spencer, 1994). It took an average of 4 hours per interview. This was an extremely helpful step in the analysis as listening to my own voice in participation with the respondent's helped me very clearly remember my own internal process while conducting each interview; it also gave me some distance from the interview which allowed for greater understanding of the reflexive process in the data gathering.

Step 3 of FA is coding (Gale, et al., 2013; Parkinson, et al., 2016; Ritchie & Spencer, 1994) which I completed once I had re-familiarised myself with all of the interviews and it was at this stage that I began to use NVivo to code the data. I coded all the interviews using open coding to stay as close to the data as possible, and to allow anomalies and new themes to emerge as I continued. I devised a set of codes based on what the participants contributed and then began thinking ahead to designing the framework matrices, step 4 of FA (Gale, et al., 2013).

To check the accuracy of my coding on NVivo, I designed a table of frames and sub-frames to help guide my thinking (see Appendix 6) and with the knowledge I had gained from the familiarisation step and the initial attempt at coding. When the table was completed, I returned to the NVivo document and compared it against my proposed framework matrices. At this point, it appeared that some important, finer themes were emerging that thinking about framework matrices had identified. I then began a new approach to coding starting from the beginning, with a greater list of themes and re-coded all of the interviews. This work was part of both steps 4 and 5 in FA, developing a working analytical framework that is flexible and responsive to emerging data. Gale et al. (2013) advise that several versions of the analytical framework are likely to be needed. Working in this way keeps the researcher close to the data and the data close to its contributor whilst simultaneously allowing for one contributor's views to be compared with those of others.

After re-considering the data again in light of the new framework, it appeared too varied and rich to do justice to some contributions. More, smaller framework matrices were subsequently devised in NVivo to make analysing the components

of the frameworks thoroughly more straightforward. The structure of the revised framework was maintained, but the comments from participants were broken down into more categories. Some of what was found and coded for was not expected, and some of the emerging data did fit in with the *a priori* coding expected.

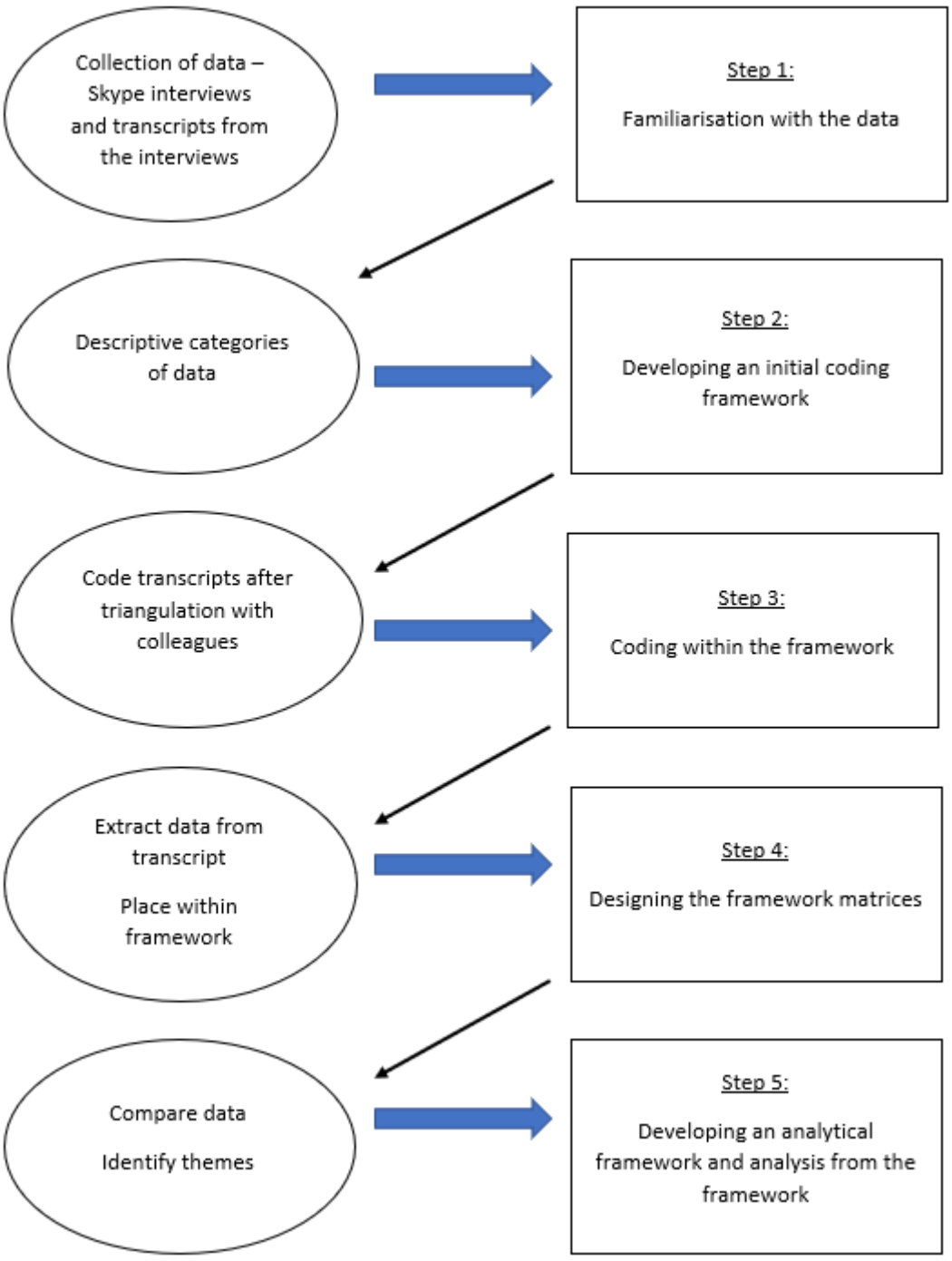

Figure 1. Flowchart illustrating the steps in Framework Analysis, based on Spencer and Ritchie (1994)

3.4.5 Pilot interview

Before commencing the interviews, I considered whether to send the list of questions to participants ahead of the interview and decided against this to encourage open, spontaneous answers (Wertz, 2005). I then ran a pilot interview with a colleague who is not an EFT practitioner but is a therapeutic counsellor. After conducting the interview over Skype as I planned to do for the data collection, we discussed her impressions of the questions and her experience of

being interviewed by me. No further changes were made to the list of questions following the pilot interview, nor to my approach to interviewees.

3.4.6 Ethical considerations

Guidelines for ethical considerations were refined from Walker's (2007) discussion of ethical considerations in phenomenological research. Ethical approval for the research was granted by the University of Exeter's ethics committee on 26 July 2016 (reference: 2016/1309). Provision was made for a colleague of mine to be available to speak to participants who might find themselves distressed after the interview and this was made clear to participants. The opportunity to withdraw from the study without penalty at any point up until the final copy of the thesis is submitted was made clear to participants on the Information and Consent form circulated (see Appendix 2).

Although the identity of the participants was known to me, their confidentiality was assured through the use of pseudonyms. The pseudonyms I used are gender-specific (female names for female participants), but no further disclosures about participants were made. There was one exception to this rule, which was also clearly outlined: that, if necessary, to increase reader understanding it was important to mention participants' places of work non-specifically to contextualise their comments, this would be done. For example, I do mention within the results section that one of the participants works within an NHS service. It was explained to each participant that the results of the work may, in part or in whole, be published at some time in the future.

Bracketing, the practice of identifying researcher bias and so far as is possible keeping that separate from the findings, was achieved through the use of an in-depth reflexive section (Fischer, 2009). The material from the research interviews was coded for some themes that were *a priori*. In this study, the *a priori* themes existed in researcher understanding and thinking and might have been found in contributors remarks. The coding for these themes was established before coding for the whole of any individual interview. This allowed for a level of separation before participants' interviews were coded.

3.5 Planning for the quality of the research

To ensure as far as possible that the research was as reliable as it could be, and in turn that it makes a valuable contribution to thinking about the use of EFT within

psychotherapy and its impact on the therapeutic alliance, I consulted the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist. COREQ is a 32-item checklist developed by Tong, Sainsbury and Craig (2007) to ensure quality in qualitative research, particularly in research that involves one-to-one and focus group methods of data collection. Its aim is to be comprehensive, and it is similar to checklists that have been developed to ensure quality in quantitative research. It was developed with the explicit aim of ensuring that qualitative research makes as valuable a contribution to the current state of knowledge as quantitative research and will thus no longer be regarded as second-class.

Tong et al. divide their 32-item checklist into three domains: (1) research team and reflexivity; (2) study design; and (3) analysis and findings. What follows is an explanation of my adherence to the 32 items in the COREQ checklist, divided into the same domains that Tong et al. used.

3.6 Reflexivity in the research

There is also a chapter on reflexive observations containing reflexive observations that participants made about themselves, and observations on what occurred between me and respondents as the interviews were taking place. Finally, there are reflexive observations about my involvement in and influence on the research and how my views changed over the course of the research. I was guided by Lazard & McAvoy's (2017) contribution to thinking about reflexivity in psychological research in my reflexive activities.

The chapter on reflexivity was essential in this research for several reasons. First, because the research questions arose out of an episode in my own clinical practice that initially seemed as though it would have application to other therapists' clinical practices. It was impossible to entirely separate myself from the participants in this work and therefore, a reflexive approach was necessary to establish rigour in the research and contribute to the quality of the results (Tuval-Mashiach, 2017).

Secondly, the activity of researching the experiences, thoughts and beliefs of other therapists in relation to the research questions and then examining those views through a reflexive lens was pursued to produce greater context of meaning within the process and ultimately the results (Lazard & McAvoy, 2017). Through

reflexive enquiry, the process of viewing myself separately from the research participants clarified both differences and similarities between us and made particularly the similarities more transparent.

Chapter 4. Analysis

After organising the data into framework matrices, analysis of emerging themes within them was possible. The overall framework matrix can be seen at Appendix 6. Working on an inductive principle and beginning from the smallest sections of data moving upward and outward, the data was coded into 60 themes in nine categories. They were organised into four over-arching frameworks: (1) practitioner understanding of the therapeutic alliance; (2) the effect of EFT use on the therapeutic alliance; (3) practitioner likes and dislikes about EFT and how that may affect therapeutic alliance; and (4) reflexive observations. The first three categories are discussed here, and the fourth category is discussed in Chapter 5.

4.1 Practitioner understanding of the therapeutic alliance

Before exploring what respondents believed was the effect of EFT on the therapeutic alliance, it was important to understand how they conceptualised the therapeutic alliance generally. It laid the groundwork for understanding what they believed happens when EFT is introduced and what EFT use may or may not be affecting, in their experiences. Overall, respondents were somewhat vague and uncertain in their depiction of the therapeutic alliance. There appeared to be an undefinable element of therapy of which participants were aware, but that was difficult to put into words. All respondents knew of the concept of the therapeutic alliance but seemed to struggle to name it or put it into words.

When the question was directly asked, respondents answered with explanations of their role in the therapeutic alliance, or the client's role, or qualities that must exist for the therapeutic alliance to form, but not what the therapeutic alliance is. Emma spoke about knowing whether it was present and that she would have noticed if it had been absent, but that thinking about it as a concept was difficult to put into words:

> 'It was just a given so you're with a person, you do have that connection, work together and I've never given it a lot of thought … and what I would say [is] that if I didn't feel that alliance something would have been really wrong and I would have noticed it if it wasn't there, but it was sort of a given that when I'm with a person in that capacity then there is the connection, there is the relationship … ' (*Emma, lines 546-553).*

An important theme emerged in responses to this question and is seen in Emma's answer: that of the therapist's embarrassment at not having a more concrete and clearly defined way of talking, or perhaps thinking, about this concept. On first hearing this direct question, many respondents seemed to hesitate and then to answer in a very formal way as if their knowledge were being tested. That said, it may be that the therapeutic alliance, at least as therapists experience it, is more to do with a feeling that is difficult to articulate.

Emma spoke about the alliance, initially saying that she did not like the word 'alliance', as it seemed to imply a uniting between therapist and client against something, which was not how she sees a therapeutic alliance.

> 'Okay so I'm not sure if I like the word "alliance" … but er it reminds me of the … er … alliance what is it? It's so funny, that … It's like alliance *against* something else … er … so to me it's kind-of more "collaboration" I would probably use that instead of 'alliance' (*Emma, lines 636-640).*

This was interesting because it is a sense of collaboration that seemed to have gone missing in my work with the client from which the research question arose. However, what Emma said does not necessarily imply a lack of alliance, nor even a lack of collaboration. If therapist and client are allied against something, there could still exist a sense of collaboration in that union. Her comment is implying that something exists in collaboration that does not necessarily occur in alliance. She may also be referring to a more widely known alliance, the name of which she was unable to place. To me, this suggested a more global alliance, perhaps some political, economic or war-like alliance.

Emma then went on to say:

> 'I have had that with some clients … where there is just kind-of a talking that's quite superficial and nothing happens and you know I leave the session feeling "well nothing bloody happened then, nothing" … which is really frustrating ... So something needs to happen, some action needs to be taken in that alliance and actually could be verbal action it could be to do with words. But yes there is some kind-of a level of proactivity … yeah that's actually … that's a good one I had not actually thought about it but I think in their life the client is also proactive not just me and I'm not just kind-of prodding them and pushing them in a certain direction so that they actually take some responsibility' (*Emma, lines 620-627).*

This is a sense of shared responsibility for the client's movement and that both therapist and client need to have a near-equality in that responsibility. In this

sense, despite Emma's doubts about the use of the word alliance, the client and therapist would be allied, perhaps drawing on each other's contributions toward the goal. Taking Emma's sense that the word 'alliance' suggests to her that an alliance exists against something, in this context it could be that the client and therapist are allied against the client's struggles. This is reminiscent of Bordin's (1979) conceptualisation of the therapeutic alliance, but rather than one of its three elements, this is about the starting point of agreement that exists between client and therapist, whether tacit or explicit, from which the three elements of the alliance arise. Bordin's naming of the agreement, tasks and goals of the alliance also implies a sense of movement which Emma refers to in her need for action within the alliance.

When asked about the therapeutic alliance generally, with or without the use of EFT, participants talked about the therapist's role most frequently, some talked about the client's role and all talked about the qualities within the relationship that must be present for the alliance to form. Elizabeth talked about her role as a facilitator and about the equality of the therapeutic alliance:

> 'Providing a facilitating environment … as a fellow-struggler with difficult issues … challenging, being challenged' (*Elizabeth, lines 300-303).*

Here again is the sense that client and therapist are working together and acknowledging that they may both be struggling at times. She is also referring to the changing nature of her role within the alliance when she says, 'challenging, being challenged'.

Victoria talked about the alliance and the therapeutic relationship and brought in the idea that this occurs on a physical in addition to psychological level.

> 'For me, it's about … when you share molecules with someone and you're creating a relationship, a way of relating' (*Victoria, lines 321-325).*

Victoria talks about sharing molecules with a client, which implies a sense of a two-way exchange that Elizabeth also indirectly named. It is also a sense of exchange at a very basic level: our bodies are composed of molecules. Although Victoria did not say this, her comment has the sense that she experiences this sharing as very open and lacking any artifice that might be occurring on a less basic level. Creating a relationship implies some action on the part of the client, even if that action may be to refuse to take action. There is again the sense of a

two-way exchange in sharing a space and sharing herself to the client experience and the client sharing her or himself to her contribution.

Grace first acknowledged her surprise and perhaps discomfort at the question and then spoke about the caring that therapists must communicate to their clients. It seemed important to her that clients understand the caring the therapist offers.

> 'Ooh! It's a long time since I've thought about that! … I believe that you have to be … genuine, caring … and that they have to be able to see that you're genuine and caring … and that you're not just … mainly teaching them a technique' (*Grace, lines 273-276).*

The technique that Grace refers to is EFT, and she is emphasising the importance of the basis for the relationship that must exist with the impartation of the method of EFT. It was important for Grace that these qualities exist at a minimum alongside the use of EFT, perhaps before EFT is used. Interestingly, this is something she saw as separate from EFT.

Most of the respondents talked about the qualities of trust, caring and safety that must exist and be provided by the therapist for the therapeutic alliance to form and to survive. Trust was something that the client had to feel in the therapist, and equally it could be argued that the therapist must trust in the client, though no one discussed that aspect of it directly.

Use of the word alliance seemed to imply to all the respondents a working together between client and therapist. It was also important therefore to think about how these therapists perceive the client role in the alliance.

Emma raised the idea of working with the client towards something in her definition of the alliance initially when she cited her experience of working with clients whom she felt she had to push and prod toward their healing. In these circumstances, client and therapist may have had a very different understanding of the alliance, because if Emma was pushing and prodding clients, it seems to speak of client unwillingness about the process whether or not an agreement on the tasks, the goals or the purpose of therapy exist (Bordin, 1979). Ben went on to echo Emma's thinking with an emphasis on his belief that the client must have a willingness to participate:

> 'Their role I think is um … is to turn up, is to be … as honest as they can be, or as straightforward as they can be in that experience and to join in … with the experience … because neither of us have any idea where it's going to go … I think initially there's kind of natural

> concerns about safety and trust … the first session or maybe the first couple of sessions or you-know if I'm very lucky the first ten minutes have kind-of allayed their … allow them to trust enough and to feel safe enough to offer the first … thing but they … have to be willing to do that' (*Ben, lines 386-393).*

Formation of the alliance is a process between two people, and Ben is explicitly noting that the therapist must initially offer safety so that the client can trust him. While both trust and safety are not the entirety of the therapeutic alliance, they are elements of it and expand its formation. He goes on to say that both he and the client must be willing to make the effort to not only trust, but also to take the next step of working within the therapy. The willingness that Ben talks about is similar to the collaboration that Victoria, Elizabeth and Emma also spoke about. It may also be a precursor to the element of movement, or something happening, within the therapy that Emma focussed on.

Most of the respondents did not talk about the client's role in the therapeutic alliance; rather, they focused much more on their own role. This may be because they are less able to know what their clients are thinking, and it could be an indication of where therapist focus is – on themselves – in the formation of the alliance and their beliefs about their responsibilities and duties within that formation. Ben was the only therapist who mentioned the client role explicitly. He talked about the client role as being one of 'turning up' and this implies both a physical turning up to the appointment, as well as a psychological turning up or willingness to do the work. Other respondents spoke about what they themselves did in the therapeutic alliance, or what they did to enable it to form and they talked about the observable effects of these stances on the client and whether they believed an alliance was present.

Repeatedly, respondents named the qualities of trust, safety and caring that they both had to provide for their clients and that the client had to allow themselves to experience for the alliance to form. From this, there is a sense of alliance simply in the sharing that happens on this level – the therapist offering trustworthiness, safety and caring while the client makes themselves available to receive these attributes and to benefit from them. There is a sense of alliance when client and therapist come together that seems to pre-exist the methodology of therapy.

4.2 Effect of EFT use on therapeutic alliance

In trying to establish how EFT may affect the therapeutic alliance, questions were posed that asked when EFT is introduced to the work. For the two respondents who work for the NHS, they were working within their respective services as EFT practitioners, though they both use other approaches to therapy in addition to EFT. They both talked about introducing EFT gently and that it would most likely be introduced in the first session because the client would have already participated in an assessment session, either with them or with a colleague and the client would very often have been referred to them specifically for EFT work.

The participants working in private practice said that they advertise themselves as therapists who use EFT and a range of other energy therapy approaches rather than simply as an EFT practitioner or an EP practitioner. They believed this was why the majority of their clients approached them for therapy rather than for EP specifically. In these instances, there was a delay between the client first arriving and the introduction of EFT when it was used. Groundwork was seen to be necessary to establish before EFT work could begin. Although no respondent said this, there is an implied sense that commencing EFT work almost immediately was inappropriate. Repeatedly, EFT was introduced gently and gradually in these therapists' work and this could be a statement about the alliance that had to be a precursor to EFT work. It suggests that introducing EFT may threaten the formation of an alliance in these therapists' views. The discussion with the client about the possible uses of EFT was conducted cautiously and, in some cases, psycho-education was provided alongside the introduction of EFT. Though Victoria did not talk about using psycho-education in her introduction of EFT to clients, she emphasised the caution and gentle approach she used when bringing it into therapy:

> 'I tend to go through it very gently I introduce it very gently. I also give them really good sheets that they can take away and practise. I also give them resources to look up online that they can watch a demonstration being done and tap along' (*Victoria, lines 75-78).*

Introducing EFT gently implies that there is some concern that EFT work might upset something that client and therapist had established. That element may be the therapeutic alliance.

There were occasions when respondents were approached specifically for EP, but these were far less frequent. In this case, however, the introduction of the use

of EFT would have happened prior to the first verbal contact: when the client would have seen the therapist's website which included information about EFT and other energy modalities. Half of the respondents who were in private practice said that they would often introduce EFT in the first session, but this would again be done cautiously and slowly to see if the client liked it and would be amenable to its use.

Whenever EFT was introduced, there had to be agreement within the dyad about its use. The alliance must be in place in these therapists' views, in some form or other before beginning EFT. Elizabeth noted this quite clearly:

> 'It *has* to be present to be able to … er … in the same way an interpretation has to be … er or a shared … or developing a shared understanding or asking a difficult question or … it's an *intervention* and any intervention … you have to have *some* sense of a therapeutic alliance' (*Elizabeth, lines 272-275).*

Equally, it also seems to state that EFT itself is not disturbing nor impeding a therapeutic alliance. In Elizabeth's view, it seemed possible to maintain a therapeutic alliance while using EFT, indeed necessary to do so, then therapeutic alliance and EFT seem to be separate processes that run alongside, and complement, each other and this may be similar to other therapeutic interventions.

Victoria also seems to be offering clients choice about the use of EFT when she is talking about giving clients the resources to look up EFT online; not only a choice about using it at home with an online demonstration, but also about forming an opinion of it, and presumably whether they wish to use it in therapy. Offering the client a choice about EFT's use is also an act that may lead to greater alliance within the dyad as it empowers the client to decide about the treatment he or she receives and is independent of EFT use.

Ben spoke about the forming of the therapeutic alliance as beginning before he ever meets the client in person. He talked about how he screens for whether a client and he will be able to work together.

> 'Trying to make clear what I do and how I do it at the beginning and that's part of them, if you like, taking me for a test drive really, to see if what I've got fits kind-of fits *them' (Ben, lines 204-206).*

Although Ben is talking about the use of EFT primarily the idea that the therapeutic alliance is beginning to form from the point that the client first sees

his website and decides to contact him is an interesting one that no other respondent raised. This raises the idea that the client is to some extent self-selecting for working with Ben and that as the client may be looking for EFT, and Ben is able to offer it, the alliance may be more easily formed. The agreement, then, is about the modality of EFT, so the effect of EFT on the alliance in this case might be beneficial. Certainly, it would mean that the alliance is unlikely to form if the client does not wish to use EFT because that is what Ben is offering. Whether the EFT use increases or strengthens the alliance, however, is unclear.

Most of the respondents talked about introducing EFT if and when it felt appropriate to the therapy but how these clinical judgments were made, and on what basis, did not yield any clear themes. The overall theme that emerged was that it seems to be more of an intuitive process for therapists that perhaps they were not able to articulate. This suggests that there is some assessment by the therapist, either tacitly or explicitly, of whether EFT is an appropriate way to work with a particular client. This then further suggests that there is probably some assessment by the therapist, whether subconscious or conscious, about the strength or vulnerability of the therapeutic alliance along with other factors.

4.2.1 Frequency of EFT use in therapy following introduction

The therapists in this study unanimously focused on the client to determine the frequency of EFT use, as they had when considering whether to introduce it. In some cases, and with particular clients, that may have included never introducing EFT work. Olivia's and Ben's clients often approach them specifically for EFT, and so that might have been why they were the only therapists who said they used it in most of their sessions. Others thought about whether to use it every session or not, for the entire session or just a part of it or not at all. Every therapist said that they are guided by the client in the frequency of its use. Olivia said that she would probably use EFT in every session, but how much of the session was used by tapping would vary from client to client. Olivia also was the one therapist who advertised her therapy services under an EFT banner and had what she estimated as 95% of her clients specifically seeking EFT work. This would explain why she used it with more clients and in the majority of her sessions. She was also the one therapist who said that she almost always introduced it in the first session, and again this seems to relate to her billing of herself as an EFT therapist. What this seems to suggest is that clients are self-selecting before they

begin working with Olivia and so there may be some sense of alliance in the therapist choice to offer mainly EFT and the client choice of Olivia as therapist because of her orientation to using EFT.

In response to a question about the frequency of EFT use in Olivia's practice, she said that she would choose to use EFT sooner perhaps with anxious clients than with other client presentations. She is also implying that talking alone is not helpful to particularly anxious clients and says she believes it is important to interrupt the anxiety-driven talking of the client.

> 'So it's a bit like, the triggered clients who are just hyper they're in fight-or-flight already, they're running their stories, so with them, as I say I'll bring in EFT quite soon after the beginning of the session … … um … and that's true for ones who've got an issue that's just happened so say they've just had an accident or something like that they can be really talky as well, so talkative, … um try and bring in EFT pretty soon' (*Olivia, lines 311-316).*

Olivia's comment seems to imply that the 'talky' behaviour of clients when they are very anxious is interrupting a process that might be helpful to the client. That is, there is some sort of barrier that is put in place by this behaviour and its motivator, anxiety. Although she did not directly say this, it appears that a part of the relationship, and perhaps this is the alliance of which she is speaking, is blocked off from both therapist and client in these circumstances. She uses EFT to allow the alliance to form and take shape, which suggests its importance in developing a therapeutic alliance.

Therapists apart from Olivia varied their EFT use according to client need as they perceived it, and client request. They used their clinical judgment to decide when to bring it in and for how much of each session to use it for. This implies that what is, in the therapists' opinions, good for the client and therefore good for the therapeutic alliance takes precedence over the use of EFT.

4.2.2 Effect of EFT on therapeutic alliance

Unanimously, participants agreed that the therapeutic alliance was strengthened or deepened through the use of EFT. How they described the alliance deepening, and how they believed the introduction of EFT caused the deepening to occur varied. Michael attributed this deepening of the alliance to the efficacy of EFT; that it works, and that the client can experience it working, perhaps physically, perhaps psychologically helps the alliance. There is a sense that EFT is a tangible

change for the client that in turn enables the alliance to strengthen. The proof or tangibility appears to be lacking in talking therapy for Michael:

> ‘Well, usually I think it would enhance and deepen the therapeutic alliance … because the client has a sense of something real being done that helps them. Whereas in conventional psychotherapy very often much of the time the client may doubt whether it’s very effective and may keep coming out of hope or faith that it’ll eventually be helpful’ *(Michael, lines 206-211).*

Ava spoke about how EFT brings client and therapist closer together, as it removes the distance between them – both mentally and physically – which she says is part of the psychodynamic or psychoanalytical relationship.

> ‘Once you start working with … energy … with touch … or movement, the energetic field … of course it changes the relationship. It … I can only explain it in that there there’s … it brings you together in an energetic loop … which … is not the same as the psychoanalytical or psychodynamic distance … … it’s very different’ *(Ava, lines 421-427)*.

The addition of physical movement or touch seems to strengthen the bond, in Ava’s opinion. This seems to refer to an extra dimension of the alliance, perhaps the same sharing of molecules to which Victoria referred. Ava seems to be talking about a shared energy in an energetic loop that she does not experience in talking therapy. This may be a reference to tangibility in the application of the method wherein the client is touching their own body, rather than the tangibility of the results which seemed to be more Michael’s focus. There is a sense of alliance in this both when the therapist is touching the client to use EFT and an alliance of the client to themselves when they are tapping on their own bodies.

Isabelle talked about an added dimension to therapy with EFT and struggled to define it:

> ‘This isn’t a good way to describe it but I’ve often thought my CBT work was two-dimensional I feel CAT work is three-dimensional and somehow I feel EFT is four-dimensional, but I can’t really clarify that better than that but there’s these different dimensions that operate, come in’ *(Isabelle, lines 387-391)*.

The fourth dimension she refers to may be a physical one, but because she was finding it hard to put into words, it seems likely that had it been limited to a physical dimension she might have found the words to describe that. It may incorporate a physical element; however, it is more than that and this may be something to do with energy as Ava defines it.

John, too, discussed in a more oblique way the tangibility or visibility of EFT to the client that he believes enhances the therapeutic alliance. When the client can see that the therapist is tapping with them, it strengthens the alliance because the client is more aware that the therapist is alongside them:

> ‘In my experience … because therapy tends to at least appear to be a one-way process for clients on the surface, so having your therapist tap something along with you probably makes it more explicit that they’re really in there with you as opposed to being sat on the other side of the room’ (*John, lines 305-310).*

Emma said that the use of EFT created a greater intuition in herself as a therapist, which she believes helps the client and enhances the relationship. She is not talking about what the client experiences, but her belief that her intuition increases implies she has a greater understanding of the client and perhaps this is the element that allies them more closely:

> ‘Well, when we start using the EFT and when we use it quite a lot I do think it enhances the relationship … for me it makes me more intuitive. When I tap I’m more intuitive than when I don’t tap’ *(Emma, lines 283-286)*.

Emma went on to say that EFT has a ritualistic call and response nature that is similar to earlier tribal practices and that this in itself is healing. She was talking about the EFT protocol of the therapist leading the client through a round of EFT tapping in which the therapist repeats the client’s pre-determined words first whilst tapping, and the client then repeats the words whilst tapping on the same point on themselves. This is similar to the mirroring that is found in NLP practice and the mirroring that was identified by Stern (1985) in his thinking about the relationship between client and therapist or the relationship between an infant and their early caregivers.

Olivia cited both a history behind acupuncture and the physical changes that occur in clients when tapping as being elements that strengthen the therapeutic alliance. She seems to be implying that their difficulties, when linked to a physical symptom, make the clients more believable in their own eyes, so this suggests both a sense of tangibility and an alliance of the client to themselves.

> ‘Let’s say pain in their lungs you can say “that might be to do with grief” … and then that gives them more credence for their story so they can go “yes it is to do with grief” and “yes that reminds me of when my uncle died”’ *(Olivia, lines 393-396)*.

Abigail also talked about how the experience of change for the client that occurs through EFT increases client commitment to the therapy and in that way the client is more open to working within the therapy, and is thus more allied than they otherwise might be:

> 'Generally, I think with EFT what is maybe the nice thing is, I see that spark of hope in their eyes like "wow! This made a difference" … That makes for more commitment to therapy, commitment to the work' (Abigail, lines 386-388).

Participants struggled to put into words what changed in the therapeutic alliance with the introduction of EFT, but they were clear that something changes. Deborah's comment illustrates that well:

> 'It seems a little bit more direct. It allows the flow to happen, so you can pick up things that … It stops it from being purely cognitive … it's in something else as well … I can't be more clear than that really' (Deborah, lines 82-84).

It is, however, hard to know whether what she and others struggled to put into words was something about the therapeutic alliance itself, or about the change in it with the introduction of EFT.

An unexpected theme emerged during the analysis about the change in the therapeutic alliance when EFT work began. Three people talked about how EFT use might interrupt or damage the therapeutic alliance if it is introduced into a talking therapy after some time; that the client may wonder at what has happened to the therapist. If the EFT is then found to be effective, the client may query why it wasn't introduced earlier and this could damage the relationship and the alliance. Michael said:

> 'The only way that it sometimes could um be a bit *disruptive* initially is if the therapist has been working for some *time* with a client in a more conventional way and then introduces something like EFT then the client may wonder if the therapist has gone a bit weird or … "why is this suddenly being introduced?" Then if it's helpful the question becomes "why didn't we do this before?"' *(Michael, lines 211-216).*

Elizabeth, too, remarked about this same phenomenon and although she did not say it directly, the suggestion was that it might cause the client to wonder about the relationship and perhaps threaten any alliance that previously existed.

4.3 Practitioner likes and dislikes about EFT and how that may affect the therapeutic alliance

Practitioner likes and dislikes about EFT as a modality were related to its impact on the therapeutic alliance and questions for the interviews were set about this at the beginning of the interviews to encourage participants to begin to think about the topic generally. Another aim for asking questions about practitioner likes and dislikes was to determine whether there was anything about the modality that therapists believed specifically contributed to the therapeutic alliance or alternatively, specifically imperilled it. They were also set with the intention of establishing a rapport between interviewee and researcher and to allow the respondent to become comfortable within the interview. I believed, and to some extent the research has borne this out, that most of the *a priori* themes would emerge in the answers to this first group of queries. Participants overwhelmingly said that they liked how EFT brought them and their clients closer together in the work, which supports the assertion that EFT has a helpful effect on the alliance, or at least not a deleterious one.

> '…but EFT I do tap with the client so there is a kind-of togetherness in that…' *John, lines 191-192*

> 'because there've certainly been clients who it's been *extremely* helpful and it's actually helped us move on in our work *together…' Victoria, lines 313-315*

4.3.1 Qualities of the EFT modality and participants' use of EFT

The qualities of the modality that emerged from participants are its efficacy, its gentleness, its speed at bringing about change for the client, and that EFT is a tool that clients can take away from therapy and use for themselves. Many of these comments overlapped, and participants, for example, spoke about how EFT was both fast and gentle.

> 'you can go much faster, much smoother [when working with EFT]' (*Ben, line 325).*

Although the question was not asked, practitioners spoke about their own experiences of discovering EFT and the powerful effects it had on them which had prompted them to train in EFT use and bring it to their clients. Isabelle spoke of the accidental nature of her discovery of EFT: that she had happened to be in

a place where it was shown to her and its effects were powerful enough to motivate her to learn more.

> ‘By chance I went to a conference and one of the speakers was delayed in traffic so somebody out of the audience stood up to fill in the time … and it was just one of those really lucky things and he was “I don’t know if you’re interested but this is what I use in our department” and it was the first time I’d seen or heard about EFT … and as I was doing it I thought “this is what I’ve been looking for” because I could feel the physiological impact on myself just trying it’ (*Isabelle, lines 49-53).*

This comment raises the issue of adding something to talking therapy and the client-therapist relationship. Talking therapy alone seemed to Isabelle insufficient; she had been looking for something else but did not know what. Although none of the participants made this link, it does appear that it might be a tacit understanding about why some therapists choose to use EFT in their work and that it could potentially have a significant effect on the therapeutic alliance. It may be that the therapeutic alliance is strengthened because of adding something Isabelle was looking for.

Victoria made a comment about how powerful EFT had been for her while training to use it:

> ‘I couldn’t *not* use it after coming across it and realising what happened to me in the training. It was so profound and I’ve been in therapy for a lot of years leading up to working in this field and I touched stuff in that one weekend that I hadn’t touched in three-and-a-half years in weekly therapy so … that was a pretty big er … impression [laughter]’ (*Victoria, lines 465-470).*

Both Sophie and Liam talked about how it helps them in their work with clients. Sophie spoke about how it helps her tolerate perhaps more difficult clients and Liam spoke about clearing the space in his room to allow for the next client.

> ‘I certainly use that for my own sort-of ‘okay I’m not sure how I’m going to sit for an hour with this person when they’re like this’ and so it’s partly for myself and partly for them and I’ve found that to be really really useful’ (*Sophie, lines 200-203).*

> ‘I was always doing that but it, it’s intensifying my … awareness of the space and residues from one client. I might have three or four clients at once sometimes and and the need to sort-of protect and develop the energetic space and it’s my room as well which I’ve always had an awareness but I feel I’m being given more … tools … to, to prepare that better’ (*Liam, lines 589-694).*

Although not explored further, Victoria's, Sophie's and Liam's comments discuss the therapist's role generally which obviously has a profound impact on the alliance. All three are aware that EFT helps them, so they will be more able and freer to contribute to their work within the relationship, and thus increase their chances of enabling a good therapeutic alliance. Victoria's reference to how EFT helped her to process things about herself that had been difficult to access previously suggests not only that EFT has been powerful for her, but also that she might gain greater insight into her work through having used EFT because of her greater self-knowledge. Liam and Sophie spoke more specifically about how they continue to use EFT on a regular basis to clear space for a client and allow whatever needs to happen in therapy to occur. This suggests that the therapist can better remain available to each of her clients and the therapist can be better able to foster the development and growth of the therapeutic alliance.

Both Victoria and Isabelle spoke about the power of EFT as they were learning it, neither of them mentioned the person with whom they were working, who would have been in a therapist-like role in a training session. The focus of their comments was on the power they felt in use of the method, not on what it might have done to the relationship or alliance they experienced with whomever they were working at the time.

They may also have been referring to the physiological changes that have been noted when EFT is used. Both Kalla et al (2017) and Bach et al (2019) have researched the efficacy of EFT when used with patients with chronic illnesses and claim that it addresses both emotional and physical difficulties associated with chronic illness.

In describing the efficacy and speed of EFT, participants often struggled to put into words what they were trying to convey. They said that they were aware that EFT was working, indeed that it was working in a way that talking therapy may not, and they seemed to both feel a need, but simultaneously struggled at times, to explain what it might be doing that talking therapy does not do.

> 'In the words of the old beer commercial, it reaches the parts other beers doesn't reach, it seems to be able to go to things very, very quickly and speedily' *(Ben, lines 49-51).*
>
> 'It greatly enhances the process … um … makes it much … um … quicker and easier and deeper than er talking-therapy alone … the difference is um the therapy becomes um much more effective er

> when using EFT or other energy methods … that's the main difference' (*Michael, lines 59-61).*

The impact of the pressure to help the client in therapy would have an impact on the therapeutic alliance. At its most basic, the therapist is aware that the client wants something that is the raison d'etre of the work, but in a more peripheral sense. It has a strong influence on whether the goal of the therapy is achieved and indeed may be a goal in itself. If the therapist is unable to assist with relief, containment or resolution of the client difficulty there may be a threat to the therapeutic alliance.

The gentleness of EFT use was a theme because it is a feature that was an important consideration, particularly when working with traumatised clients. Deborah spoke of how it was a gentler version of EMDR saying:

> 'I use EMDR as well so … I'll quite often use it [EFT] as a run-up to EMDR [be]cause it's a gentler version so … so that would be used with PTSD or … past … things in the past' *(Deborah, lines 49-51).*

Her comment suggests she might find EMDR more effective for PTSD, but that EFT can pave the road to EMDR use which she thinks of as more difficult for the client. It seems important to Deborah that the client feels both appropriately challenged (not overwhelmed) and safe. Therapists noted frequently when talking about the therapeutic alliance, and particularly their role in establishing it, of the need to develop a sense of safety for the client.

There were attempts to explain how or why EFT works in some respondents' experience. They said that EFT has an ability to bypass the conscious mind. Practitioners talked about EFT getting to the root of what the client is presenting, particularly if it seems to be at odds with what they are saying. Liam was very clear about the presence of energy, and perhaps some un-nameable quality in an EFT therapy that might be unnoticed in a talking therapy:

> 'But I think by focusing on using particular strategies enables some people to begin a conversation where if you're limiting them to just er talking therapy um … you-know it [EFT] opens doors and becomes part of a broader inclusive thing' (*Liam, lines 47-50).*

Olivia, too, talked about an added dimension to the therapy when EFT is used:

> 'It's a bit like you're playing a game which changes the dynamic within the therapeutic context so instead of sitting and doing 'this is the story and this is my interpretation' and that kind of tennis match

> backwards and forwards and you do this thing [EFT]' (*Olivia, lines 79-82).*

When looked at through the lens of EFT's impact on therapeutic alliance. Olivia talks about how it 'changes the dynamic within the therapeutic context' which indicates that it likely changes something in the alliance, or in a wider sense, something in the relationship. Liam also suggests that something comes into therapy that feels 'broader, inclusive' which would also be about the relationship or the alliance. It could be a suggestion of a quality of acceptance of all the parts of a client. This acceptance comes both from the therapist and from the client and allows for full presence therefore in the relationship and perhaps a greater alliance of both members of the dyad.

Another strong theme that emerged was that practitioners believe that EFT is something that clients can take away and use to regulate themselves outside therapy. They saw this as something that was empowering for the client, and this empowerment was seen as helpful to the client and to the relationship.

> 'I've had a couple of instances where clients have had … um … where clients feel more … independent er more capable … and they've gone away and they've used it themselves once they feel more confident so I think that's the thing is about helping them feel confident … so I think that changes it for the client suddenly they realise they're in control a lot more' (*Charlotte, lines 7-12).*

Charlotte's comment alludes to a sense of equality in the therapeutic relationship. Therapy relationships are never wholly equal (Mcelvaney & Timulak, 2013; Holmes, 2012), but EFT seems to provide a way for clients and therapists to make the relationship more equal than it might be if it were made up of talking alone. The level of control that the client realises, in Charlotte's estimation, might also contribute to a sense of safety within the relationship for the client and indeed for the therapist, which in turn has a beneficial outcome for both the therapeutic relationship and the alliance (Mcelvaney & Timulak, 2013; Levitt, Butler, & Hill, 2006; Holmes, 2012).

Ben also said that he liked that clients could take EFT away and use it themselves, and he saw this as making the client and therapist more equal in the therapy.

> 'One of its big selling points is it's something I can teach my clients … EFT is something you can take home and use for yourself so I … I find it um very democratic in that regard' (*Ben, lines 65-67).*

Overall, participants seemed to be of the view that EFT is most suited to working with anxiety-based difficulties such as phobias, general anxiety and stress, and were largely in agreement that trauma also can be treated effectively by EFT use.

> 'Phobias … or when it's quite specific like a particular phobia that we've … talked about … and it still hasn't … changed' (*Ava, lines 436-438).*

Ava's answer particularly suggests that she would try talking therapy first, but when it is ineffective against phobias, she might then use EFT. This is not only evidence for her belief about its suitability when working with phobias, but also a reflection of her unexpressed belief in the power of EFT to work when talking therapy has not. However, this does raise queries about why she might not use EFT initially, trying talking therapy first. It may feel to her that a therapeutic alliance cannot be established through EFT use alone, or this may be a reflection of her training as a psychotherapist first, EFT practitioner second.

Olivia talked frequently about using EFT to treat anxiety and why EFT particularly works. Here she is talking about the protocols of EFT (that while the client is tapping on themselves, the therapist is tapping on themselves, too) and why in her opinion it produces the effects of calming for anxious clients:

> 'And there's another thing as well – it's the mirroring of doing tapping with each other … that immediately like de-escalates any stress levels so you're doing something with them, so like whatever you're talking about or not talking about, you're mirroring their behaviour and I think that's really comforting to very anxious clients' (*Olivia, lines 103-107).*

She also raises the idea of mirroring, which first occurred in Stern's (1985) thinking about the therapeutic alliance. Her comment suggests that she sees the mirroring of behaviour as important and that she may be talking about a greater empathic attunement, something Clarkson (2001) saw as a crucial element in the therapeutic alliance. She talks particularly about the comfort it provides for anxious clients and this suggests that anxiety may be interfering with therapeutic work or the therapeutic alliance. What it also implies by omission is that the EFT, though it is the tool by which the client achieves comfort, it is the comfort element for the client that is important within the relationship, not the EFT.

Ben commented about anxiety itself – that often there is something behind it. This raises the question of how these therapists conceptualise anxiety: whether anxiety is a difficulty in its own right, or whether it is a response to something else.

He uses EFT to calm and soothe a client so that work on whatever is driving the anxiety can begin:

> ‘Anxiety … usually the symptoms they have something behind them so I would say anxiety would be a fairly good one but then in about half of the cases whatever it is that’s behind the anxiety isn’t addressed just by the simple tapping so that would kind-of be a fleeting … relief … and sometimes I’ll do kind-of you-know soothe somebody if somebody’s very agitated or … um distressed in a session might just do tapping to kind-of calm the system down and I might show them how to do tapping but I’m always interested in what’s provoking the disturbance in the system in the first place’ (*Ben, lines 278-293).*

Ben’s comments seem to echo Liam’s thoughts about using EFT to work with the most immediately apparent aspects of a client’s presentation on arrival, which seems to clear the way for working on the issues at the core of the difficulty. This suggests that building the therapeutic alliance requires the establishment of some level of calm so that the client can engage in the work. These comments from Ben, Liam and Olivia suggest that the work of the therapy is something other than either the EFT or the talking. What is unclear is whether that is the alliance itself specifically, or the relationship more generally.

Some practitioners in this group did say they would use EFT to treat depression, though they expressed a note of caution about that. Abigail suggested how she would approach that:

> ‘Ah, depression actually um … with EFT we’re finding that as people are able to address some of the issues that have maybe brought them to depression as they’re able to also pick up tools … and sometimes moving into that better place where they can start to pick up the tools … to move into a space where they feel like they’re in charge of their life again’ (*Abigail, lines 233-235).*

Abigail’s comment does suggest that there may be other things that people coping with depression may find helpful and that EFT can assist them to make use of these things. One of those things may be the therapeutic alliance. It appears from Abigail’s comment that the EFT alone may not be playing a large role, either in treating depression or in the alliance. EFT may be the tool that allows other things to happen, including the alliance which then enables the client to help themselves.

All but three of the participants said that they used EFT to work with traumatised clients. This could in part be because the three who did not talk about EFT use

with trauma may not work with traumatised clients. Equally, it could have been because they did not use EFT for this kind of work.

In some cases, participants compared EFT to EMDR. In other cases, EFT was used by the practitioner as a gentler lead-in to working with EMDR, which suggests that EMDR is more difficult for clients and that EFT may allow some way to establish trust in the relationship for the client, a necessary component of the therapeutic alliance.

Emma said that EFT was more effective and easier to use than EMDR for trauma work:

> 'We can work with certain things certainly things like specific phobias and simple trauma and complicated trauma [EFT] does seem to be surprisingly … er … more kind-of effective and more easy to use and more practical an approach than others including EMDR' (*Emma, lines 139-142).*

Victoria spoke about how it is dependent on client presentation, and that a number of therapeutic approaches might be helpful, depending on the client:

> 'I work as a supervisor for [a therapeutic organisation] and one of the other offices had somebody with such severe PTSD that their worker was just completely out of their depth and they'd heard through the … networks that I'd worked with Rewind Technique, so they referred her [the client] privately to me to have some intense work just to help this PTSD. And I did Rewind Technique and all that on it … and yet some of the trauma was still there. I started working with her with EFT and it just cleared. It was incredible. So, you-know it's horses for courses. For some people using a Rewind or EMDR would just have really cleared that trauma but with this particular client it was EFT and she just found it incredibly effective' (*Victoria, lines 263-271).*

What all these comments share is some thinking about how to reach the client, and what situation or state the client and therapist have to be in to be able to work together and therefore to form an alliance. It also suggests that EFT, when used in this way, may help establish an alliance.

4.3.2 What participants perceived their clients like about the use of EFT in therapy

In the same way that asking therapists about their likes and dislikes of EFT was one approach to drawing out themes about the impact of EFT on therapeutic alliance, asking therapists what they believed their clients liked or disliked about the method was important for the same reason. Although it is impossible for any

therapist to know exactly what is going on in the mind of their client, their impressions were based on what clients may have said or changes they witnessed in the therapy room. Participants also spoke of their own experiences, particularly from training to use EFT during which they would have experienced as a client or recipient. These impressions provide a foundation for further exploration.

It was notable in the responses that participants were less clear than they were when talking about their own opinions and experiences or likes and dislikes about EFT. This was understandable because even though they may be able to witness client change and to converse with clients about their changes, accurately capturing a client's internal experience would be difficult.

4.3.2.1 The speed with which EFT seems to work

Many of the participants spoke about how their clients liked that EFT seemed to work, and to work quickly. There were several anecdotes about how a particular client had remarked that things had changed and they had felt better. There was a double meaning to this as well, that sometimes clients liked it when it worked, but may have been doubtful when EFT was first suggested. Clients had not arrived in therapy expecting it to work, or even perhaps expecting to be offered EFT and perhaps had been hesitant at first. Deborah's comment suggests that EFT must be tried to be appreciated and that client appreciation of the efficacy of EFT occurs only after the method has been used, presumably despite what the therapist may say when suggesting it:

> 'It appeals to them when they find it working because it's odd, it's unusual and they don't expect it to work' (*Deborah, lines 49-50).*

Elizabeth talked about this element of it, too, and said further that as she could give a client written instruction to take away and use EFT at home this is an additional effective element of EFT, unlike with EMDR or talking therapy:

> 'it appeals to those for whom it's helpful because it *is* helpful [laughter] and because they can replicate the methodology very easily. It's also very easy to give them written instructions about it that are easy to process, easy to digest' (*Elizabeth, lines 44-47).*

Ava also said that clients like the effectiveness of EFT and suggested that this has to do with the immediate effects, rather than perhaps shifts that begin in therapy and continue later, when the client is away, as might happen in talking therapy.

> ‘That it’s simple, that it seems to in the moment shift’ (*Ava, line 128).*

Abigail talked about her clients liking the speed of EFT. Again, it was sometimes difficult to distinguish whether what therapists believed that their clients thought or experienced about the speed of EFT was their own opinion or that of their clients, but sometimes the therapist is reporting what a client has said, so the possibility of this being a projection is lessened:

> ‘One client … she says she’s been in therapy since she was six years old and she’s never made this kind of progress. So she stumbled on the group five months ago and has been coming consistently and says for the first time in her life she feels like she’s making progress she wishes she’d made years and years ago’ (*Abigail, lines 58-63).*

Abigail’s comment echoes what Victoria said she experienced when training to use EFT. The feeling that something is working in the therapy might be likely to establish or strengthen an existing alliance

For the therapists who offered opinions about what they believed their clients might like about EFT, that it can be used by the client on their own outside of sessions, emerged as a theme. Those participants who mentioned this said it offered clients a way to manage distress between sessions and that this element then empowered clients; something clients were presumably able to notice and feel supported by. Often one of the aims of therapy is to empower clients and this particularly seemed to be indicated by the participants in this group. Client empowerment often leads to enhancement of a therapeutic alliance and thus to greater outcomes for the therapy (Simpson, et al., 2005).

> ‘it’s simple and it's also a method that the client can take away with them’, *Elizabeth, lines 39-40*

> ‘I also give them really good sheets that they can take away and practise. I also give them resources to look up online that they can watch a demonstration being done and tap along to it kind-of borrowing the benefits kind-of-thing. Um I think that they find it very um *reassuring* that there's something that they've got from me which has got credibility.’, *Victoria, lines 76-80*

Four participants talked about the gentleness of EFT from what their clients had expressed about liking the method. These comments were brief, and often in the context of what the therapist themself thought about the gentleness of EFT, so in this theme, like others, it was difficult to distinguish whether this was the therapist's view projected onto the client or the client view. Liam said:

> '…and it's simple and it allows that sort of access without it being threatening' (*Liam, lines 70-71).*

This may be a reflection of Liam's own liking of the gentleness of EFT as much as it is a representation of what he believes his clients like. What is interesting is Liam's statement that EFT allows access for the therapist to the client or for the client to the therapist, which seems to be an indirect comment about the alliance. On the basis that an alliance can be formed when client and therapist have access to each other, access is then a necessary element of the alliance, which Liam believes EFT enhances.

Both Abigail and Victoria talked about both the speed with which EFT works and also the way it can reach issues which seem to be obscured from the conscious mind. People who have been in therapy for a number of years are presumably engaged in the process of trying to discover things about themselves, so their willingness to look at these issues, at least their conscious willingness and motivation, is apparent. But they report that even though they have been in therapy for a substantial period, they were not able to reach certain elements of their experience, or their understanding of themselves and use of EFT made it possible to access that experience. This suggests that there is an access that is needed by both client and therapist to the client's experience even if it is subconscious. There then may be an alliance of client with herself that EFT allows.

For those clients for whom experience had previously been difficult to reach, it could feel threatening or overwhelming and could threaten the alliance. However, the clients who reported to this group of clinicians that they were making progress in areas they had been working on in therapy for years may have felt the alliance strengthened.

4.3.3 Participants' beliefs about the limits of EFT

The theme that emerged most prominently in exploring what practitioners do not like about EFT was more focused on clients and their reaction to the introduction

of the idea of EFT use in therapy. When clients were resistant, practitioners generally believed that EFT work would not be suitable, which is very much in line with any therapy modality. It is also interesting because it reinforces the idea that perhaps practitioners believe it can be used on any difficulty, but the client must be willing to take it up. This is an interesting comment on therapeutic alliance – that where it may be threatened by the use of EFT, it was important not to try it. More importantly, it notes that EFT can threaten an alliance.

Because EFT is currently outside the mainstream, it may also be an indication of client perception. Many clients arrive in therapy with very little idea of what is going to happen, but because of depictions of therapy in the popular media, they often imagine that it is about having a verbal exchange with the therapist. They have a vague idea that talking is on the agenda, but they do not necessarily know what they are going to be talking about and what the therapist may say in response.

Michael highlighted a specific group of clients who would likely be resistant to EFT use; however, this group might also be resistant to change in any therapeutic context:

> ‘Um, yes, occasionally some clients don’t like it if they are particularly invested in maintaining their problem for whatever reason’ (*Michael, lines 97-99).*

A client who is invested in maintaining their problem would include people with Cluster B personality disorders (American Psychiatric Association, 2013), such as borderline personality disorder, for example. This group of clients might be resistant to change through any therapeutic means, and therefore perhaps unwilling to take up EFT. However, it is also notable that people with cluster B personality disorders frequently challenge and test the therapeutic alliance when any therapeutic intervention is used and it is not a reflection on the intervention, but on the client and the therapeutic relationship of which the therapeutic alliance is a part.

There are numerous other reasons why a client might be resistant to EFT: resistant to the physical element of therapy; lack of clarity around how, why or whether EFT may work; embarrassment at the use of the method; or worry about what it might bring up (Craig, 2011). All of these could threaten the therapeutic alliance. Isabelle said that she might not offer it, at least initially, to men who were

very accustomed to coping on their own and managing their own problems. She suggests that this group of clients would likely be more resistant to EFT use because of this element of their presentation.

> 'I used to feel reluctant to offer it, maybe more to men actually … your sort-of typical very manly north-eastern man, what are they going to make of this and then I don't know if it's my confidence growing in it but then I started to think "d'you know, I don't want to deprive anybody of the chance to learn this" so I mention it and I think then they have a choice' (*Isabelle, lines 162-168).*

Isabelle suggests that it is partly the client and their presentation that would bring about hesitancy around EFT use. This is a remark not only about a type of client but also about the therapist herself. Implicitly, it speaks about the therapeutic alliance and the therapist's role in it. By offering a choice to the client, the therapist is offering them what she knows and is able to do for the client. The client is left with the choice of whether to pursue EFT, which leaves them far more in control of the tasks of therapy (Bordin, 1979).

Grief was a presentation that two of the practitioners said they would not use EFT to work with. They clarified their remarks by saying that if it was older grief, from bereavement in the more distant past, they might use it, but they seemed to regard an older bereavement in terms of trauma because it was still affecting a client after a significant period, and therefore not purely a bereavement. Thus, what they would be working with would be trauma, not bereavement.

> '[A] woman who has had a bereavement … um … her husband died very suddenly of a heart aneurysm aged only 58 … the whole thing, it was so shocking for her and she had complex bereavement also because she'd not really worked through the sudden death of her mother 40 years before almost so we worked on that with the tapping um but then with the present bereavement … um, it felt important that she … feel the … feel the feelings somehow as long … until it came to the point where she just said I don't want to cry any more you-know I've had enough of this and that's where I sort-of sometimes question whether I should use it or not' (*Sophie, lines 296-304).*

Victoria echoed these thoughts, and went on to say that grief, although difficult and unwanted by the client, is a necessary and natural process so trying to shift that with EFT would be inappropriate:

> 'Well, I would be nervous about using it with natural processes like grief. I think if somebody's got stuck in their grief … then it can be helpful to help move them on to the next phase but I would be very

> wary about a practitioner presupposing with the client that they're going to feel better after using EFT because actually I think grief is a very healthy natural process' (*Victoria, lines 280-285).*

With regard to the therapeutic alliance, it seems that both Sophie and Victoria are saying that non-traumatic grief demands something from the therapist that is not well served with EFT use. What this is they did not say, but their comments indicate that perhaps a sense of containment comes from talking through the grief for the client and that EFT does not provide this containment. Using EFT in these circumstances would likely threaten or destroy a therapeutic alliance.

There was one theme that emerged from two of the interviews about not using EFT with people who had difficulties around their bodies, either psychological or physical. John said he had had a client who had been the recipient of many physical and sexual assaults in her past and because of this, he felt uncomfortable using EFT with her due to it being a physical intervention. He also believed that he, as a man, treating a woman who has been physically or sexually abused using EFT was not appropriate.

> 'It felt like it wouldn't have been appropriate I can't really put a finger … put a finger on why but there was something about the fact that I was a man … she had had some kind-of quite serious transgressions in the past it just didn't feel' (*Tom, lines 251-254).*

There might equally have been difficulty in a man acting as a talking-only therapist for a woman who has been previously abused by men, so this could be suggesting that there is something intrusive in the physical element of EFT that may have been causing John particular discomfort around this client. It is difficult to know exactly what might have happened, but John was worried this might have affected the therapeutic alliance.

Olivia talked about working with a person who was recovering from cancer treatment and in that instance, EFT seemed inappropriate.

> *'She* hadn't come to *me*, the hospice had *sent* her to me and she wasn't clear on what the EFT *was* … and to play that game of … er … of EFT to do that *thing* with her was wrong?' (*Olivia, lines 286-288).*

This suggests that there was some element of the EFT that would have been difficult for clients that have significant levels of prior physical suffering or intervention and suggests EFT might have been overwhelming or a physical aspect of the protocols may have been causing the therapist to worry. Particularly

for this study, the physical element of EFT may have been seen as a block to formation of the therapeutic alliance, or an interruption to it. Particularly with Olivia's client, it seems that there might have been something else going on, too, that would have affected the therapeutic alliance whatever treatment modality was used. That the client had not chosen therapy, much less EFT, would be a block to the formation of a therapeutic alliance.

There were two themes that emerged in thinking about what clients do not like about EFT. There were also accounts of what the therapist witnessed in clients that may be able to help shed light on what the client's thinking was.

The first theme that emerged was that clients were sometimes embarrassed to use the EFT protocols. Some therapists reported that the sequence of tapping on hands and points on the head was embarrassing for the client, or the act of repeating the phrases that, although established in the client's own words, still left the client feeling embarrassed.

> 'The one thing I think that people do say to me … um … is 'I'm glad we're doing this in your room because no-one is watching us do this' (*Liam, lines 145-147).*

The tapping itself seems to produce a feeling of embarrassment and may be added to by the repetition of the reminder phrases. It was difficult to know precisely what clients felt was embarrassing. During formation or maintenance of the working alliance, it is most likely that a client who feels embarrassed, ashamed or threatened by the protocols of EFT will find it hard to engage fully in the alliance, if at all. This is likely to be a threat to any alliance, therefore.

The second theme that emerged was that clients simply did not like EFT. Religious reasons were named by one participant, another said that some clients feel uncomfortable saying the set-up phrase 'even though I have this [difficulty], I deeply love and accept myself' because they do not, at least at that moment, love themselves. This, too, could feel humiliating or embarrassing for a client which would prevent the therapeutic alliance forming or developing and this is directly linked to the modality.

Two participants talked about clients who have a need for control being unwilling to use EFT, which suggests that it feels to the client as though the EFT may bypass their conscious attempts to control what is happening in therapy. In an indirect way, this seems to be more evidence for the power or efficacy of EFT,

because the ability to bypass conscious control for clients was seen as an advantage by many of the participants. However, it may also represent a serious threat to the alliance. This is also linked to another concern that therapists believed reluctant clients may have, that EFT reaches their bodies rather than having attention solely focused on the cognitive aspects of therapy. This may be perceived by the client as a threat, which in turn would threaten the therapeutic alliance.

While talking about the advantages of clients being able to use EFT outside therapy sessions, practitioners noted that clients can be overwhelmed. There were therapist experiences in which clients initially took to the method very enthusiastically in the therapy room, went home and continued to use it and stumbled into something on their own that felt overwhelming. After these experiences, clients were much less likely to want to use it.

> 'And I think one of the difficult components is that it actually sometimes feels too powerful for people. It's scary when the emotions come up that have been stored somewhere' (*Emma, lines 225-227).*

All the therapists who reported they had had clients who were reluctant to use EFT and some of those who did not, spoke about the need to introduce EFT gently. This seems to be evidence that the method is powerful and effective and therefore needs to be approached with some caution. This is important with respect to the therapeutic alliance as the introduction of something that the client feels is intrusive or overwhelming is unlikely to assist alliance. It may also suggest that clients are often reluctant to use the method for some reason, and it may be as simple as it being a strange method that is very different to what clients often expect when they come into therapy. What is important with regard to client hesitancy or refusal to use EFT is that it may be having an unquantified and negative impact on the formation or maintenance of the therapeutic alliance.

4.3.4 The physical element of EFT

Like EMDR, EFT involves a physical element in the protocols. It was this element perhaps more than others, that prompted my speculations about any change within the therapeutic alliance when it was introduced into the therapy from which the research question arose.

John talked about the body in therapy – both the therapist's body and the client's body – and about guiding the client toward including a physical felt sense in their experience within the therapy while using EFT. This comment is interesting because it indicates a sense that the physicality of EFT allows it to be more explicit – and by this John seems to mean tangible – which moves it away from being tacit.

> '…and it's explicit, you're both there as bodies … I've always told the client "as we do this try to focus on the feeling or the sensation or whatever's coming up when any movement in your body or any images"' (*John, lines 181-184).*

Olivia talked about how client and therapist track client emotions through the client's body while using EFT. She regards the body as another source of information for the therapy, rather than relying only on the client's verbal account in which they may or may not include a verbal account of their physical experience.

> 'That's just such a beautiful thing their body is telling us what's going on for them' (*Olivia, lines 433-434).*

Isabelle, also talked about her experiences of EFT not only providing a pathway into healing trauma, but also the union of mind and body and how healing the trauma helped heal physical symptoms and reduced or stopped hospital admissions for one of her patients.

> '… particularly one person had been in therapy on and off since she was a young adult really. She's got a lot of physical health problems and a lot of psychological difficulties as a result of significant childhood trauma … well this person had had a lot of … hospital admissions um … so her medical team funded her for the psychology service to keep providing input because … it massively reduced well, sort-of stopped really, hospital admissions' (*Isabelle, lines 312-322).*

Charlotte mentioned how EFT use can, at least initially, increase a physical reaction for her client, in this case, marked physical pain. This suggests that perhaps the EFT is reaching elements of an earlier experience that the client had been avoiding or was unable to contemplate without being overwhelmed.

> 'so, she was very hard on her[self] she actually experienced deep pain, excruciating pain, while she was doing the tapping … I mean absolute agony with it' (*Charlotte, lines 322-326).*

Victoria talked about a phenomenon of EFT that therapists are often aware is occurring, which is that sometimes the client appears (to the therapist) different

after a round of EFT but seems unaware of that change, at least in the therapy room. This is a very difficult thing to explain; if change has happened, how do we as therapists and as clients know that it has? This was not a question that was posed to participants, but it is something that occasionally happens in my experience as a psychotherapist and EFT practitioner:

> 'I love the way it actually allows people to get in touch with their body even if they are very dissociated and even if perhaps they are right off the scale and not particularly able to feel things the EFT still has an a positive effect even if they're not noticing that' (*Victoria, lines 113-116).*

One thing that seemed important to the therapists in this study was the joining of body and mind in thinking about the use of EFT, and how EFT allows that to happen in the therapy. This may have been what attracted these therapists to the use of EFT, it may be what attracts some clients to the use of EFT and it may also allow for the incorporation of an added dimension to psychotherapeutic approaches generally and therefore create a more holistic way of working with clients. It seems to have some impact on therapeutic alliance. There is a sense that in the joining up of physical and mental elements of the client, a deeper alliance is forged within the client to a greater number of aspects of their experience. It may also allow for the therapeutic alliance to form more fully than with talking alone. If the client experiences physical change with EFT use and more of their personal experience becomes available to work with during the therapy, it suggests that there is more experience on which therapist and client can come into alliance.

Olivia talked about how she experiences what the client is experiencing in EFT work. She referred to it as mirroring and although this is a comment about the physical nature of EFT, it is interesting because she talks about how when she is working with a client her body spontaneously mirrors their physical experience. This suggests that therapist and client are more aligned and would thus be having potentially a great impact on therapeutic alliance.

> 'cause the shifts that go for the client, for me quite often I actually I mirror with them so sometimes I feel what they're feeling … so I'll say "something happening?" (laughter) because my tummy'll be hurting or my shoulder'll be hurting and they'll go "oooh yeah" [laughter] and I'll go "yeah" [laughter] and we'll tap through … yeah, it's just a beautiful thing the symmetry is different yeah it's more symmetrical. It feels more asymmetric, it shouldn't be but it feels

> more asymmetric when it's just straightforward counselling' (*Olivia, lines 448-456).*

Although she wasn't using the words 'therapeutic alliance', she is describing a greater similarity in feeling between herself and a client. Discussions of therapeutic alliance often involve mention of a mirroring of experience between the client and therapist; the element of recognition of, and sympathy toward, the client's experience are a crucial part of the alliance. Equally, this might not be seen as evidence of alliance, but perhaps of collusion. The therapeutic role within the alliance is not as much to exactly experience client experience, but more to perhaps experience it whilst being aware of the therapist's own separateness and boundaries.

The spiritual beliefs of practitioners and how they developed through EFT work particularly, and a spiritual quality to the change that EFT brings for clients was something discussed by four respondents.

Ava spoke about dark entities that came up within a client during their work together and how it made the work impossible for a time. She referred this client to another practitioner who uses EFT and other energy therapies ('the magician') to clear the dark entity so that she and the client could continue together:

> 'It wasn't because she was over-analytical, it was because she was possessed by a family trauma entity and I could see it … I thought she needed, it needed, to be cleared and although I can do that work and that's nothing to do with EFT that was psychic energy that was very very dark and needed to be … worked with and I I thought I'd send her to a magician' (*Ava, lines 239-245*).

This is an interesting comment because Ava suggests that possibly there are other-worldly entities within all of us. The 'magician' implies that magic was needed to deal with a more sinister entity. This could also be a part of Ava's own magical thinking around being a therapist (Zusne & Jones, 1989). This may also be a reflection of how EFT practitioners see themselves. The speed with which EFT has an effect is also surprising to many, both clients and therapists, which may lend it a magical quality, particularly when considering it against a background of conventional talking therapy. The effect of the magical elements of EFT could be having a positive or a negative effect on the alliance. Ava's comment suggests that there was something inside the client, but that was not a part of that client that was preventing their further work together, which was reminiscent of the psychoanalytical concept of resistance. However, when

resistance appears in therapeutic work, it is seen as part of the client's internal process though it has an impact on the relationship. Ava seems to conceptualise it as something outside the client, not something that the client is bringing from within themselves to the therapy that is making the work difficult. Ava sees this entity as a concrete existence and resistance is often described as an abstract concept. She does seem to be indicating that the alliance may be threatened by this because its effect is that they cannot work together until the element is no longer there.

Charlotte spoke about how witnessing a client's rapid change with EFT use has a spiritual quality to it, though she found this hard to put into words. She believed it had something to do with the client's vulnerability and affected both client and therapist simultaneously. She went on to say that if a client has spiritual beliefs, they are more likely to consider EFT:

> 'One of my questions in my consultation's about spirituality ... so, it's not just about religion it's about anything that takes you above the normal self and that will give me clues into how normally people would react to EFT … I find that a lot of people that are more spiritual are quite open to it' (*Charlotte, lines 247-254*).

This is interesting in light of the alliance. A shared belief in something spiritual might promote greater alliance initially but could also lead to collusion, and Charlotte seems to be looking for a way to build the alliance from the outset.

4.3.5 Problems with EFT

Every participant in this research did not use only EFT in their work. In fact, that was one of the criteria for inclusion in the study – that participants had to have both a therapy degree or qualification *and* have an EFT qualification. The criteria for inclusion were set because I was interested in the effect of EFT on the therapeutic alliance and I was uncertain whether people who only use EFT would be aware of what therapeutic alliance is as a concept without at least a basic counselling training.

Safety for the client was a strong theme that developed around the therapeutic alliance in this study. It emerged that several of the respondents believed it might be difficult to provide safety if the EFT practitioner does not have training in psychotherapy.

> 'I think it's one of the dilemmas if you're a therapist that's already got a mainstream training and you've got other tools as well … you-

> know if I was just trained in EFT I would feel obliged to use it with every client every session but it isn't like that' (*Victoria, lines 244-246).*

This suggests that something is missing from the use of EFT alone. This may be the ability to form a therapeutic alliance, it may be an awareness of whether it exists. One of the difficulties for people who are trained only in EFT may be that they would attempt to use it when it was not the best way of working with a particular client. This, in turn, might very well adversely affect the alliance. Clinicians who use or know only EFT would be obliged to use this approach and other elements of therapy and client experience might be missed.

Charlotte also spoke about this, pointing out the dangers of being trained only in EFT, and citing that there is no requirement for a counselling training to train to use EFT:

> 'Because anybody can go on a three-day EFT course … and you can open up Pandora's Box and when I did my first training in it I was like "Ooh I can cure everybody … I can cure the world" and I did open up Pandora's box and I didn't know how to shut it … and I think that's the important thing about any course. Without understanding that if you're going to go there you're going to go there quickly sometimes and it's about bringing the client back to safety' (*Charlotte, lines 107-115*).

It is also possible that were such an EFT practitioner and a client to find themselves in this situation, the client might not wish to proceed with EFT if it was the way they accessed feelings of pain and lack of safety. It seems to oppose the basic ethical consideration of doing no harm to clients and seems highly likely that it might not allow the alliance to form or might threaten an existing therapeutic alliance.

Although the beliefs of almost all the practitioners in this research was that EFT is not a standalone therapy, that does not make it a problem with EFT *per se*. However, it was the thinking about what might happen if someone with no therapeutic training offers EFT to clients that seemed problematic for these participants. Although not mentioned specifically in thinking about EFT as a standalone therapy, the possible subsequent deleterious effects on the therapeutic alliance are present. There is something that happens in conventional therapies that seems to these participants to be under threat when EFT is the sole treatment modality.

Another closely linked theme is that because it is not well known nor in widespread use, this may contribute to client embarrassment or hesitancy at its use. Again, this could have a very negative influence on the working alliance. Isabelle, while talking about potential client confusion about the method, said:

> 'Often when I mention it people have heard about it or they've seen it on the television and people often say 'oh is that what Paul McKenna does?' It's quite a few years ago now but Coronation Street had … one of the characters was experiencing depression and … panic attacks … his mum said to him "why don't you do that tapping thing?"' (*Isabelle, lines 504-513).*

It is very difficult to know what the level of public knowledge is about any kind of psychological therapy, so it may be that EFT is not very different from therapy generally in this regard. However, the level of ignorance of the method may be having some effect on the therapeutic alliance for those clients and therapists who engage in EFT work. It may, for example, put people off coming for therapy if they expect to be treated with EFT. However, Isabelle's recounting of what her clients say to her when she introduces the method seems to suggest that there is some awareness of it, and that this might lead to a closer alliance if the client believes he is doing something that has assisted a character in a television programme he watches.

Practitioners talked about their worries or doubts about the way that EFT is marketed. This emerged as a very clear theme and between the four who mentioned this aspect, there was clear agreement.

> '[It's] not about the process *per se* I think … … because it's proliferating on the internet and you get a lot of people making very large claims for instant cures in less than an hour … I think that can give people an unreasonable expectation of what's possible so people come along expecting a miracle cure and finding out that it's not going to happen in one session you-know that it'll require more work on their part so I think that's I don't think that's a problem with EFT I think it's a problem with the way that it's marketed and portrayed as people do their best to make money out of it' (*Ben, lines 86-95).*

Ben's comment was typical of what the other three practitioners who contributed to this theme also said. None of them disliked the method itself, rather they disliked the way it has been marketed and the irresponsibility of marketing it in this way. Liam saw it as being similar to how CBT has been marketed in the UK – that it works quickly and can be used with any condition. He suggested that

there is also a demand for therapies that work rapidly and that in the 21st century we have, as a society, come to expect this. The effect of this on the therapeutic alliance could be deleterious as it sets up a potentially false expectation for the client and when the therapist is unable to help them significantly in one session, the client may lose trust in the therapist and the process.

This ties in with the theme that developed around practitioner concerns that people who are not trained as therapists are able to train to use EFT and then go on and market their skills to the public. It is very difficult to assess what effect this may have on the therapeutic alliance, but certainly there may be dangers to the formation or maintenance of the alliance in having to cope with client disappointment.

Four respondents discussed what can happen when using the modality and how this may carry some risk. Emma spoke about the power that lies in being able to help somebody feel better quickly:

> 'I was very sceptical and reluctant for a long time … and I guess there is a degree of kind-of a power in it and I don't like to admit it and I wouldn't have admitted it a while ago but having learnt a little bit about power and the therapist's shadow being the kind-of thirst for power I have to acknowledge and recognise it in myself … so that kind-of almost magical ability to help somebody to feel much better I think you know that does flatter our ego a lot [laughter]' (*Emma, lines 144-161).*

She did not directly say that with great power there is an associated risk of abuse of that power, but she did imply that this could be the case because of therapist need in any therapeutic relationship (Edwards, 2013; Holmes, 2012). This would additionally have an effect on the therapeutic alliance.

Charlotte and Emma spoke about observers not taking EFT seriously. For Emma, this led to studying psychotherapy after having learned EFT, so that she would have authority behind her. This suggests that EFT may be dismissed or regarded as suspect and what this may do to the later formation of a psychotherapeutic alliance is likely to be negative.

Charlotte spoke about bias or prejudice against EFT in a much stronger way than any of the other respondents, relating a story that was unusual in its level of fear about prejudice toward the modality:

> ‘I find with therapists themselves there isn’t a problem with it … but I am finding … there’s a lot of prejudice … I have a colleague who’s doing a lot of research on EFT who’s been … treated … terribly and had threats … trying to bring EFT into the field. And I’ve noticed on our training as well … you’d got GPs and a psychologist on there they would actually state … so they’d say “Do not mention … I will get shot for being on this course, I will get shot for advocating it so do not mention that I’ve been on this course”’ (*Charlotte, lines 704-717).*

The GPs and psychologist of whom she was speaking appear to have been very worried about what their use of EFT might do to their careers, yet they attended the training. This suggests that, had they gone on to use EFT in their work with clients, it is likely to have had a very negative effect on the therapeutic alliance, certainly on the therapist. Charlotte seems to be implying that these people had an interest and belief in the use of EFT, but may have had to practice it somewhat furtively, if at all. This would likely introduce an element of fear from the therapist of being discovered. Clarkson (2001), quoting Malcolm (1981), Jourard (1971), Jung (1946) and Buber (1970), highlights the need for therapist truthfulness in the therapeutic relationship, and it seems highly likely that a therapist who is worried about being discovered using EFT may well be secretive about it, or some aspects of its use with clients.

Although Isabelle was working specifically with EFT (and other therapies) in her work in an NHS specialist unit, she also felt some reluctance around using EFT initially. This was not due to lack of approval of the method but related to the way it might be perceived by clients.

> ‘I used to feel reluctant to offer it maybe more to men actually and I'd maybe hold back…’ *Isabelle, lines 162-163*

Although there was not any reason that Isabelle could not use EFT, the limiting preconceptions that she imagined she might meet would, had they existed, have challenged the therapeutic alliance. That she imagined the preconceptions were there and thus did not offer it in some circumstances, or to particular clients, may also have affected the therapeutic alliance.

4.4 Conclusions from the analysis

This group of therapists all found the use of EFT largely beneficial to the therapeutic alliance. Despite their different ways of working with and without EFT, overwhelmingly they believed it strengthened or deepened the therapeutic alliance. These respondents talked about EFT adding an extra dimension to the

therapeutic work which in their opinion increased the connection between client and therapist. They cited the physical connection, the almost intuitive sharing of experience with a client and the exchange of energy or Victoria's use of the phrase 'sharing molecules with someone' (line 322) that they believe occurs when EFT is used.

However, what the therapeutic alliance is seemed to be a question that was difficult to answer. Respondents knew of the psychotherapeutic concept of the therapeutic alliance but found it difficult to describe what it actually is. This reflected the difficulty the researcher had in defining it or in locating a description by someone else that defined it. The clearest description of the therapeutic alliance that emerged from this research is a description of the qualities that must exist for it to form, or to be strengthened.

Additionally, these therapists all felt strongly that EFT should not be used as a standalone therapy and none of them used it in this way. This is not surprising because these therapists were selected because they had training as a psychotherapist, counsellor or psychologist in addition to training in EFT. Their belief that EFT should not be used as a standalone therapy suggests that something else is needed to assist clients. What that something else is, however, remains unclear. In thinking about the importance of the therapeutic alliance in the therapy relationship it may be this element that these therapists believed perhaps would not form in a solely EFT approach to the work.

They also believed that when EFT was introduced into a therapy it must be done gently and carefully. This appears to indicate two things: one, that their belief is that EFT could upset the therapeutic alliance; and two, that a therapeutic alliance must be present for these therapists to feel it might be appropriate to introduce EFT work in their clinical judgment.

Chapter 5. Reflexive observations

The term ‘reflexive’ is used in this paper in two contexts: of the researcher about herself in the process of research, and of the participants both of themselves and within their relationship to the researcher. It is also intended as an examination of the sometimes unspoken views of both researcher and participants and how that might have influenced the research itself (Finlay, 2008) Reflexivity as a practice in this research is particularly important because of the similarities of the researcher to the participants. In a 2017 paper which discusses the role and method of the reflexive process in psychological research, Lazard and McAvoy (Lazard & McAvoy, 2017) emphasise that researcher subjectivity cannot be left out of the process of research. This is especially important in this particular work because of my similarity to the participants and also because the question for the research arose out of my own experience in the therapy room with a private client. Thinking about how the participants talked about their experiences and the way they made sense of them during the process of data gathering and analysis and how that affected the dynamics between researcher and participant was essential. There were also reflexive observations that participants made about themselves during the course of the interviews that were important to how they see themselves as therapists who use both talking therapy and EFT and how they think about that in the context of the therapeutic alliance.

5.1 The alliance between respondents and researcher

The initial query which prompted me to investigate thinking about the effect of EFT on the therapeutic alliance was my own lack of understanding around working with a particular client. No participant in this research mentioned an episode similar to mine in their work. They did speak about clients with whom they would not use EFT, either due to particular presentations or client unwillingness. They also mentioned times when it had not worked. There is the possibility that they may have had similar experiences to mine, but as the conversation we were having occurred during a research interview, they chose not to mention it. Once the formal parts of the interviews were concluded, I offered participants a chance to ask me any questions they might have had. Many asked what had brought me to research this topic and I briefly related the story of this client, without compromising client confidentiality. Their responses to hearing this were often to offer advice about what I might have done or considered, rather

than sharing a similar experience of their own. This was an interesting dynamic that formed, as it seemed to shift a power in our conversation from me to them. I was surprised by this because I had felt myself to be relatively powerless with each of them: I was dependent on their cooperation to ensure the interview happened, and I was asking for an hour or more of their time freely given to complete the interview. However, it seemed when this shift happened, that they might have felt themselves to be somewhat powerless in our relationship in the interview circumstances.

I believe this arose from the nature of the questions, specifically that many were asking directly about the therapeutic alliance. That had been a difficult thing for respondents to articulate and it seemed to put them into the position of feeling as if the interview was in fact almost an oral examination of what they knew as therapists about therapy theory. With many respondents, until I asked the question about how they conceptualised therapeutic alliance, the conversation had felt as if it flowed easily and they were speaking freely. When the question about therapeutic alliance came up, they often verbally stumbled or asked for clarification of a relatively simple query, or even remarked they felt as if they were back in their therapy training. Very quickly, I appeared to move from being a friendly researcher and colleague into being an examiner.

At the end of the interview when I invited them to add anything they believed relevant, respondents seemed to markedly relax again. When I then shared the story of how the research question had developed, they may have been able to identify with something in that story and the power in our relationship shifted back to a more shared nature. Those who offered advice may have been reasserting their authority in our relationship; or, were further trying to help me as a colleague in a supervisory capacity.

Like many of the participants in this research, I too found it hard to analyse my own thinking about the therapeutic alliance. Like Emma, I believe I am aware of it when it exists and when it does not, but what it actually is, is difficult to define. Attempting to refine my own ideas about what the therapeutic alliance was frustrating because everything I read to help clarify my thinking appeared to speak to only part of what it feels like in the therapy room with a client. This may also be the reason that many of the respondents appeared to struggle with thinking about it in their interviews, and instead spoke about what they as

therapists must do to make the formation of the alliance possible. Some also spoke about what the client role in the formation of the alliance is but defining the alliance itself was difficult.

There is the use of the word alliance, which (perhaps incorrectly) seems to imply something greater than a therapist and client working together; for example, an alliance between two countries for political or economic gain. Although within a functioning therapeutic alliance it is expected that the client gains, and so, too, does the therapist, because of the use of the word alliance and my association of it with a union that initially seems to lack the intimacy of two people working together around the emotional difficulties of one, I struggle with the term. Emma echoed this in her contribution when she expressed her discomfort with the word alliance and said:

> 'I'm not sure if I like the word 'alliance' maybe because … um, it reminds me of the … er … alliance what is it? … It's like alliance against something else' (*Emma, lines 642-645*).

Additionally, though Bordin's (1979) understanding of the alliance breaks it down into three separate elements, the overall alliance continues to feel undefined for me. Clarkson's (2003) postulation that it is a felt sense in the room for both therapist and client that is difficult to define because it is felt, echoed my own experience of the alliance. Its absence can be more keenly experienced and perhaps put into words because when it does not exist, its absence is so marked. Equally, in thinking about it further for the purposes of this research, it may be something that cannot be defined beyond its elements, though in experience it is greater than the sum of its parts. In a conversation with one of my academic supervisors, he contributed that the alliance is difficult to talk about because it is not a thing but is instead a process (Sarra, Academic Supervision, 2018). Initially, this seemed to make sense, but after further thought, it seemed clear that a process, too, is also a thing; though the process of it implies movement, where the thing of therapeutic alliance seems to imply something more fixed.

It is also important that in this lack of clarity or articulation, I was in yet another way very much like the participants in my research. In one way, the research was an attempt to answer my own query about what had happened in the therapeutic alliance between me and a particular client. It was also to make sense of how others saw whether and how any change to the therapeutic alliance occurred

when using EFT. Additionally, it was to take what was learned and consider whether it was generalisable to all practices of EFT. When participants struggled to answer the queries put to them about what the therapeutic alliance is, on many occasions I colluded with their lack of understanding about what it is and how it is experienced by the therapist by not delving further into what they were able to say as I could see they were uncomfortable and I wanted us to stay together, perhaps aligned, working on this research.

Instead, I accepted that they, like me, were struggling to articulate it. In that acceptance, there may have arisen an implicit alliance between me and those respondents who struggled with the query. With other respondents, I experienced a frustration in listening to them in the interviews when they could not define therapeutic alliance. When their answers chose to define instead their own role in the alliance, or the client's role, or to define the qualities that must be present for the alliance to form, I did attempt to inquire further, but was often met with an observation that they had already been asked and had answered that question.

5.2 From participants about themselves

The participants made some comments about their own experiences in the interviews and their role when working with clients. There were not many of these, but they were significant because they indicated how participants were thinking about themselves as therapists, whether or not they were using EFT. Because this research was about trying to understand how participants who use EFT in their work make sense of their experiences and how that may have influenced the therapeutic alliance, whether their comments were directly about their role in that alliance is important.

Victoria spoke about the potential bias of using energy methods and how this might affect her career and work in private practice:

> 'It was a bit of a risk to introduce it when I was first qualified as I thought "Oh my goodness … self-employed, this is my profession, this could be really risky"' (*Victoria, lines 165-166*).

This same thought was echoed in a recorded interview with Dr Erin Shannon (2012), an American psychologist who found her way into using EFT and other energy methods after initially training to use both CBT and psychoanalytic methods. Shannon was not speaking specifically about the therapeutic alliance, rather her interview was about the marriage of psychology and EFT. However,

she too had been worried about what the effect on her practice might be. Both Victoria and Shannon seemed to believe that stepping away from what is generally accepted and known about therapy (that it is a form of talking) would deter future clients from approaching. Both Victoria and Shannon suggest that moving away from the mainstream is potentially threatening to their practices as it places them outside of the mainstream of psychological treatment practitioners' ways of working. Through the view of the therapeutic alliance lens, this suggests that they would become un-aligned from psychotherapy practice in the main. If, as a result of using EFT they then no longer had clients with whom to work, there would be no opportunity to form working alliances. In a sense, this indicates a worry about EFT's perceived negative effect on the therapeutic alliance. However, both Victoria and Shannon said later in their respective interviews that EFT use had not had this effect on their careers.

Elizabeth, too, spoke about some of the bias or concern that she had experienced from the UKCP in trying to bring EFT into the mainstream of psychotherapy:

> 'It's important to … get it on the map … with colleagues we're trying to get UKCP to publish a series of papers on working energetically … and they're very sceptical' (*Elizabeth, lines 330-331)*.

Other respondents spoke about their own travels through learning EFT and using it with their clients more generally. Ava talked about how the use of EFT by the therapist is often the first step into a larger world of energy work.

> 'It doesn't really matter in the big analysis it doesn't matter which energy, energetic approach you take so EFT is, I think, a simple way in, it's a portal to a whole world of … this wonderful energy psychotherapy or energy field and I think once people get that they start to naturally explore and expand their work' (*Ava, lines 702-705)*.

Many therapists in this group including me have also experienced that the use of EFT leads to thinking in perhaps more creative ways about not only clients, but also the work with them. EFT is a simple way in largely due to its protocols and the way that it can be and is formally taught, but many of the therapists in this group use other widely varying energy psychology approaches of which EFT is only one. Without having been trained in other energy psychology methods, and because this research was specifically about the use of EFT, informal enquiry about other energy methods seems to reveal that they are much more freely associative to what is happening in the therapy at that moment and to the

therapist's judgement about where to go next and are, perhaps, reflective of client wishes. This suggests that the therapist is making all the decisions in the room; however, in practice it appears that whatever energy psychology approach is being used, and often it is more than one at a time, this is frequently based on client presentation and material and often at the client's request as well as the therapist's clinical judgment. The aspect of its being a more freely associative way of working with clients suggests that it is more closely linked to psychoanalysis than it may initially appear. It also suggests that therapists are searching for a way to become more aligned with their clients by offering them whatever method seems to be most useful at the moment it is offered.

I shared some of the respondents' ways of thinking, understanding of the bias against EFT and the need to prove its efficacy and difficulty in thinking about the therapeutic alliance generally. This both drew me closer to respondents and also may have obscured some elements of their thinking, because I assumed I knew. Despite carefully considering this point, and being aware of it before data collection began, it was repeatedly revealed to me through the course of the analysis how similar I was to my group of participants.

5.3 Efficacy of EFT and helping it gain NICE approval

The pursuit of NICE approval for EFT was an *a priori* theme that introduced inappropriate considerations into the research. In considering it, and analysing comments that participants made about it, I highlighted my own unconscious bias in part of this work. That EFT is not yet approved for the treatment of anything by NICE is something that EFT practitioners often talk about in my experience, and a quarter of the respondents mentioned this. Ava and Victoria both spoke about the need for good quality research into the modality for it to gain NICE approval. The urgency of both their comments suggests that it is a matter which they consider, and with which they are preoccupied. In one exchange between me and Ava after the interview questions had been completed, she rather surprised me by asking how my research was intending to help EFT: 'I wonder how much of this … will help EFT really' (*Ava, lines 667-669).*

Ava's concern about whether this study will be of use to EFT is an area where EFT has struggled; it has been difficult to gain NICE approval, partly because it is almost impossible, at least for the time being, to run a double-blind randomised

controlled trial (RCT) into EFT's efficacy. EMDR also struggled with this issue yet has gained NICE approval (NICE, 2005).

The participant from Canada, remarked that EFT had been approved for use in many states in the US for the treatment of veterans. She said that the UK situation was the same in Canada where EMDR had been approved while EFT had not.

Despite its lack of NICE approval, EFT is used in the NHS at least by the two practitioners in this study who work within the NHS. They are both using EFT almost exclusively and are both part of integrated mental health care teams. One of the more reliable service evaluations about the use of EFT was conducted in an NHS drop-in clinic (Stewart, et al., 2013), so there is evidence that some NHS services find it effective, despite it not having NICE approval. This is the background against which the preoccupation with NICE approval for therapists who use EFT (including myself) emerges.

What is important here is the presence of the idea that underlies most of the participants thinking about EFT and my own. We all feel the importance of justifying the efficacy of EFT. My own thinking around this was heretofore largely unquestioned so it was initially difficult to access. It became apparent in writing up the analysis that while I was looking for participants' thinking about EFT's impact on the working alliance, I was also making an argument for EFT's efficacy, which was no part of the research question. I read and compiled a list of quality studies supporting the use of EFT in various trials. None of the studies on that list spoke to anything to do with its impact on therapeutic alliance. Ava's wondering aloud whether my study would 'help EFT' seems to indicate that although she had been informed prior to the interview of the research question, she had perceived it as a study that was undertaken to help EFT.

Deborah, too, when offered the chance at the end of the interview to ask any questions said: 'Well, this is very much on the therapeutic alliance isn't it?' *(Deborah, line 281).*

I was surprised by her query, as it had seemed very clear to me when writing the information and consent sheet that every participant completed prior to interview that the research was around therapeutic alliance when EFT is in use. The emphasis in the conception of the study was on the alliance, not EFT. Deborah seems to have perceived that quite differently when agreeing to take part, which

was evidenced to me in the surprise in her comment. Deborah was one of the respondents whom I had not known previously and agreed to take part after she had responded to an email newsletter from another participant. It is therefore unknown what was said to her about the study by the other participant. However, what he and I agreed when he offered to circulate a call for participants was that he would circulate the original email I had sent him, describing the purpose of the study. From his answers to the study questions, he appeared to more clearly understand the focus of the study was EFT's impact on therapeutic alliance and not its efficacy.

Deborah's next comment, after I confirmed that the study is indeed about the therapeutic alliance, seems to underline her emphasis that what she finds important about EFT is that it works with her clients.

> 'From *my* perspective it, it does have a huge *bearing* on the therapeutic alliance but it has more of a bearing on … er … shifting things and *how* it shifts things' (*Deborah, lines 283-285).*

This comment suggests that for Deborah, although EFT does have a big influence on therapeutic alliance, the important element of EFT and what is effective about it is not the therapeutic alliances that form when using it, but that it works and how that happens. It can, of course, be argued that the therapeutic alliance on which EFT has a bearing is the element that is working, but Deborah seems to separate these two things decisively and to believe that it is the EFT that shifts things, not the working alliance.

Abigail, too, seemed not to understand clearly the criteria for inclusion in the participant group. In a longer discussion (Abigail, lines 542-692), again after the interview had formally concluded, Abigail was thinking of people she could encourage to participate in the study. She suggested a person to me and then said:

> 'But she's very enthused about EFT … and it doesn't look like you're looking for someone that does it all the time' (*Abigail, lines 559-562*).

It seems Abigail was clearer that the study was not about the use of EFT *per se*, but only after her participation in her interview.

In this discussion with Abigail (Abigail, lines 542-692) my own comments were particularly telling. We were talking about the dangers of practising EFT without

also having counselling or therapy training, and we touched on that quite frequently in the discussion. This indicates to me that there is something we both perceived about the importance of the therapeutic training which indicates our mutual concern with some understanding of the formation of a therapeutic alliance through being able, as a practitioner, to keep clients safe. I also said, in response to Abigail's query about why I had chosen this area for study,

> 'EFT hasn't been able to gain NICE approval although there are a growing body of people who use it even within the NHS and I'm really interested in it gaining NICE approval and if … the work that I do about integrating EFT into a traditional talking-only therapy can be of any help for that then I, I really hope it *can* … offer some help'. (*Abigail, lines 569-574*).

This is very clear evidence that one of my previously unacknowledged aims in the work was in part about seeking NICE approval for EFT.

The interview with Abigail occurred after the interviews with Ava, and it is my use of the word 'help' in conjunction with speaking about NICE approval that is also interesting. Ava wondered how my work would help EFT. Although I remember feeling very surprised by her comment and thought when I heard it that she had misunderstood the purpose of this work, I clearly subconsciously picked up on the idea of being of assistance to the modality, particularly in terms of it gaining NICE approval.

During the analysis, it became apparent that there were areas I had not directly asked respondents about. The first of these was about the physical element of EFT, both in its use and its effects on clients and therapist. Many of the respondents talked about this in their interviews, but I had not asked them directly about this part of the therapy.

It began to emerge in my thinking that I had not asked about it because it had seemed so fundamental and obvious a feature both of EFT work with clients and its effects on them, that it was not useful to single it out as a feature of EFT. It was an unacknowledged feeling that asking about it specifically would be similar to asking about the impact of talking on a talking therapy rather than considering perhaps what might be said, or what the effect of wording something in a particular way might be.

However, in thinking about the work with the client from which the research question emerged, one of the ways that I had thought about it was to query

whether the somatic element of EFT had changed something in our alliance. There were many ways this could have happened: it stopped us talking for short periods as we performed the tapping, I could have put myself into a teacher's role, or he simply may not have liked the tapping and perhaps felt it distracted both of us from what he wanted to talk about, that it changed how I listened to him and instead of linking what he told me back to earlier childhood events or relationships, we were experiencing his feelings rather than articulating them. The alliance seemed to break down temporarily through the use of EFT, and perhaps the most obvious difference of EFT to the talking therapy we had been engaged in previously was the addition of a physical tapping, which was bringing about physical and psychological changes in him. The tapping in EFT is also a physical act and while it is going on, both therapist and client are only using short, pre-determined phrases. Though I personally explore what has happened for any client after each tapping round when talking is more free-associative than it is during tapping, the tapping may have felt disruptive or distracting for this particular client. It may also have interfered with a particular transference the client was experiencing (Weightman, 2018). Whilst that possible interference with the client's transference may well have been having an effect on the therapeutic alliance in focusing my queries on the physical nature of the EFT protocols, I did not explore the possibility of a transference that may have been interfered with.

Additionally, EFT's focus prior to tapping is very often on the physical manifestation of the difficulty, which is used to anchor the tapping and to make the feelings more tangible and therefore easier to work with. Olivia talked about this in her interview when she said 'that's just such a beautiful thing, their body is telling us what's going on for them' (*Olivia, lines 433-434*).

This comment suggests that the body is telling the truth of the client experience, whether their cognitive processes allow them to do so verbally or not. Because whatever may be happening is happening right now in the therapy room, it has an immediacy that the client may not be aware of through talking alone. This is, in fact, one of the reasons that I endorse the use of EFT because I experience my own emotional feelings with a physical component and a significant number of my clients appear to do so as well. The client in the work from which the research question emerged had quite notable and marked physical manifestations of feelings which came into the therapy from the first session and

remained throughout. For example, in every session, he loosened the belt of his trousers before sitting down and commencing. This could have had many meanings in psychodynamic therapy, and I tried to explore this with him with little uptake by him. A part of the reason that I suggested EFT work with him was this physical element that felt difficult to find meaning around in thinking about it through the lens of the therapeutic alliance. The shift to work involving a physical element may have given me access to something he did not want me to know about, or us to talk about, which may have negatively impacted the therapeutic alliance. Importantly, although I am conceptualising the alliance as different and separate from transference, I do believe they have an effect on each other within the therapeutic relationship.

The second area in which I did not pose any direct questions was spirituality. My own spiritual beliefs are ill-defined and not something I consider often. Neither are they not something that I discuss with other people. I am uncomfortable when queried about my spiritual beliefs because I am unclear what the word 'spiritual' means. Recently, it seems to have replaced 'religious' and it is this that causes my discomfort. I therefore did not ask participants about spiritual beliefs, either their own or their clients', or how spiritual beliefs might affect the use of EFT.

The Oxford English Dictionary (2019) defines 'spiritual' as 'relating to or affecting the human spirit or soul as opposed to material or physical things'. Because this is a somewhat woolly definition, it may have encompassed what some respondents were talking about when they discussed the way that EFT connects themselves and their clients. It may be the element that some of the therapists who spoke about energy meant, while other therapists referred to this as spirituality. I was concerned that a discussion of spirituality might undermine any positive contribution that EFT might make to therapy. I was also worried that participants' contributions about spirituality would devalue the use of EFT in therapy, which underlines again my concern about approval of EFT.

It may also be useful in establishing or maintaining a therapeutic alliance. For example, when Deborah said that clients with spiritual beliefs are, in her opinion, often more open to trying EFT, this may open the door to a way of working with a client that particularly appeals to that person and thus alliance can be more easily achieved. Deborah did not go on to define what she meant by 'spiritual beliefs' and I did not ask her to expand. My own inclination, thinking about it

afterwards, was that she was talking about a belief, or a system of belief, about something that is intangible and unseen and that has some influence on people. Beyond this, it is difficult to know exactly what she meant.

The concern about the efficacy of EFT was also present for me in conducting this research initially. Over time and with the development of the research process, it became ever clearer to me how ubiquitous in my own perception the need to substantiate EFT's efficacy is. However, over the course of the project, as I delved more deeply into EFT's effect on therapeutic alliance and the questions that occurred about it, the wish to prove EFT's efficacy stood in increasingly greater relief and was much more clearly seen. This work was about its effect on the therapeutic alliance, and not the efficacy of EFT. Perhaps as important is how EFT's efficacy is seen by clinicians who do not use it, and this underlined how ingrained this worry about whether EFT works is.

Chapter 6. Discussion

This chapter discusses the results of the research in line with its aim and how it sought to answer the five research questions outlined in sub-section 1.3. It also discusses the research strengths and limitations puts forward further research recommendations and the clinical implications of the work.

6.1 Discussion of research questions and research aim

Generally, it was found that the use of EFT probably strengthens the therapeutic alliance, in the opinions of the respondents to this study. Mollon's (2008) ideas that energy psychology in the main is helpful to clients and that there are also times when energy psychology does not work also both emerged in this research. However, it was not always clear why it worked or did not. Participants provided many reasons for both outcomes and when the discussion was around their likes and dislikes of EFT, nobody directly identified the alliance being either strengthened or threatened. There were assertions, particularly about the times that EFT treatment was not thought appropriate, that seemed to have little to do with EFT's influence on the therapeutic alliance. These assertions indirectly suggested that perhaps the unstated reason it may not work is that the therapeutic alliance is not sufficiently well established for EFT work to begin, rather than interrupting or breaking a therapeutic alliance. .

With regard to the incorporation of CAM therapies (of which EFT is one) within conventional, talking approaches to ameliorating mental health, respondents largely spoke of introducing it gently and ensuring the client felt safe. It can be assumed that any reputable counselling or psychotherapy training would address these issues within the course. That there is a lack of information in this area is interesting because it suggests that there is poor guidance on these issues for practitioners of CAM therapies. These guidelines contribute to the safety of the client and the therapist in the therapeutic endeavour, a quality that therapists in this research repeatedly cited as necessary to the formation and maintenance of a therapeutic alliance. Practitioners in this study also cited client safety as crucial to therapy generally and the lack of formalised counselling or psychotherapeutic training as a pre-requisite for EFT use was a concern highlighted by participants.

The existing research about the efficacy of the therapeutic alliance and research about what the therapeutic alliance is, has varying results. It is generally found

that greater use of common factors by therapists seems to lead to a greater therapeutic alliance with patients than does strict adherence to the principles of any particular modality, as Solomonov et al (2018) found. Respondents in this research repeatedly highlighted the use of common factors in their work using both EFT and talking therapy. It is hard to know whether psychotherapists who use EFT also use common factors more or less consistently than their colleagues who do not incorporate EFT into their work. However, many of the respondents for this study made mention of common factors within their work and in how they saw their role within the therapeutic alliance while using both EFT and other approaches, whether combined or not. This suggests that EFT specifically may not have a significant impact on the therapeutic alliance, and it is the use of factors common across many therapy interventions that leads to the greater alliance. Additionally, although EFT was the modality being researched, many of the therapists who participated in this research used not only EFT, but other energy psychology approaches as well. Therefore, it is possible that the existence of common factors is more important than any specific therapeutic approach. It could be surmised that therapists who choose to train in and use EFT and other energy psychology treatments already have a greater tendency toward the use of common factors, although this research is not able to support nor refute that assertion.

Thinking about alliance ruptures and repairs within EFT use, it is possible that the simple introduction of EFT could lead to a rupture. The EFT modality is not yet widely known, so it is possible that clients could arrive for therapy not expecting it to be offered, and some respondents reported that. This, in turn, could surprise or embarrass clients and interfere with the therapeutic alliance. Respondents spoke frequently about both the surprise and embarrassment some clients reported to them after beginning EFT use; however, working from Bordin's (1979) three-part conceptualisation of the alliance, their discussion centres around providing a sense of safety for the client initially in establishing an alliance. They go on to say that when the tasks of therapy are not what the client expected this can lead to a rupture in the alliance, even in circumstances where the goal has been agreed (Watson & Greenberg, 2000). It seems possible, therefore, that EFT introduction and perhaps use could lead to therapeutic alliance threats, particularly when clients are unaware that the therapist might suggest this way of working.

These are, again, the common contributing factors to a therapeutic alliance and to a helpful client-therapist relationship and were supported by the findings of this research. Several respondents spoke about how EFT can bring the therapeutic dyad into areas of client feeling and experience that can be surprising in their intensity, particularly when it is painful for the client. They also said that continued tapping through the pain provides soothing when these painful areas are found, thus widening the windows of affect tolerance. It also reinforces, by implication, that the therapeutic alliance may not be affected, either positively or negatively, by the use of EFT.

Respondents spoke frequently about the creativity of using EFT. This is interesting because it can be argued that use of EFT at all is a creative step in any talking therapy, but for this group of practitioners, they were discussing not only the introduction of EFT work *per se*, but also the flexibility of the method. It is a marked departure from the activity of talking and many of the respondents mentioned how this factor alone is at times interesting or off-putting for clients. Many of the participants noted that EFT training and use vary between therapists, so EFT with one practitioner may be very different from EFT with another. Participants also spoke repeatedly about staying with their clients, which on occasion necessitated a departure from the protocols of EFT that they had learned in their training. Some of the participants described sometimes using breathing exercises as a prerequisite to EFT use in an attempt to make the introduction of EFT gentler, for example. Anderson, Ogles and Weis (1999) argue for the use of creativity in therapy to enhance therapeutic alliance. Whilst acknowledging the difficulty of defining creativity in therapy, and allowing for the constraints of the time-limited therapies under their investigation, they contend that therapists who work creatively using their interpersonal skills are better able to establish and maintain therapeutic alliance than those who more rigorously pursue the treatment protocols of whichever modality they are using. The results of this work certainly support that assertion. However, Anderson et al. may have been referencing common factors when they wrote about interpersonal skills. Although respondents to this work talked about common factors frequently, it is difficult to know whether those are more prevalent in the work of EFT practitioners as a whole. Common factors that therapists possess and use, no matter their way of working, would presumably include and extend beyond EFT use into talking

therapy, for example. This then also supports the argument that the use of EFT does not necessarily hinder nor promote the therapeutic alliance.

Most respondents said that EFT use was beneficial to the therapeutic alliance. Although they were unclear or unable to articulate clearly how and why this occurred or to explain the mechanisms by which it occurs, they were overwhelmingly clear that when it works, EFT strengthens the therapeutic alliance. In attempting to explain why or how this happens, a broad theme emerged that because it is so different to talking therapy, EFT bypasses many of the usual ways that clients have of dealing with human relationships (including those with their therapist) and their own difficulties, and thus allows a new kind of relationship to form between client and therapist and within the client themself. The effects of this are also felt by the therapist, and many respondents cited this phenomenon. This supports the idea that EFT is a creative step in therapy because the respondents believed not only that the alliance was maintained, but that through EFT it deepened or strengthened as there appeared to be an added dimension to the connection within the dyad.

The experience of what the alliance is was difficult to assess because the focus of the research questions was on the use of EFT and its effect on therapeutic alliance. Respondents were asked about their conceptualisation of the alliance generally and a theme emerged around their answers. They had difficulty defining the therapeutic alliance, both within EFT work and outside it. Respondents appeared to be uncomfortable when asked how they conceptualised the alliance generally. Several remarked in joking tones that they felt as if they were being asked a question as if for an exam. From this reaction, what was clear was the somewhat indefinable nature of the therapeutic alliance; nevertheless, whether it existed or not was clearly felt by respondents. Nobody said that they had used EFT with a client with whom they did not sense or feel an alliance. Participants generally believed that without evidence to the contrary, the therapeutic alliance exists in some form within any therapy. This reiterates Clarkson's (2003) contribution that an alliance is rarely noticed when it exists and is far more noticeable by its absence. This suggests that EFT itself is not having an effect on therapeutic alliance. Additionally, it may suggest that the alliance instead comes from the existence of common factors that are present in both talking therapies

and in EFT and other ways of working and this is supported by the existing research (Nienhuis, et al., 2016).

There may be a generalised pressure that therapists perceive, either from themselves or from their clients, to help their clients get better. This would be an indication of the presence of goals in therapy, as Bordin (1979) defined an element of the alliance. Because the therapists in this study frequently remarked on the speed with which EFT brings about change, EFT may be helpful in supporting the alliance by achieving the goals of therapy more quickly than talking therapy. It may be that client change is widely understood by both therapists and clients to be a slow process (Fonagy, Bateman, & Lutyen, 2012) and therefore anything that works to speed the process up is helpful both to the client and to the therapeutic alliance.

Another element to EFT use within a talking therapy arose within this research, that is not widely discussed. It was the assessment by therapists of whether client change had occurred. Several therapists mentioned that there were occasions when they could observe a change in the client, but the client was unaware of any. If the therapist believes that change has occurred but the client does not, the question then is whether it has occurred. Thinking about this in the context of EFT use and therapeutic alliance, if change does occur, it may interrupt the therapeutic alliance as it represents a fundamental difference in client and therapist opinion and so there is no agreement and the foundation of Bordin's (1994) conceptualisation of the alliance rests on an agreement. However, the respondents in this study were clear that change occurred in some circumstances. If there is pressure in a real or perceived sense to assist the client in achieving their therapy goals, then it may become difficult to know when the goals have been achieved.

Another interesting point is that it may be that the difficulties around the articulation of the therapeutic alliance might be something that EFT practitioners particularly experience whether or not they also then go on to form stronger or deeper alliances with their clients. It might also be that articulating the therapeutic alliance, because it is so infrequently consciously considered, is something with which many therapists, no matter their ways of working, would struggle (Sarra, Academic Supervision, 2018).

There is a lack of understanding generally about which of the protocols of EFT are the most effective. Although that was not the purpose of this work, how this might affect the alliance was considered. It could perhaps be having an effect by creating suspicion on the part of the client about what the therapist is trying to do. Equally, it might have a very positive effect on the alliance as clients begin to feel better, particularly when this happens relatively rapidly, as several participants pointed out. The incorporation of a belief in spirituality either by client, therapist or both may also be helpful to the alliance because it provides a common ground for therapist and client. Alternatively, if EFT is introduced after the establishment of an alliance, and it is experienced as helpful to the client, the alliance may be threatened by the client's wondering why it was not introduced earlier, as two respondents pointed out. Or it may have very little specific effect on the alliance as clients are sometimes unaware of what about therapy is helpful to them, when they find it helpful (Bachelor, 1995).

The presence of a negative therapeutic reaction, as conceptualised initially by Freud and later altered by Spillius (2007) was not dealt with in this work. None of the respondents mentioned this, apart from Michael who said, 'some clients don't like it if they are particularly invested in maintaining their problem' (Michael, lines 97-98). He did not expand on this point because he was responding to a question about the effectiveness of EFT. A negative therapeutic reaction would threaten any therapeutic alliance. However, it is hard to know if a client may disagree about the tasks of therapy (Bordin, 1979), whether that is because of a negative therapeutic reaction. In either case, it might threaten any formation or furtherance of a therapeutic alliance. It might be possible then, that distinguishing between a negative therapeutic reaction and a disagreement about the tasks of therapy would further the alliance (Sarra, 2019).

Clarkson (2003) discussed the felt sense of the alliance's existence whilst exploring what it is. She noted that it is essential to effective therapy and says that it is a difficult concept for therapists to describe, but they do know whether it exists or not. Certainly, the results of this research would support this. In some interviews, participants clearly stated that they knew or assumed it existed because they would have been aware of its absence and, not feeling that, relied on its existence. This also suggests that if the therapeutic alliance is essential for

effective therapy, it must exist when EFT is in use if EFT is considered to be an effective modality for working with client distress.

In other participant contributions, because the contributor did not mention its absence, it was assumed that it existed because its lack, as such an essential part of therapy, would have been keenly felt. Clarkson (2003) expands by stating that it does exist, whether optimally or not, in most therapeutic endeavours wherein both client and therapist are willing participants. In the work of the respondents who contributed to this research, all the client work they referred to or discussed was willingly engaged in by both themselves and their clients. Whilst this indicates that the likelihood of the alliance occurring was therefore very high, whether they were using EFT or talking therapy or some combination of both, it may be that the tacit nature of the alliance is so strong that the alliance can only be experienced as a felt sense, rather than a concept it is possible to put into language. It may also mean that its presence during EFT work is tacit and assumed in much the same way as it is in talking therapy, and that EFT is having little effect on the alliance.

There was one theme that emerged from two of the interviews about avoiding EFT use with people who had difficulties around their bodies, either psychological or physical. In the context of the therapeutic alliance, touch by either the therapist or the client on the client's body may be perceived as a transgression by the client and in this way could threaten the alliance. In Tom's comment about not using EFT with a client who had a long history of physical and sexual harm perpetrated against her, it may have been the threat to the alliance he was seeking to avoid when he said 'it didn't feel right [to use EFT with her]'. With the client to whom Tom was referring, the alliance may already have existed (the client had sought therapy and Tom had agreed to provide it), so he may have feared that EFT would have destroyed any alliance rather than preventing it from forming. His thinking around this was centred on the physical nature of the EFT work and not its effects.

EFT may also have a very negative effect on therapeutic alliance. The beliefs of almost all the practitioners in this research were that EFT is not a standalone therapy. This may be suggesting that the therapeutic alliance can be established only when there is another therapeutic approach already in use, or an understanding of how to build an alliance that comes with psychotherapeutic training without which EFT should not be brought in. Respondents said that EFT

can take clients and their therapists to very rich but also painful and sometimes surprising elements of experience very quickly, and that without a counselling background for the therapist, this could result in both client and therapist feeling unsafe. Safety is one of the common factors that therapists in this study, and in much other work into the therapeutic alliance, cited as essential to building an alliance (Clarkson, 2003; Kendra, Mohr, & Pollard, 2014; Solomonov, et al., 2018; Bachelor, 1995). This strongly suggests that EFT could have a negative effect on the alliance if the practitioner does not have the skills with which to build, maintain or repair the alliance if traumatic or painful material is uncovered that threatens it. The worry that participants in this research expressed with regard to the practice of EFT without a psychotherapeutic nor counselling background was both about keeping clients safe, and about how EFT could be written off despite its anticipated effectiveness in appropriate therapeutic contexts.

The question of when the alliance begins to form was not directly addressed by any of the respondents apart from Ben. This is, however, an interesting point and one that Horvath (2001) noted in that early therapeutic alliance is more important than alliance overall because of its links with positive therapeutic outcomes, and that over time within a therapy, client and therapist opinions of the alliance tend to converge. Ben described his process for client intake, which includes a telephone conversation prior to the commencement of therapy, in which he assesses the client, particularly for any difficulties with which he does not work. He commented that because he performs this assessment process with each client, the alliance is already forming in this telephone conversation and its beginnings are in place by the time the client arrives for their first appointment. Because he refers on work that he does not want or feels unable to do, this suggests that the alliance is, therefore, more likely to form or continue to develop with the clients he feels able to work with. Ben as a therapist is perhaps in a more confident stance at the beginning of therapy and therefore better able to provide the common factors that lead to a good therapeutic alliance. However, this suggests that EFT *per se* is not having a significant effect on the alliance, positive or negative; the focus then is on building the alliance generally prior to EFT use.

No other respondents specifically mentioned their client intake process, though they were asked whether clients approached them specifically for EFT work. Some said that on occasion they were approached for EFT work specifically, and

one respondent estimated that 95% of her clients initially approach her for EFT work. Olivia was unusual in this group of respondents because the principal method of all her work was EFT, although like the other respondents, she is trained as a counsellor. What this suggests is that the clients are choosing therapists who work in ways that those clients find appealing. In this instance then, there is probably a higher likelihood that an alliance will form initially or may have already begun to form in the client's thinking prior to their arrival in the therapy room.

All but one of the 16 participants in this research said they were approached for therapy but not EFT specifically. Clients were surprised when EFT was suggested as a way of working. The therapeutic alliance is likely to begin forming perhaps even before a client contacts a therapist. The client has made a decision about whether to seek therapy, and about which therapist to contact. They will have conscious or subconscious ideas about why they have chosen this particular therapist, and these are the initial steps in the formation of the alliance. In an interesting investigation into client-therapist match, Dolinsky et al. (1998) studied the match between both members of the dyad and concluded that what they were terming 'match' is in fact likely the therapeutic alliance.

The theme of surprise and in most cases the happy reactions of those clients who tried EFT and found it effective echoed the respondents' own reactions when discovering it. Some participants believed this conferred on them a responsibility to share EFT with their clients after they had completed training in its protocols. Respondents also discussed that, in part, their like of EFT came from it being something that a therapist can give to the client to take away from therapy and use at home on their own. This is something that therapists who do not use EFT do not, or cannot, do because what the client is able to take away from therapy is less tangible, though perhaps at times it may be very powerful. It also more clearly emphasises the therapist's role in the alliance and relationship as being, at least in part, one of therapist giving something to the client. While this study did not explore the client's reaction to a therapist giving them something more concrete than thinking, feeling and discussion within a session, there is some limited evidence that emerged that male clients rate the alliance as greater when they are given advice in a marital therapy session (Thomas, Werner-Wilson, & Murphy, 2005). Advice is normally given verbally, so a direct comparison with

EFT is not being made. However, advice is somewhat more concrete than discussion, challenge, acknowledgement or re-framing that is the basis of talking therapy. The same reaction was also not observed in female clients in the same study. The idea of a therapist giving the client EFT to do at home between sessions also links strongly to the physical element of EFT. There is something tangible the therapist is giving to the client which may enhance alliance, maybe particularly for male clients.

6.2 Strengths of this study

This research has identified several themes from which further research could emanate. There was no existing knowledge in this realm when research began, so everything found is new information. There are numerous avenues down which later research could proceed, as identified by the themes found in this work.

With regard to EFT's impact on therapeutic alliance, this research found not only that EFT seems to have a beneficial impact on therapeutic alliance, but it brings the issue of what the therapeutic alliance is to the table again. For an element of therapy and the therapeutic relationship that is widely regarded as essential to any successful therapeutic endeavour (Horvath, 2018), this is an important question to continue debating, at the very least.

This research also found that the therapists who use EFT find it difficult to articulate their thoughts about the therapeutic alliance. This may indicate a need for more comprehensive education of therapists in general. It may also indicate a need for greater understanding of the differences between therapists and why some choose to use EFT while others do not. It is a strength of this research that possible differences between those therapists who use EFT and those who do not has been highlighted.

Finally, this research may indicate a need to look at the way that NICE evaluates new treatments. There are certainly difficulties in the way that EFT has been tested for its efficacy and how trial results have been considered. There are also difficulties in how to design double-blind randomised controlled trials for EFT that would provide the evidence that NICE seeks. However, these difficulties also existed when EMDR was considered for NICE approval for trauma treatment and yet it has gained this endorsement. A problem exists either in the evidence that NICE considers, the difficulty of performing randomised controlled trials for EFT's

efficacy or the requirements for what is considered acceptable evidence of efficacy. While this research did not address any of these questions, it did very strongly highlight the wish of therapists who use EFT to be using a NICE-approved therapy. Further, this may have a very strong influence on EFT's impact on therapeutic alliance, if therapists using it are anxious about its lack of NICE approval when they are using it.

6.3 Limitations of this study

The most obvious limitation of this study is that it focused on the experiences of therapists and not their clients. Any therapeutic alliance is one forged between therapist and client together, so while the work here is a good basis from which to conduct further research, it does leave the clients' view of the therapeutic alliance during EFT use unknown for the time being. As this research was in an area in which almost nothing existed previously, and very little was known about what might be found, it was important to keep the size of the enquiry to manageable proportions and therefore the client view was not sought.

There were limitations too in the use of FA methodology for this research. Gale et al (2013) say that the spreadsheet approach that FA demands provides a structure and organisation to the data that is helpful to inexperienced researchers. While this was certainly true in this thesis, it also brings the danger of attempting to turn qualitative data into quantitative data and sacrificing some of the subtleties of meaning participants might contribute (Gale et al, 2013). All attempts were made to avoid this outcome; however, the temptation was there to present results in a quantitative language by, for example, stating in early drafts that 4 of the 15 respondents contributed to a particular theme.

6.4 Further research recommendations

Many avenues of further research could be explored from the results of this study. Most obviously and importantly a study regarding the perceptions that clients who use EFT in work with their therapists have of the existence or strength of the therapeutic alliance would be valuable. Because the therapeutic alliance is an element that is formed from the input of both members of the therapeutic dyad, the client's view would be useful in developing a greater understanding of what happens within the alliance, if anything, when EFT is in use. It would also be interesting to understand whether clients and therapists who are part of the same

therapeutic dyad had differing perceptions of the therapeutic alliance while EFT is in use.

Moving away from the perceptions each member of the dyad holds about the therapeutic alliance, an enquiry into which therapists choose to train in and use EFT would be of value. There may be differences in their initial therapeutic approach that would influence their choice to train in EFT use. As was seen in the results of Lister's (2017) study, the varying training in therapeutic conceptualisation leads to different perceptions about, and use of, the therapeutic alliance in therapy. It therefore follows that for therapists who choose to use EFT, there may be a difference between them and their perceptions of therapeutic work to those therapists who choose not to train in EFT.

Research about the use of common factors and the frequency of their use by EFT practitioners might also be useful. Although a clear definition of therapeutic alliance remains elusive, many studies highlight these as important in the formation of a strong therapeutic alliance. Therefore, their use by EFT practitioners specifically might provide some further insight into firstly their role in the therapeutic alliance when EFT is used and secondly whether EFT practitioners' use of common factors is greater or lesser than therapists who do not use EFT.

Finally, research involving greater numbers of EFT practitioners would be useful. There was not the scope to allow for a bigger sample size within this study. A larger sample size was also not possible because homogeneity of the participants was sought as much as possible. The justification for attempting to recruit a homogenous participant group was that with so little research already existent in this area, it was important to compare similar practitioners and their varying views. A several-tiered approach to differences in psychotherapeutic training and EFT training initially followed by the impact that this might have on conception of therapeutic alliance and then the establishment of therapeutic alliance with EFT, would be of value.

6.5 Clinical implications

There is an urgency which was widely felt by participants in this research to find a way for EFT to gain NICE approval. For this to happen, it would need to be done against a background of what is already known. Currently, different

treatments are approved by NICE for various difficulties (National Institute for Health and Care Excellence (NICE), 2005), and therapeutic alliance is currently believed to be the effective element of many approaches to therapy, no matter the protocols of any given one (Bordin, 1979; 1994; Horvath, 2018). However, therapeutic alliance is not the measurement with which NICE concerns itself in evaluating treatment options (Barkham, Moller, & Pybis, 2017). If therapeutic alliance is indeed the healing element of any modality of therapy, then it is an essential element in whether any particular therapy is effective. Although it might be impossible currently to change NICE's criteria for determining inclusion in their recommendations for treatment, this research supports the assertion that EFT should not be ruled out based on its impact on therapeutic alliance.

The question of what the alliance itself is continues to be elusive, however. In this research, it seemed possible for respondents to name several factors that they believed would lead to an alliance, but not what it is. Horvath (2018), too, appears to be opening more discussion about what the alliance is and says explicitly that it is difficult to define. This raises the question of whether it is possible to know both if and when it exists and what it is. However, respondents in this study were clear that the use of EFT strengthened the alliance. As that is the case, then there must at least exist a felt sense of the alliance even if it cannot be verbally articulated.

All the participants in this study were chosen because they were trained both as therapists and as EFT practitioners. The thinking behind this choice was that, as trained therapists, they were more likely to have some understanding of the concept of therapeutic alliance than a practitioner who has only trained to use EFT. In my own EFT training, no mention was made of the therapeutic alliance in any context. Several of the therapists in this study also identified concerns about the importance of therapeutic training in addition to training in the use of EFT. This perhaps suggests, at least in part, that the therapeutic alliance is something they would have learned about in their therapeutic training. It may also suggest that there are other elements that are taught in therapeutic training that are missing from EFT training. Although it is unclear what these elements are, it seems likely that they are such things as the common factors of therapy that have traditionally been thought to lead to the alliance. The significance of the working alliance to the process of client change was underlined by these therapists'

concerns about the lack of client safety that might arise in work between a client and practitioner who has only EFT training. Thus, some understanding of what the alliance is, and how important it is to establish and maintain it, came out of this study through participants' concerns about what could happen if it is not present, or not maintained. None of the respondents noted an example of when they believed the alliance had been broken or had failed to form in their work, and this could be attributed to their reluctance to speak about such episodes. However, it also suggests that, particularly in their work using EFT, these therapists have not experienced it. That in turn suggests that EFT is, if not strengthening the alliance, not threatening it.

There were references by participants to the differences in EFT training. Although this theme was not developed within this paper, it was mentioned by several respondents in different contexts to ensure that understanding between the researcher and the participant was clear. Importantly when thinking about contributions to theory and practice that this research represents, it obliquely points to a need to standardise EFT protocols. Respondents also did not use EFT exclusively, despite their strong and unanimous endorsement of the modality. They acknowledged that sometimes it is not appropriate for some clients for a host of reasons. Many of those reasons were to do with a particular client feeling out of control in EFT work, or client resistance to the idea of using EFT. When a therapist judged that EFT was not appropriate, or the client expressed hesitancy or refusal to use it, this group of therapists did not use it. This leaves the client more in control of the therapeutic process, whether they are aware of this or not and is likely to contribute to the formation or strengthening of an alliance. While this does not mean that EFT damages therapeutic alliance, it does suggest that practitioners who use EFT are sensitive to client needs. They can be sensitive to client needs in other forms of therapy as well, and this is not a direct statement about EFT and working alliance; however, it suggests that therapists who are trained to use EFT are not necessarily using it in all client work whatever the circumstances of the client or therapy may be. In turn, this may suggest that the therapeutic alliance is vital to all client work, and these therapists are using EFT only if the therapeutic alliance exists and will bear the shift to a very different way of working.

Many of the therapists in this research had training in other modalities, particularly in other energy psychology ways of working. They used what they believed appropriate in individual circumstances and this sensitivity to client presentation and need may be what allowed the working alliance to form and to be maintained. EFT was, for this group, a tool they employed just as they used the other modalities in which they were trained. Apart from the few respondents who used EFT with most of their clients, almost all said directly or implied that while the use of EFT does not harm the alliance *per se*, it is important to have other tools with which to help clients. This suggests that while EFT does not harm the alliance, it and any other tool or modality could if the therapist lacks sensitivity a more common factor seen in most of the recent research into the alliance.

The concerns of practitioners that EFT gains approval for treatment by NICE was strongly apparent both in this group and highlighted through this study in the researcher. It is not immediately apparent from this concern what the effect of this is on individual therapeutic alliances built in the treatment room. It speaks to an indirect sense of alliance (or lack thereof) with medical and psychological healthcare policy more widely. These therapists are partly seeking alliance in a wider sense, professionally, with practitioners of other forms of therapy and the bodies that decide which therapies are effective. The results of this study suggest there is no reason why EFT should not be a viable treatment solely due to its impact on the therapeutic alliance between client and clinician.

The more detailed findings from this study indicate that, although all the therapists involved in it use EFT, they do not use it exclusively and nor do they advertise themselves exclusively as EFT therapists. The reasons for this were unclear and this theme emerged when participants were queried both about how their clients seek them out (most were in private practice) and when the alliance begins to form. Most did not discuss when they believed the alliance begins to form; however, they seemed to speak to an unasked question about how the relationships with their clients form, which indicates some awareness of the alliance beginning to take shape from the first time a client finds them online or hears of them. This, in turn, suggests that there may be some prior knowledge among the clients about the therapist's ways of working which appeal to the client. This is likely to positively influence the formation of the alliance, particularly at the beginning of the relationship. It also indicates that, as clients are self-selecting to

a certain degree, the alliance has a greater chance of forming. This suggests that EFT may be having an effect on the alliance from the client's point of view. A client who is looking specifically for a therapist who uses the modality is likely, at least at the beginning of the work, to be more amenable to forming their part of the therapeutic alliance. Therefore, its formation would depend more on the ability of the two individuals in the dyad to bring it about than on the method of working.

6.6 Summary of the discussion

This research supports the idea that EFT leads, in the main, to a stronger therapeutic alliance from the therapists' point of view. What also emerged is that thinking about the alliance, particularly during the sessional work, is not something to which these clinicians were giving conscious attention. They assumed that because they did not experience a noticeable lack of alliance, an alliance existed in their work. They also struggled to define the alliance verbally. The struggle to define the alliance is echoed in the recent literature. Horvath (2018) argues that perhaps what we have been terming the alliance requires greater research and a change in psychotherapeutic thinking about it. He goes on to say that the alliance itself is one of the common factors of therapy, like therapist genuineness, warmth and empathy and is not an element separate from or formed out of these other common factors. This may be why the therapists in this research struggled to define it as a separate element and named what common factors they could in their thinking about it.

Horvath (2018) goes on to argue that the alliance must exist (and does) in all therapies no matter their protocols. He says that it is a part of the thinking from all the differing orientations of therapy, be they psychoanalytic, psychodynamic, humanistic or existential. This suggests that whilst the alliance is playing a significant role in client shift and healing during EFT use, EFT alone may not be having a great effect on the alliance. Therefore, the focus may need to shift back to the individual therapist-client dyad and what both together are able to build and sustain to assess or predict the outcome of any therapy involving EFT.

Finally, one of the major themes that emerged in this work was the urgency that emerged around EFT therapists looking for validation of EFT, both by NICE and by the wider community that provides psychological support. This was an interesting finding because it indicates that EFT practitioners, whether they are also psychotherapists or not, seem to want this very much. It is also of note

because it is seen, within these respondents, that they do not seem to feel allied with the mainstream of psychological support workers. There is a lack of perceived therapeutic alliance in a broader sense within the community over the use of EFT. The primary objective of agreeing to participate in this research seems to have come from a wish to contribute to a study that might, in their opinion, support EFT and demonstrate its efficacy. That feeling was also replicated in me. It was such an ingrained part of my thinking prior to commencing this research that I had not recognised what a strong presence it has not only in my, but also in other practitioners' thinking about EFT.

Although I believe that most respondents do not consciously see it as an element affecting the therapeutic alliance when they are working with their clients, it may well have an effect. For example, if a therapist believes they are employing a modality with which to work with clients that may be regarded by other therapists as ineffective, or worse, suspect, this may create a pressure on the therapy to be helpful to the client. This also may have implications beyond the effect that lack of credibility would have on therapeutic alliance. Although at the moment this is supposition, it seems important for EFT to gain some credibility as a therapeutic intervention to limit the likelihood of it being used covertly.

Finally, it is an important theme because these therapists are already using EFT because they find it effective for their clients. Rather than finding their contributions to therapeutic thinking suspect because the method is mistrusted, if EFT had some credibility, its uses and effectiveness could be more fully investigated and this might be of benefit not only to the therapists and clients who already use it, but to those for whom it might be useful who may, as things currently stand, never use it.

Chapter 7. Conclusions

The broad findings from this study support the assertions that therapists who use EFT believe it strengthens the therapist-client alliance but are often unclear about what alliance is. An unexpected finding was that therapists who are also EFT practitioners experience an urgency around obtaining more widespread approval from governing bodies about EFT's efficacy.

Thinking back to the client work from which the research question arose, I concluded that something may have changed within the alliance between us, particularly within the task element (Bordin, 1979) of that bond. If the tasks of therapy – in this case, EFT – lead to the client's and therapist's agreed goal (in this case, that the client can feel better and manage his day-to-day emotional life more independently and easily) then perhaps something had happened in the execution of the tasks that threatened the bond. Whilst this was my bias at the outset of the work, my thinking about the therapeutic alliance and how my conception of it developed in trying to define it, with regard to this particular client and our use of EFT, has changed to include considering whether we were, in fact, in agreement about the goal or whether there was a transference neurosis in operation of which I had been unaware. If there was a transference neurosis being enacted, then it certainly seems possible that it was there before the EFT work began, and existed throughout the therapy, including the sessions in which we used EFT. He may have been experiencing a negative therapeutic reaction which I can only guess at now; however, what seems more certain is that we were not fully aligned.

Therapists in this study who use EFT at least sometimes in their work believe, and sense in the therapy room, that EFT strengthens the bond between them and their client. This occurred on a physical level when therapists experienced a physical mirroring of client symptoms of distress. It also occurred on a cognitive and emotional level when therapists felt what they believed their clients were also feeling – emotions such as sadness, anger and anxiety were all named. Both of these experiences of mirroring brought the therapists to believe that they were strengthening the bond, and therefore the alliance, with their clients. However, the majority did not use only EFT, which suggests that in some cases it may not strengthen the therapeutic alliance, or indeed may threaten it.

The participants also struggled with the conceptualisation of what the alliance is. Because they found it difficult to put the concept into words, they named the factors that contribute to the alliance: safety, ease and control for the client were all cited repeatedly. They spoke about how these common factors helped them and their clients form a working alliance. Though less frequently, participants said that they had never been aware in their work of being unable to form a working alliance with a client, whether while using EFT or not. However, this raises the question of whether, if respondents could not define the therapeutic alliance, they were able to identify the common factors that lead to the therapeutic alliance and not the alliance itself.

7.1 Quality of this research

Against the COREQ checklist (Appendix 6) which was used in planning this research, almost all the points outlined on the COREQ were achieved. There were some exceptions, however, that are worthy of mention. Item 18, repeat interviews were not performed. The decision not to use repeat interviews came about because although principally they would have been used in this research to seek clarification about points that were raised in the initial interview (Vincent, 2013), they also represented an opportunity to strengthen the relationship between myself and a participant (Vincent, 2013) which I believed might impact my ability to evaluate their original contribution to the research. It was difficult to separate my views from participants' in the analysis of the interviews; I did not want to risk further enmeshing my views with theirs and perhaps make it more difficult to analyse this phenomenon.

The other item from the COREQ checklist which was not met was item 28, whether participants had provided feedback on the findings. Participants have not yet been offered this opportunity. However, they have all been informed that if they wish to read this document when it is completed, I will inform them of its completion and send them a copy of it. My justification for not showing participants the analysis chapter, for example, was that in the face of the urgency participants experienced around producing evidence to support EFT's efficacy, participants might wish to dispute the analysis or influence the findings. Ava's query about how this research would help EFT suggested to me that participants might wish to have more influence on how EFT is seen and might alter their original comments to reflect that.

Appendices

Appendix 1: CASP

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Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference: .....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

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4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

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6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

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8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix 2: Information and consent form

Participant Information and Consent Form

Before you decide to take part in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with someone else if you wish. Caroline Nairn, the researcher, can be contacted on 01730 776121 if there is anything that is not clear of if you would like more information.

Name of the research project:

From the Outside In: Incorporating the use of EFT into traditional psychotherapeutic approaches to mental health care

Purpose of the study:

This study is seeking to understand how EFT is incorporated into psychotherapeutic practice by the clinicians who use it in their work. The study will be completed by September 2018.

You have been approached to participate in this study because you are a recognised psychotherapeutic practitioner who uses EFT in their work with clients. I am interested in finding out how you use EFT within your practice and particularly how you believe the use of EFT impacts the therapeutic alliance and relationship.

I am seeking your own views, opinions and if appropriate any experiences you wish to relate about this, and there are no wrong answers or assertions.

Taking part:

Taking part in this study is entirely voluntary. Withdrawal from participation will involve no penalty or loss, now or in the future. Should you choose to withdraw, this will be possible up until submission of the work for approval for the DClinPrac degree at Exeter University.

It is expected that the final manuscript will include verbatim extracts from semi-structured interviews recorded over Skype. All comments will be anonymous and your identity will not be revealed – nor will it be possible to identify you from the comments you have contributed. Raw, un-edited transcripts of interviews will only be seen by Caroline Nairn and her supervisors.

It is expected that participation in this study will *not* cause distress to participants; however, if you experience distress as a result of participation, I will offer you extra time following the interview in which to de-brief.

What will happen:

The data will be collected by means of semi-structured interviews, conducted over Skype. The interviews will be audio-recorded and from the recording a transcript will be produced. All information in the recordings and the transcripts will be held securely. There will be one Skype interview per participant of a duration of 60-90 minutes, and certain commentary may require later verification and clarification (which will be conducted by email). All recordings and transcripts and other data collected will be destroyed upon completion of the research and final acceptance for the degree by Exeter University. All recordings, transcripts and any other commentary by email will be identified by a numerical code and will not be used nor made available for any further purposes than this research project.

Ethical Approval

This project has received ethical approval from the College of Life Sciences ethics committee at the University of Exeter.

Consent:

Working title of the research project:

From the Outside In: Incorporating the use of EFT into traditional psychotherapeutic approaches to mental health care

- *I confirm that I have read and understand the Participant Information Sheet*
- *I have had the opportunity to ask questions and had them answered*
- *I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified (except as might be required by law)*
- *I agree that data gathered in this study may be stored anonymously and securely*
- *I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.*
- *I agree to take part in this study*
- *I confirm that I have a recognized counselling, psychology, psychotherapy or psychiatry degree*
- *I confirm that I work with clients seeking psychotherapeutic support*
- *I confirm that I use EFT in my work with some or all of my clients*

Participant's signature:

Participant name (printed or typed):

Date:

Best telephone number to contact you on if necessary (I am not anticipating having to contact you by telephone):

Skype address:

Email address:

Should you have any complaints about any aspect of this study, in the first instance, please contact the researcher, Caroline Nairn on either can209@exeter.ac.uk or 01730 776121.

In the second instance, please contact Caroline Nairn's research supervisor, Dr Jean Knox on J.M.Knox@exeter.ac.uk

If the matter is not satisfactorily resolved, please contact the programme director, Dr Richard Mizen, on R.F.Mizen@exeter.ac.uk

Appendix 3: List of participants by pseudonym

Name	Gender	No of clients per week	Works in NHS or private	Therapist first	Age group:
Emma	Female	15	Private	No	40-50
John	Male	3	Private	Yes	30-40
Olivia	Female	3	Private	Yes	50-60
Liam	Male	20	Private	Yes	40-50
Sophie	Female	8	Private	Yes	50-60
Ava	Female	10	Private	Yes	60-70
Isabelle	Female	11	NHS	Yes	50-60
Ben	Male	5	Private	Yes	50-60
Michael	Male	10	Private	Yes	70-80
Abigail	Female	10	Private	Yes	40-50
Charlotte	Female	9	Private	Yes	40-50
Elizabeth	Female	17	Private	Yes	50-60
Victoria	Female	20	Private	Yes	50-60
Grace	Female	24	NHS	Yes	50-60
Deborah	Female	10	Private	Yes	50-60

Appendix 4: Table and explanation of literature review

1. Table of all works used in literature review

Author	Title	Year	Research topic
Lambert, M.	Implications for more outcome research for psychotherapy integration.	1992	Work on integration of psychotherapeutic methods (not EFT nor EP specific)
Mollon, P.	Psychoanalytic Energy Psychotherapy	2008	Energy psychologies and their use
Cook, J.S.	Apples Don't Fall Far From the Tree: influences on psychotherapeutic adoption and sustained use of new therapies.	2009	Examination of the uptake of new psychotherapeutic interventions by psychotherapists (not EFT nor Energy Psychology specific)
Williams, C., Dutton, D., & Burgess, C.	Communicating the Intangible: A Phenomenological Exploration of Energy Healing.	2010	Case study describing the use of Thought Field Therapy (TFT) and EFT
Mason, E.	Energy psychology and psychotherapy: A study of the use of energy psychology in psychotherapy practice	2012	EFT and other energy therapies and their use in psychotherapy as experienced by psychotherapists
Gaudiano, B., Brown, L., & Miller, I.	Tapping their Patients' Problems Away? Characteristics of Psychotherapists Using Energy Meridian Techniques	2012	Characteristics of psychotherapists who use EFT and other energy meridian techniques
Shannon, E.	The Marriage Between Traditional Psychology and Tapping.	2012	Recorded interview with a psychologist who uses EFT and her approach to integrating it into therapy
White, I.	It helps me to love my work; An Interpretative Phenomenological Analysis of the senior therapist experience of using energy psychology in psychotherapy for trauma.	2014	EPs and their use in work with traumatised clients
Fife, S. W., et al.	The Therapeutic Pyramid: A Common Factors Synthesis of Techniques, Alliance and Way of Being	2014	Work on therapeutic alliance within different psychotherapy interventions
Fogel	Killing Me Softly	2014	Article detailing a case study with use of EFT
Nichols, L.	The Use of Mind-Body Practices in Counseling: A Grounded Theory Study	2015	Study of the use of complementary therapies in counselling and impact on therapeutic relationship
Bennett, M.	A Thematic Analysis of the use of Emotional Freedom Techniques (EFT) as a self-care tool in trauma therapists	2016	Use of EFT by therapists to support themselves in their work with traumatised clients
Feinstein, D.	A Survey of Energy Psychology Practitioners: Who They Are, What They Do, Who They Help	2016	Survey results from the membership of ACEP

2. Works that specifically addressed EFT

Mason, 2012

Bennett, 2016

Williams, et al., 2010

Feinstein, 2016

Gaudiano, et al., 2012

Fogel, 2014

Shannon, 2012

3. Work that addressed EP, but not EFT specifically

White, 2014

Mollon, 2008

Williams, et al., 2010

Feinstein, 2016

Gaudiano, et al., 2012

4. Works that did not address EFT or EP directly

Lambert, 1992

Fife, et al., 2014

Nichols, 2015

Cook, 2009

*Note: some of the work listed above appear in more than one category because they fit the criteria for both.

Appendix 5: List of questions posed to participants in the conduction of the semi-structured Skype interviews:

Confirm that participant has a recognised therapy training?

Confirm that participant has read and understood the consent form?

Confirm that participant uses EFT sometimes in practice?

How many clients does participant work with (on average) in a week?

1. Why do you choose to use EFT as part of your approach to psychotherapy?
    - What about EFT appeals to you?
    - What about EFT seems to appeal to your clients with whom you use it?
    - What do you not like about EFT?
    - What do you believe your clients may not like about it, if you are aware of whether they don't like the treatment approach?
    - Does the use of EFT change your working relationship with the client?
    - Is there any difference in using EFT to using talking-only therapy?
    - Do you sense or know whether EFT changes aspects of the working relationship for the client?
2. How do you decide when and with which clients to introduce EFT?
    - Is EFT something you introduce (at least the idea of it) within the first session?
    - Are there particular clients who approach you seeking EFT-only treatment?
    - Are there particular clients with whom you choose not to use EFT – on what basis do you make this decision?
    - How often do you use EFT with clients (every session, occasionally, only with particular difficulties)?
    - What symptoms are best addressed with EFT use?
    - What symptoms are worst addressed with EFT use?
3. In your experience of using EFT and psychotherapy, how has EFT use affected the therapeutic alliance?
    - What is your understanding of the therapeutic working alliance?
    - If EFT was introduced after the establishment of a therapeutic working alliance, what was your experience of any change of the therapeutic working alliance after beginning EFT work?

- If EFT is introduced after the establishment of a therapeutic working alliance, what was the quality of the alliance prior to EFT use?
- What was the quality of the therapeutic working alliance after EFT use?
- How do you view yourself, within the working alliance, during EFT use?
- How do you view yourself within the working alliance when not using EFT?

Appendix 6. Table of frames and sub-frames

Overarching frameworks	Themes	Coding
Practitioner understanding of the therapeutic alliance	Practitioner understanding of TA generally	Qualities needed in relationship Therapist role Client role Communication between therapist and client
Effect of EFT use on the therapeutic alliance		Same as in talking therapy Different to talking therapy Therapeutic alliance can be established through use of EFT Therapeutic alliance improved by EFT use – strengthened, deepened
	How/when is EFT used in working with clients	When EFT is introduced Introduced in first session How is EFT introduced Frequency of use over course of therapy Therapeutic alliance must be established before EFT use Therapeutic alliance can be established through EFT use Introduction of EFT not about therapeutic alliance Therapist giving client something
Practitioner likes and dislikes of EFT and how that may affect therapeutic alliance	Qualities of EFT as a modality	Efficacy Gentleness Speed Anomalies Tool clients can take away
	Participant use of EFT	Participant self-use/discovery of EFT EFT not a standalone therapy
	What is EFT good for	Depression, anxiety, trauma, phobias, other symptoms
	Perceived client likes about EFT	client surprise speed efficacy tool clients can use at home
	Anomalies about practitioner likes about EFT	Spiritual beliefs Physical element of EFT
	Practitioner experience and opinion about limitations of EFT	EFT not accepted by NICE EFT protocols inconsistent EFT use not widespread Over-selling of EFT Prejudice against EFT

	What is EFT not good for	Symptoms/difficulties not suitable for EFT work
	Perceived client dislikes about EFT	Embarrassment at use Clients don't want to use EFT
Reflexive observations		Collusion with participant Participant worry about answering questions 'correctly' Participants commenting on researcher stance in interviews Researcher anxiety about the interviews Researcher frustration in interviews Researcher bias about lack of NICE approval for EFT

Examples of quotes for coding:

Framework	**Code**	**Example quote:**
Practitioner understanding of TA generally	Qualities needed in relationship	*'*I believe that you have to be … genuine, caring … and that they have to be able to see that you're genuine and caring … and that you're not just … mainly teaching them a technique' *Grace, lines 273-276*
Practitioner understanding of TA generally	Same as in talking therapy	'It was just a given so you're with a person, you do have that connection, work together and I've never given it a lot of thought', *Emma, lines 546-547*
Effect of EFT use on TA	TA improved by EFT use	'usually I think it would enhance and deepen the therapeutic alliance …', *Michael, lines 206-211*
Effect of EFT use on TA	When EFT is introduced	'I'll bring in EFT quite soon after the beginning of the session', *Olivia, lines 311-316*
Practitioner likes and dislikes of EFT and how that may affect therapeutic alliance	Gentleness of EFT	'I'll quite often use it [EFT] as a run-up to EMDR [be]cause it's a gentler version' *Deborah, lines 49-51*
Practitioner likes and dislikes of EFT and how that may affect therapeutic alliance	Efficacy of EFT	'the difference is um the therapy becomes um much more effective er when using EFT', *Michael, lines 59-61*

Reflexive observations	[Researcher] Collusion with participant	‘when I came back and brought it [EMDR] back to my clients I felt like … it it it was *patchy* about whether or not it worked and it sort-of seemed to depend on the level of trauma and the complexity of the trauma’ *quote from the researcher in lines 785-787 of interview with Liam*
Reflexive observations	Researcher anxiety about the interviews	**‘**Well um you're the first interview, so I'm a little bit nervous’, *quote from the researcher in line 17 of interview with Emma*

Appendix 7: COREQ Checklist

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the inter view or focus group?	
Duration	21	What was the duration of the inter views or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

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