A Thematic Analysis of the use of Emotional Freedom Techniques (EFT) as a self-care tool in trauma therapists

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ABSTRACT

The aim of this study was to investigate the use of EFT (Emotional Freedom Techniques) as a self-care tool by trauma therapists. Professionals working with trauma are subject to deleterious effects such as compassion fatigue, vicarious traumatisation and burnout. EFT is an innovative therapeutic and self-help tool, combining the use of acupressure point stimulation with mental focus on, and verbalisation of, the distressing issue. Empirical research supports the efficacy of EFT for a range of conditions including post traumatic stress disorder, anxiety and depression. Thematic Analysis was used to analyse the data collected from semi-structured interviews with 8 experienced trauma therapists who are also EFT practitioners. The main findings of the study are: (a) EFT may act as an 'inoculation' agent, protecting the therapist from the effects of client's traumatic material during sessions; (b) EFT is a useful stress management and emotional regulation tool for therapists in their personal and work life; (c) the use of EFT may contribute to enhancing levels of compassion satisfaction in therapists.

DECLARATION

The work is original and has not been submitted previously in support of any qualification or course.

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LIST OF ABBREVIATIONS

ACA	American Counselling Association
ACE	Adverse Childhood Experiences
APA	American Psychological Association
ASD	Acute Stress Disorder
BABCP	British Association of Behavioural and Cognitive Psychotherapists
BPS	British Psychological Society
EFT	Emotional Freedom Techniques
EMDR	Eye Movement Desensitisation & Reprocessing
ISSTD	International Society for Study of Trauma & Dissociation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NET	Narrative Exposure Therapy
NLP / NLPt	Neuro Linguistic Programming / Neuro Linguistic Psychotherapy
PTSD	Post Traumatic Stress Disorder
TFT	Thought Field Therapy
UKCP	United Kingdom Council for Psychotherapy

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1. INTRODUCTION

Therapists working with psychological trauma are subject to stress-related conditions, including burnout, compassion fatigue and vicarious traumatisation (Canfield, 2005; Craig & Sprang, 2010; Figley, 1995; Pearlman & Saakvitne, 1995; Radley & Figley, 2002), which potentially impact on their ability to offer safe and effective treatment to their clients (Sommer, 2008). Therapists' ability to look after their own emotional, psychological and physical health is considered an important part of ethical and reflective practice by all major professional organisations (UKCP, 2009; BACP, 2016; HCPC, 2016). It is widely recognised that it is essential for all workers in the field to have a good level of self-awareness and a varied toolkit in taking responsibility for their wellbeing, and range of stress management and other self-care approaches has been recommended in the literature to help protect mental health professionals against deleterious effects of trauma work (Figley, 2002; ITSS, 2016; Richards, Campenni, & Muse-Burke, 2010; Rothschild & Rand, 2006).

This study investigates an innovative therapeutic and self-help tool, Emotional Freedom Techniques, that offers potentially valuable approach for self-care in trauma therapists. The is a growing volume of research on its efficacy for post-traumatic stress (Sebastian & Nelms, 2016), anxiety (Clond, 2016) and depression (Nelms & Castel, 2016), however this is the first empirical study of the use of Emotional Freedom Techniques in the area of therapist self-care.

2. LITERATURE REVIEW

The literature review will focus on three main themes offering the necessary background information, and underpinning the rationale for carrying out this research project: 1) Effects of working with psychological trauma, 2) Therapist self-care, 3) Introduction to the Emotional Freedom Techniques.

2.1. Effects of working with psychological trauma

The term “psychological trauma”, in the narrowest sense, can be defined as a set of symptoms satisfying the DSM-5 criteria for post traumatic stress disorder (PTSD) (Appendix 1) or acute stress disorder (ASD) (American Psychiatric Association, 2013), and, with the more recent understanding of the profound impact of early and/or multiple traumatic experiences, the term would also encompass van der Kolk’s proposed criteria for developmental trauma disorder (2005), and the diagnostic category of complex post traumatic stress (Busutill, 2009) which is due to be included in the next edition of ICD-11.There are ongoing discussions on whether other distressing sets of symptoms such as those linked with personality disorders (van der Kolk, Hostetler, Herron, & Fisler, 1994), as addictions (Khoury, Tang, Bradley, Cubells, & Ressler, 2010) and eating disorders (Johnson, Cohen, Kasen, & Brook, 2002) are correlated with childhood trauma, even though no conclusive causal links have been proven. It should be noted that certain life events may produce sets of symptoms which may not fully fit within the scope of narrow diagnostic categories but nevertheless still have profound negative physical and psychological effects, as proposed in the Adverse Childhood Experiences (ACE)

studies (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998), and are potentially perceived and experienced as traumatic by the individual/and or their treating health professional. It is not surprising that mental health professionals who work with people who had suffered trauma and are witness to the the intense distress and sometimes harrowing stories, are can sometimes be profoundly impacted by their clients' experiences (Baird & Kracen, 2006; Canfield, 2005; Craig & Sprang, 2010; Figley, 1995; Pearlman & Saakvitne, 1995; Radley & Figley, 2002; Sommer, 2008).

Sabin-Farrell and Turin (2003) give a general definition of trauma work as "working with clients who have experienced traumatic events… and have subsequent psychological difficulties" (p. 451). In this study psychological trauma will be viewed in its broad sense rather than within the strict definition of PTSD. People in helping professions, and in particular those who support traumatised individuals, can themselves suffer a wide range of challenging symptoms as a consequence of the nature of their work (Refs. …). Some of the ways that these professionals can be affected are through suffering burnout (Maslach, 2003), compassion fatigue (Radley & Figley, 2002), or vicarious traumatisation (Baird & Kracen, 2006). A significant proportion of mental health professionals are believed to experience burnout due to the pressures of their employment (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2011). The term 'burnout' is not specific to trauma clinicians but is common in many professions; it is usually a slow-onset syndrome, with characteristics of emotional exhaustion, depersonalisation, reduced sense of accomplishment, and is typically caused by excessive demands of employment and the worker's environment, including long work hours, complex and challenging

clients, high workloads, lack of control, insufficient support (Maslach, 2003; Craig & Sprang, 2010; Morse et al., 2011).

Those clinicians who regularly engage with clients suffering from the effects of psychological trauma can experience further negative impact on their own health and wellbeing, potentially developing symptoms of compassion fatigue, also known as secondary traumatic stress (Figley, 2007, Craig & Sprang, 2009). The symptoms of compassion fatigue, are typically faster in onset than those of burnout, and can closely mimic symptoms of post-traumatic stress disorder, including hyperarousal, numbing, avoidance of people, situations and other triggers that may remind the worker of the client and their trauma, as well as re-experiencing symptoms such as intrusive images (Figley, 2002; Baird & Kracen, 2006). Helplessness, confusion and pre-occupation with the client are also typical features (Finley, 2002). Apart from professionals, compassion fatigue has been recognised in significant others such as family members, carers or friends (Figley, 1995; Lynch & Lobo, 2012).

Vicarious traumatisation, a term suggested by McCann and Pearlman (1990) has sometimes been confused with compassion fatigue/secondary traumatic stress. Baird and Kracen (2006) differentiate between these terms, by describing vicarious traumatisation in terms of negative changes in practitioners' schema related to safety, trust, self-esteem, intimacy and control, which relate to damaged perceptions of themselves, other people and the world due to the exposure to the information about client's trauma (Baird & Kracen, 2006). Vicarious traumatisation is likely to affect the worker's motivation, efficacy, and their levels of compassion towards clients (Baird & Kracen, 2006, Sommer, 2008) which has implications for the quality of the helping relationship and the service the client is likely to receive. Both compassion fatigue and burnout can be experienced on a number of

levels: physical, cognitive and emotional (Figley, 1995; Maslach, 1982). Vicarious traumatisation, whilst focusing on the changes in beliefs and cognitions, can also have consequences for the physical health and the emotional wellbeing of a therapist (Canfield, 2005; Sommer, 2008), and some authors emphasize the potential loss of meaning, and an impact on the spiritual dimension of an affected professional's (Canfield, 2005; Pearlman & Saakvitne, 1995). Stress-related conditions associated with working with traumatised clients are acknowledged by the International Society for Traumatic Stress Studies (2016) as important potential risks to mental health practitioners that require addressing.

It can be hoped that mental health professionals who are based in specialist trauma treatment services are more likely to have received trauma-specific training and education as part of their professional learning and development. They should be conversant with potentially harmful effects of working with individuals who had been traumatized, as well as take action to prevent this from happening, which should include supervision with a clinical supervisor experienced in trauma work (Sommer, 2008). However, it is important to note, that due to the likely high levels of under-diagnosis of PTSD (Miele & O'Brien, 2010; Wimalawansa, 2013) therapists, counsellors and other mental health professionals of any theoretical orientation, specialisation or level of experience, working in almost any context or setting are likely to come across traumatised clients who may initially be referred with issues of depression, substance misuse or unexplained physical symptoms (Brady, Killeen, Brewerton, & Lucerini, 2000; Wimalawansa,2013). Some studies suggested that 95% of psychiatric outpatients have experienced traumatic events and around 43% have PTSD (Mueser, Trumbetta, Rosenberg, Vivader, Goodman, Osher, et al., 1998; Switzer, Dew, Thompson, Goycoolea, Derricott, & Mullins,

1999). This underlines the importance for all counsellors, psychotherapists and psychologists to have good awareness of PTSD and psychological trauma, and the potential effects of undertaking therapeutic work with trauma sufferers on their own health, wellbeing and efficacy.

Trauma work presents both its own rewards and its challenges, and potential risks of engaging with highly distressed and traumatised people have been described and highlighted not only in the context of psychotherapy and mental health, but also in other settings where professionals engage with individuals suffering severe psychological distress. For example some of the professions who might regularly encounter individuals who have or who are experiencing trauma are emergency services personnel (Eriksson, Kemp, Gorsuch, Hoke, & Foy, 2001), social workers (Figley, 1995; Osofsky, Putnam, & Lederman, 2008; Radley & Figley, 2007), professionals within the criminal justice system (Osofsky et al., 2008), counsellors and psychotherapists (Canfield, 2005; Craig & Sprang, 20 Figley, 2002; Sommer, 2008).

A number of different factors have been suggested as increasing the likelihood of deleterious effects in trauma therapists. For example, having a larger number of traumatised clients within a caseload (Chrestman, 1999) within a caseload can has a potential to increase the chances of the therapist experiencing the impact of compassion fatigue or vicarious trauma. Additionally, the type of trauma presented by individuals may also be a factor, for example, those therapists who regularly hear stories of sexual violence may be more likely to be traumatised (Pearlman & MacIan,1995; Shauben & Frazier, 1995). Furthermore, Woodard Meyers and Cornille (2002) identified that professionals employed in the field for longer, and those working over 40 hours per week showed high levels of trauma symptoms, and in

females these effects were greater than in males. Additional factors that may increase the risk of stress-related conditions in therapists and other professionals, previous unresolved trauma, lack of control over work stressors, low levels of work satisfaction, unresolved previous trauma, lack of personal and professional support (Figley, 1995).

Whilst many authors focus on the difficulties that may arise from working with clients suffering trauma, some positive consequences have also been described. In particular, the prospect of 'vicarious resilience' has been observed in some empirical studies. This relates to the enhancement of self-efficacy, empowerment and coping skills in therapists (Hernandez, Gangsei, & Engstrom, 2007) and is one of the possible positive consequences of working therapeutically with traumatised individuals, who with support, grow through their experience and become more resilient as a result. Additionally, the notion of 'vicarious post-traumatic growth' has also been proposed, which is a term that refers to the, adaptive integration of client's traumatic material leading to improved perception of self and other people in the therapist (Arnold, Calhoun, Tedeschi, & Cann, 2005).

Given the high likelihood for therapists and counsellors in any setting to come across clients who are traumatised, it is important to consider the protective factors that can mediate potential negative impact, and in particular the self-care practices that are considered important in mediating the effects of working with trauma (Figley, 2007; Sommer, 2008).

2.2 Therapist self-care

It can be recognised that counsellors and therapists who are unwell, stressed or overwhelmed may be unable to offer the best level of service to their clients, and thus the effectiveness of therapy is likely to be impaired (Figley, 2007; Lawson, 2007; Morse et al., 2012; Regan, 2013). Hence, a therapist's ability to reflect on, and take responsibility for their own health and wellbeing is an important component of professional and ethical practice. This aspect of practice is also emphasised in the ethical codes of major psychotherapeutic and counselling associations, including the United Kingdom Council for Psychotherapy (UKCP, 2009), the British Association for Counselling and Psychotherapy (BACP, 2016), and the Health and Care Professions Council (HCPC, 2016), and the American Counselling Association (2005).

Self-care is a very significant aspect of a trauma therapist's personal and professional development (Eastwood & Ecklund, 2008; Rotschild & Rand, 2006; Wilson & Lindy, 1994). Inadequate self-care, including poor boundaries and not looking after own physical or emotional needs, has also been identified as one of the factors contributing to compassion fatigue and vicarious traumatisation (Figley, 1995; 2002; Canfield, 2005; Sommer, 2008) and conversely, mindful self-awareness and holistic self-care have been linked with enhanced levels of resilience in therapists (Harrison & Westwood, 2009).

Four main components of counsellor self-care have been identified by Richards, Campenni & Muse-Burke (2010) with the four different aspects including physical, psychological, spiritual and support. Physical self-care involves the basics essential for body's health, including rest, appropriate nutrition and exercise (Richards, Campenni & Muse-Burke, 2010; ISTSS, 2016). Psychological self-care includes a wide range of skills and aptitudes, such as the self-awareness, the ability to reflect

on own thoughts, feelings and sensations; understanding of own trauma history and awareness of triggers, skills in lowering hyperarousal, emotional regulation; recognition of unhealthy coping strategies, willingness and ability to make time for rest and play (Figley, 2002; ITSS, 2016; Richards, Campenni, & Muse-Burke, 2010; Rothschild & Rand, 2006). Psychological self-care may also involve seeking out professional help which may be necessary to process[1] some of the effects of working with traumatised clients (Figley, 2002; ISTSS, 2016). Spiritual self-care involves activities connected to the individual's meaning and purpose, a connection to something higher than self (ISTSS, 2016; Kushner, 2002), and may include activities such as prayer, meditation, self-compassion practises, contemplative practices and acts of worship (ISTSS, 2016; Patsiopoulos & Buchanan, 2011). Support elements of self-care could include the therapist making and maintaining both personal and professional connections with others, including friends, family, colleagues, peers and supervisors (Coster & Schwebel, 1997; Figley, 2002; ISTSS, 2016). Counsellor education and professional development can also be considered a vital part of their ability to care for themselves, including teaching to raise awareness of vicarious traumatisation and compassion fatigue (Figley, 2002; ISTSS, 2016; Sommer, 2008). With regards to specific aspects of therapist training, Sommer (2008) recommends teaching skills such as breath work, progressive muscle relaxation and use of guided imagery, as part of essential education for trainee counsellors and therapists. Additionally Rothschild and Rand (2006) draw attention to skills such as awareness of body language in self and client and protective distancing techniques involving visualisation of some form of protective shield for the therapist.

[1] This may involve processing the memories of the professional witnessing client's distress or hearing their stories, using an evidence-based trauma treatment approach, typically when fragments of such memories have an intrusive or highly distressing nature

Good quality clinical supervision is thought to be essential in helping prevent vicarious traumatisation and compassion fatigue in psychotherapists and counsellors, where the personal and professional qualities of the supervisor are a significant factor: these include understanding of psychological trauma, non-defensive stance, their ability to work with counter-transference and to create a safe space for exploration and challenge (Sommer, 2008; Walker, 2004).

The concept of compassion satisfaction relates to the positive affect experienced by the worker in as a result of supporting the client (Craig & Sprang, 2010; Figley, 2002; Radley & Figley, 2007), in observing reduction in their suffering and moving away from the role of victim to that of the survivor, which is believed to act in a protective way against compassion fatigue. Radley & Figley (2007) have identified that compassion satisfaction, apart from involving pleasure and other positive emotions derived from helping clients, is also underpinned by good self-care and access to resources, including social support, as well as the individual's skills in managing stress. Figley (2002) summarised: “Stress management and self-soothing techniques are critical for surviving modern work.. it is vital to be able to gain mastery of distress” (p.1440). Given the ubiquitous nature of psychological distress and the potentially deleterious effects on professionals’ own health as well as their ability to provide the best service, every professional working with people who have been traumatised must have a toolbox of effective self-care strategies, self-soothing and stress management techniques. Among many different approaches used by trauma therapists for self-care, Emotional Freedom Techniques (EFT), also known as "tapping therapy", is now gaining greater recognition and appreciation for its ease of application and efficacy in soothing negative affect.

2.3. **Emotional Freedom Techniques**

Emotional Freedom Techniques[2] (EFT) is a set of therapeutic and self-help protocols developed by Gary Craig (1997; 2011), based on a simplified protocol of Thought Field Therapy (TFT), also known as the Callahan Technique (Callahan, 1996). The basic protocol involves tapping with fingertips on a series of specific acupressure points (Fig.1), combined with direction of attention to the issue that is troubling the client and, typically, verbalisation of this issue. EFT and TFT, together with a number of similar approaches using percussive tapping or other forms of stimulation of acupressure points in combination with mental focus on the presenting issue or its aspects, are grouped into a larger category of energy psychology (Gallo, 1999). Over the years EFT gained a significantly higher popularity and is now more widespread, partly due to the simpler protocol and ease of teaching both practitioners and clients on how to apply the technique. Faster dissemination of EFT was assisted by Craig making his EFT manual available for free on his website, and subsequently other practitioners sharing large volume of free online information for self-help purposes.

Fig 1. Location of EFT acupressure points on head, torso and hand

Top of the head

Eyebrow

Side of eye

Under eye

Under nose

Chin

[2] The convention is to use the plural Emotional Freedom Techniques when written in full, as per Craig's original manual, even though when used as an acronym EFT is usually treated as singular

Collar bone

Under arm

Thumb

Index finger

Middle finger

Ring finger

Little finger

Side of palm

EFT is currently the most widely used of all energy psychology approaches (Nelms & Castel, 2016). Both Callahan and Craig have explained the mode of efficacy of their respective techniques using the model of ‘energy’ or ‘chi’ as in the Traditional Chinese Medicine. Callahan believed that perturbations in the energy of the ‘thought field’ are the cause of psychological and emotional difficulties (Callahan, 2001). The concept of the 'thought field' echoes that of purported ‘morphogenetic fields’, described by Sheldrake (1999) as “self-organising fields of influence, analogous to magnetic fields and other recognised fields of nature” (p.258). Both Callahan and Craig hypothesised that tapping on acupressure points helps to alleviate the disturbance in the energy field and restore the natural flow in the meridians[3],

[3] Meridian - a channel or pathway through which life energy or chi flows, according to Traditional Chinese Medicine

which in turn has a beneficial effect on emotional and mental wellbeing (Craig, 1997; Callahan, 2001).

Many practitioners using energy psychology, including those who do not subscribe to the "energy" model, anecdotally report their clinical observations that tapping on EFT acupressure points often produces a surprisingly rapid calming effect in clients who are highly distressed and hyperaroused (Bennett, 2012). However the precise mechanism of such dramatic change has not yet been established, even though a number of theories have been proposed. The concentration of mechanoreceptors in the skin areas correlating with acupressure points is said to be higher than in the adjacent areas of skin (Feinstein, 2008), and the stimulation of the acupuncture points appears to impact on the limbic area of the brain (Hui, Liu, Makris, Gollub, Chen, Moore et al., 2000; Chae, Chang, Lee, Jung, Lee, Jackson et al., 2013), which could be acting in down-regulating the amygdala and thereby interrupting the fight-flight-freeze response. Whilst needling appears to have a stronger effect in down-regulating the activity of amygdala and other limbic structures than tactile stimulation of the points (Chae et al., 2013), it appears that tapping EFT acupoints with fingertips also produces similar effects.

Parallels have been drawn between EFT and a number of other therapeutic interventions by a number of authors. Its similarities (and compatibility) with Eye Movement Desensitisation and Reprocessing (EMDR) have been described by Hartung and Galvin (2003) and Mollon (2005), in that both bilateral stimulation in EMDR (eye movements, bilateral tapping or sounds) and acupressure tapping in EFT, involve dual attention on the presenting issue (memory, symptom or a trigger) and an external stimulus. One small randomised controlled trial comparing EFT and EMDR for post traumatic stress suggested that these two approaches both produce

significant effects post-treatment and on follow-up (Karatzias, Power, Brown, McGoldrick, Begum, Young, et al., 2011). Kalla and Stapleton (2016) have hypothesised that EFT can facilitate memory reconsolidation in trauma, similarly to that in other trauma-focused approaches, such as cognitive behavioural therapy (CBT) and narrative exposure therapy (NET), and comparisons of EFT with these well-established treatments for trauma have shown outcomes similar to CBT (Nemiro & Papworth, 2015) and NET (Al-Hadethe, Hunt, Al-Quasi, & Thomas, 2015).

There has been a growing volume of research on using EFT for a range of conditions, especially post-traumatic stress, with examples of populations where it showed promising results including military veterans (Church, Hawk, Brooks, Toukolehto, Wren, Dinter, & Stein, 2013; Church, Yount, Rachlin, Fox, & Nelms, 2016); survivors of road traffic accidents (Swingle, Pulos, & Swingle, 2005); Congolese female refugees who have suffered sexual violence (Nemiro & Papworth, 2015), civilian war survivors in Bosnia (Boath, Stewart, & Rolling, 2014), Iraqi students (Al-Hadethe et al., 2015), abused adolescents (Church, Piña, Reategui, & Brooks, 2012), and Haiti earthquake survivors (Gurret, Caufour, Palmer-Hoffman, & Church, 2012).

Additional applications of EFT that have been investigated include management of physical symptoms such as frozen shoulder pain (Church & Nelms, 2016) and seizure disorders (Swingle, 2010); treatment of small animal phobias (Wells, Polglase, Andrews, Carrington, & Baker, 2003; Baker & Siegel, 2010); reducing performance anxiety in students (Boath, Stewart, & Carryer, 2013; Sezgin & Özcan, 2009), and managing food cravings (Stapleton, Sheldon, & Porter, 2012; Stapleton, Bannatyne, Porter, Urzi, & Sheldon, 2016). Large treatment effects were shown in recent meta-analyses of EFT for post-traumatic stress (Sebastian & Nelms, 2016), as well as

anxiety (Clond, 2016) and depression (Nelms & Castel, 2016). With symptomatology of these conditions echoing the effects of vicarious traumatisation, compassion fatigue and burnout, it could be hypothesized that EFT may be a helpful intervention for mental health professionals affected by these conditions. As the basic EFT protocol was originally designed by its developer Craig (1997) to be a simple and easily accessible self-help tool, its use for self-care purposes by professionals subject to stress-related conditions appears to merit more consideration.

With the rising volume of research on EFT and energy psychology, the majority of published studies have been quantitative, and little qualitative research has been carried out. In recent years a small number of papers / dissertations have focused on qualitative investigation of therapists' experiences and views on using energy psychology and EFT in particular. These included Schultz (2009) using constant comparative method/grounded theory to investigate how energy psychology is integrated into treatment of childhood sexual abuse, Chalmers (2015) applying thematic analysis to describe experiences of EFT practitioners, and Mason (2012) and White (2014) employing interpretative phenomenological analysis to explore the use of energy psychology in psychotherapy practice. These qualitative studies have allowed a more in-depth description and understanding of therapists' perspectives on their use of these novel and sometimes controversial approaches, and have suggested that EFT and other energy psychology methods offer safe, gentle, quick and often transformational interventions for work with some of the most distressed and complex clients, as well as for the therapist's own personal development and healing.

Fig 2. EFT therapist typically taps on their own acupressure points simultaneously with the client

There are many anecdotal reports of EFT being used by therapists for self-care, and of its role in ameliorating stress symptoms in practitioners. The ‘Borrowing Benefits’ phenomenon observed in EFT, refers to an individual seemingly receiving indirect benefits by merely ‘tapping along' with another person who is stimulating the EFT acupressure points for themselves whilst focusing on a specific issue (Craig, 2008; Rowe, 2005; Church & Brooks, 2010; Palmer-Hoffman & Brooks, 2011). As EFT practitioners typically tap on their own acupressure points simultaneously with the client, as a way of demonstration and encouragement (Fig. 2), the opportunity for 'borrowing benefits" for the therapist arises in any session where EFT is used,

and it is not unusual to hear anecdotal reports of improvement in therapists' emotional and even physical state following a session where they have applied EFT. Mirror neurons have been tentatively hypothesized to play a role in the 'borrowing benefits' phenomenon (Church, 2013) though the mechanism of this is unclear and requires further investigation. Very little empirical research has been carried out on using EFT as a tool for self-care amongst therapists and other health and social care workers, with one relevant study looking at the range of symptoms in health professionals at several conferences who received a brief group EFT intervention (Church & Brooks, 2010); the results showed positive impact on symptoms of anxiety, depression, pain and cravings at 90 day follow up, and greater subsequent EFT use for self-help by participants use correlated with a greater decrease in symptom severity. Given the possible deleterious impact on trauma therapist's of their work, the promising outcomes of EFT for a range of stress-related conditions as well as the ease of its application as a self help-technique, point to the potential value of investigating whether it can be a helpful self-care tool for therapists working with traumatised clients.

2.4. Aim of the study

The aim of this study was to explore whether experienced EFT therapists who work with traumatised clients and are thus who are potentially subject to deleterious effects on their health and wellbeing, use EFT for self-care and in what ways.

3. METHODOLOGY

3.1. Personal statement

I have first encountered EFT approximately 12 years ago during the period of employment as a drug treatment manager in a women's prison. I have been using EFT since then in my therapy work with clients, including those who have experienced psychological trauma, in a wide range of settings, including addiction treatment services, community mental health resource centre, residential children's home, staff support team in one of the National Health Service trusts, health psychology service, an international development project in Sri Lanka, and in private practice. Initially I was very tentative in incorporating EFT into my work, despite many enthusiastic reports from clients and colleagues, as I was very skeptical with regards to the mechanism and efficacy of the EFT protocol, due to the shortage and inconsistency of scientific research evidence. However over the years this has become one of the major tools in my therapeutic toolbox, which, in addition to my original therapeutic modality, neurolinguistic psychotherapy (NLPt) (Bandler & Grinder, 1975; Wake, 2008), incorporates cognitive behavioural therapy (CBT) (Beck, 1979), eye movement desensitisation and reprocessing (EMDR) (Shapiro, 2001), Ericksonian hypnotherapy (Erickson & Rossi, 1979) and sandplay therapy (Kalff & Kalff, 2003). I currently work in private practice, specialising in trauma treatment, and whilst I do use EMDR and occasionally Trauma-focused CBT, which are the main therapeutic approaches recommended by National Institute for Health and Clinical Excellence for treatment of post traumatic stress disorder (NICE, 2005), I find EFT invaluable in processing traumatic memories and as an emotional regulation tool for clients. In addition to me using EFT in my therapy

practice, I also teach EFT skills to health professionals and general public in the UK and internationally.

EFT played a significant role in my own personal development and self-care: I have used it successfully to reduce my own anxiety in certain social situations and to address a number of negative beliefs that affected me in both personal and professional life. I also use it regularly for managing stress, anxiety, tension and any intense emotions, which helps me to remain calm and resourceful in potentially challenging situations. In addition to using it independently, I regularly swap EFT sessions with a "tapping buddy", where some of the deeper therapeutic work can take place. I have also used EFT as part of clinical supervision, with those of my supervisors who were also experienced with this technique, where it was helpful for enhancing my self-awareness and managing my responses to client's distress and any relational difficulties.

While conducting the semi-structured interviews as part of this study I found it challenging to confine myself strictly to the questions on the interview schedule, and sometimes felt the need to ask additional questions, e.g. for definitions of certain terms, or to elicit further details. I was conscious that extra questions I posed may have affected affect the participants' responses.

When beginning to write up the findings of this research project I was aware that my own practice of using EFT for myself and with clients, and my assumptions and expectations arising from these experiences, are likely to have had an influence on the way that I have identified the emergent themes within the collected data. The inclusion of information relating to my background and the use of EFT in my therapy and training practice has been in the service of aiding transparency .

3.2. Research question

The choice of research question was initially prompted by the researcher's experiences as a trauma therapist who regularly uses EFT in her practice, and is frequently exposed to distressing information shared by traumatised clients. It was observed by the researcher that when she used EFT for a significant part of the session with a client, she felt better, less tired, and sometimes energised afterwards, than on those occasions when talk therapy took most of the session. Such effect did not seem to be dependent on the level of complexity or intensity of distress expressed by the client during the session, or on whether traumatic material has been discussed. These observations led to the development of a hypothesis that EFT may have a protective effect on the therapist who is tapping along with the client. This echoes many anecdotal reports by EFT practitioners and seems to be related to the so-called ‘Borrowing Benefits’ phenomenon, which refers to the apparent positive effect of 'tapping along’ with someone else who is working on their issue with EFT (Church, 2013).

Additionally, the researcher found that when she used EFT for herself in between the sessions, she felt able to be more present and more mindful when with the clients. However, there has been no empirical research conducted on how EFT is utilised as a self-care tool by practitioners. It appeared that there could be value in investigating how EFT may be used by those therapists who regularly work with trauma, in view of the potentially damaging effects of such work and the significance of self-care as a protective factor against the development of compassion fatigue and vicarious traumatisation.

As a result of reflection on these topics and a discussion with colleagues, the research question was formulated as follows: “In what ways is EFT used as a self-

care tool by trauma therapists?". In order to answer this question, two main objectives were identified:

(1) To gather data on trauma therapists' views and experiences of using EFT as a self-care tool in the context of working with trauma clients.

(2) To identify key themes in how and when trauma therapists apply EFT as part of their self-care.

3.3. Participants

Eligibility criteria for participants were decided as follows:

(1) Experienced counsellors, psychotherapists and psychologists, either accredited with a professional organisation such as BACP, UKCP or BPS, or with at least 10 years of therapeutic experience.

(2) Trained in EFT to at least Level 2 of AAMET (Association for Advancement of Meridian Energy Techniques) or the equivalent.

(3) With at least 2 years experience of using EFT with traumatised clients as well as a self-care tool.

The exclusion criterion for participants who otherwise would have been suitable to take part in the project, was the experience of a personal trauma within the previous twelve months. This was important in order to minimise the risk of distress to the participants, and to protect them from potential triggers to their own trauma reactions. Whilst there was still a possible risk of earlier traumas being re-triggered, this exclusion served to reduce the likelihood of adverse reactions in participants. It was also decided to exclude those who were not fluent in English,

as it was not possible to make arrangements for professional interpreting during the interviews and due to the timescales and other constraints of this small project. The exclusion criteria were included on the information sheet sent out to those who expressed an interest in taking part.

Participants were recruited through advertisements on social media, email groups of EFT organisations in the UK, including the AAMET (Association for Advancement of Meridian Energy Techniques) and the EFT Guild, and at the EFT Gathering Conference.

Having decided on qualitative methodology and specifically Thematic Analysis (see sections 3.4 and 3.5), initially it was planned that ten participants would be recruited, however, of the 11 people who expressed interest, nine respondents completed the consent form, and of these, eight chose to go ahead with the interview.

All participants were experienced psychotherapists, clinical psychologists or counsellors, with between 10 and 30 years of experience of working in a therapeutic capacity. The core modalities used included person-centered counselling, cognitive behavioural therapy, integrative psychotherapy/counselling, transactional analysis, psychodynamic psychotherapy, neurolinguistic programming, and additional therapeutic skills included EMDR, Hellinger's Family Constellations, compassion focused therapy, mindfulness, hypnotherapy, guided imagery, Donna Eden energy practices (Eden & Feinstein, 2000), Reiki, and acupuncture. The types of psychological trauma the participants reported treating ranged from road traffic accidents and workplace bullying, through traumatic bereavement, domestic violence, developmental trauma, childhood abuse (sexual, physical, emotional and neglect), ritual abuse. Two of the participants had specialism in addiction

treatment, one in eating disorders, and three had previous experience of work with offenders within the criminal justice system. The participants reported using EFT for themselves and as a therapy tool with clients for between 2 and 18 years. The majority of participants worked in their private therapy practice, but two of them combined private practice with paid employment, and one was employed full-time in the National Health Service. The typical number of individual clients seen per week varied widely between different therapists and ranged from 2 to 20, with two of the participants also delivering group therapy as well as seeing individuals. The reported proportion of clients whom the therapists had assessed as suffering from trauma ranged from 50% to 100% of their caseloads.

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3.4. Epistemology and study design

One of the fundamental principles of the researcher's original therapeutic training in Neurolinguistic Psychotherapy is based on the pre-supposition that people construct their own reality (Bandler & Grinder, 1975; Wake, 2008). This places NLPt within existential-constructivist group of therapies. However in terms of the relationship with epistemology the researcher identifies more with critical realism, believing that whilst we may not be able to describe or understand the reality fully, it is still possible to identify and evaluate some aspects of reality.

Having had some experience of using quantitative methodology during previous studies in biological sciences, the researcher was initially considering employing the more familiar quantitative approach, and undertaking a survey of trauma therapists who use EFT. However, as a result of discussions with colleagues and the research supervisor, it felt important to approach this study from a qualitative angle, largely because this was going to provide richer and more in-depth data

which can be then systematically analysed. This would add value to the existing EFT research which is largely is based on small-scale quantitative studies. Additionally, qualitative methodology appealed as a challenge, in offering an opportunity to develop new skills in utilising methodology which was unfamiliar to the researcher. A mixed-method study was briefly considered at the beginning of the project, the potential appeal of which was the wide range of data that could be gathered on the topic through this type of approach (Cresswell and Zhang, 2009), however the additional complexity of the mixed-method approach could have potentially made this small study unwieldy in the available timescale.

The methodology used in this study was Thematic Analysis (Braun & Clark, 2006), discussed in more details in section 3.4. Semi-structured interviews were chosen as the method of collecting data for analysis. Other options available included focus group discussion, participant observation, and using texts for analysis. As it was probable that the number of participants who satisfied all the criteria would be limited, and they were likely to be spread widely geographically throughout the country, it did not appear practical to arrange a focus group with the aim of gathering data. Participant observation could have provided some fascinating and rich information, but would have been extremely time-consuming and impractical in the context of a small MSc level study. Utilising printed texts did not appeal to the researcher as it would have taken her away from personal interaction with people.

Having decided on interviews as the most appropriate option, a choice had to be made between structured, semi-structured and unstructured interviews, which vary in the level of direction that the interviewer can give to participants in inviting their participants' responses (Kienzler & Pedersen, 2007). It seemed most

appropriate to utilise semi-structured interviews because it was important to gather information on specific topics (such as the therapist's self-care and their use of EFT) in order to answer the research question, at the same time allowing the participants to talk freely on these and related points without constraints of a structured procedure was helpful in collecting data of greater depth and breadth.

3.5. Thematic Analysis

Having decided on qualitative methodology, the method of evaluating the collected data had to be selected. Thematic Analysis was chosen (Braun & Clark, 2006), with the main advantages of this methodology being its straightforward, accessible and flexible nature that is not tied to a particular theoretical framework (Braun & Clark, 2006; McLeod, 2011). Braun and Clark (2006) described thematic analysis as a foundational method in qualitative research and recommended it as a core skill for novice researchers, which seemed appropriate for the first experience in qualitative research in the case of this study. Thematic analysis enables the researcher to identify patterns within the collected data, analyse them, and capture significant themes (Braun & Clark, 2006), which appeared sufficient to satisfy the aims of this study, even considering the limitations of the method in producing simply a description rather than interpretation of data (O'Reilly & Parker, 2014).

In analysing the data gathered through semi-structured interview, the step-by-step guide to thematic analysis suggested by O'Reilley & Parker (2014) was followed, as summarised in Table 1. The coding was initially attempted electronically, by annotating the transcripts in the margins of the electronic files. This was later

changed to coding by hand on the margins of hard copies of transcripts, printed on coloured paper, followed by cutting out the coded sections and grouping them in relevant piles labelled as provisional categories and, eventually, themes. This felt a more stimulating and creative process for the researcher, and allowed a sense of flow and ease in transferring coded sections of transcripts between the 'piles' when exploring and identifying possible themes.

Table 1.

Thematic analysis step-by-step (adapted from O'Reilley & Parker, 2014).

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1. Clarifying the research question

2. Listening to the recorded interviews repeatedly, to familiarise myself more closely with the participants' experiences

3. Examining the transcripts, looking out for information that appears significant.

4. Beginning the coding process

5. First order coding: descriptive categorisation of all data, going through transcripts in detail

6. Second order coding: grouping some of the first order codes into larger categories

7. Third order coding: organising categories identified in the previous step into larger patterns or themes.

8. Identifying the themes that are most relevant to the research question.

9. Identifying sub-themes.

10. Start analysis of the data and address the research question.

3.6. Ethical issues

Ethical issues that had to be considered in preparation for and in conducting this study, included possible concerns about participants' emotional wellbeing, potential issues around professional boundaries, protection of confidentiality and anonymity of the participants, and issues relating to the collected data. Each of these areas has been discussed in more detail below.

Before the commencement of the research project, ethical approval was obtained from the University of Chester Department of Social and Political Science Ethics Committee. Additionally, as a registered member of the United Kingdom Council for Psychotherapy the researcher was committed to abide by their codes of ethics and professional conduct (UKCP, 2009) as well as the ethics guidelines for research in counselling and psychotherapy of the British Association for Counselling and Psychotherapy (Bond, 2004).

3.6.1. Emotional wellbeing of participants

It was important to consider that some of the topics discussed during the semi-structured interview may cause discomfort to the participants by reminding them of distressing client material they had encountered. With that in mind, participants were provided the details of support helplines, Samaritans, as well as the therapist directories of BACP and UKCP. [Appendix II].

Consideration was also given to the potential distress to the researcher, due to a possibility of hearing stories of traumatised clients. Whilst vicarious traumatisation is less common in researchers than in clinicians, International Society for Traumatic Stress Studies considers that it should still be taken into consideration when researching the subject of psychological trauma (Kennedy & Newman, 2005). Taking into account the extensive set of self-care skills of the researcher as well as access to an excellent professional and personal support network, this risk was considered to be minimal.

3.6.2. Professional boundary issues

It had to be acknowledged that some of the participants volunteering for the study may belong to the same professional organisations as the researcher, and may potentially include some former EFT students or supervisees, and hence there could be a risk that they may feel under pressure to participate. It was made clear in the information provided to interested individuals, that participation in the research project is completely voluntary, and they could withdraw from the study if they changed their mind (Appendix II). For those participants who volunteered where any cross-over of professional roles was identified (for example, one of participants was a former colleague, and two had attended training delivered by the researcher in the past), a discussion took place to clarify the boundaries of the study and the current roles of the researcher and the participant.

3.6.3. Confidentiality

Venues for the face-to-face interviews were arranged at participants' convenience, taking into consideration privacy of the room where each meeting took place, to ensure that the interview was not overheard. Issues around confidentiality for

Skype interviews were highlighted in the information sheet and verbally when arranging the online meeting.

The software used to audio record the interview was 'Simple Recorder'. Electronic files, including recordings and transcripts were stored securely and password protected. Any paper notes and hard copies of transcripts were stored in a locked filing cabinet, as was the computer containing the electronic data. In accordance with the University of Chester's Research Governance Handbook, a pseudonym was allocated to each participant to be used in the thesis, to replace the real names. In the case of this study, pseudonyms were chosen by participants. Other identifiable features, such as references to names and places mentioned during the interviews were anonymised, to reduce the risk of the participant's identity being recognised. For the purpose of transparency, the small risk of deductive disclosure was highlighted in the participant information sheet at the initial contact. Quotes from the interview used in this thesis were also anonymised, and only short extracts were used to minimise the small potential risk of the participants being recognisable through the contents of the quotes.

The participants were informed that the electronic files containing the data would be deleted after the research was written up, and that the hard copies of the data would be stored in a locked cabinet and then shredded after 5 years, in line with the University of Chester's Research Governance Handbook.

3.6.4. Consent

Gaining informed consent of the participants, and giving them a number of opportunities to confirm or withdraw their consent, is an important part of ethical research (McLeod, 2010). Each participant signed a consent form, agreeing to take

part in the study. They were informed that they had a right to withdraw from the research project without giving any reason or explanation. When arranging the interviews, and before each interview commenced, consent was revisited by verbally checking with the participants that they were happy to proceed. Member checking was used for ensuring transparency and verifying the data (Lincoln & Guba, 1985), with each transcript being sent to the respective participant for checking, which gave them an opportunity to comment on accuracy and make any corrections or additions, with four out of eight participants responding.

3.7. Gathering data

Semi-structured interviews were carried out face-to-face (with three out of eight participants) or by Skype video-conferencing (five participants) and lasted between 45 minutes and 1 hour 15 minutes.

The interview schedule was drawn to contain eight main questions with some additional prompts (Appendix III). It was not possible to pilot the interview questions prior to the commencement of semi-structured interviews with the participants due to time constraints, however the questions were discussed with a colleague who did not take part in the study but fulfilled most of the criteria for participation. At the end of the interviews the participants were invited to choose a pseudonym to help protect their confidentiality and that of their clients.

The interviews were transcribed from the audio recordings and the transcriptions sent to respective participants to check for any errors or inaccuracies. It had initially been intended for the researcher to transcribe all the interviews personally, however practical considerations and time constraints led to the

decision to employ professional assistance in transcribing five out of eight interviews, with appropriate confidentiality agreement in place to protect the privacy of the interviewees and their clients. The recordings were listened to by the researcher repeatedly, in order to refine and correct the transcripts, which also allowed immersion in the content of the interviews and to begin to make sense of the data.

4. RESULTS

Three main themes were identified through thematic analysis of the participant interview data, each containing a number of sub-themes. These are represented in the Table 2.

Table 2. Themes and sub-themes

Themes	Sub-themes
Caring for self as a whole	Healthy boundaries Re-connection Looking after the body Tools and rituals Professional and peer support
EFT helps them and it helps me	The energy goes both ways Before and after sessions Emotional first aid I am more in touch with me The joy of helping

Ethical issues / Reflective practice	Opening Pandora's box safely
	Know your stuff from client's stuff
	Put your own oxygen mask on first

4.1. CARING FOR SELF AS A WHOLE

This major theme relates to a holistic view on self-care which was expressed by all participants, with the majority describing a multi-faceted and 'whole-person' approach to looking after themselves in the context of their professional and personal lives.

The recurrent sub-themes were - strengthening and maintaining own boundaries; re-connecting; looking after the body; a toolkit of self-help techniques; and finally professional and peer support.

4.1.1. Healthy Boundaries

Most participants talked about the importance of boundaries in looking after themselves:

> Ext1: *I have this tendency to lose myself in work… it's about recognising when I'm doing that… so I have to keep my boundaries, a very big part of self-care* (Nancy)

Some participants gave examples of how they were affected during the times when they overworked or took on too much responsibility for others, which contributed to exhaustion and sometimes burnout:

> Ext2: *What I was losing with working with some of those patients, or working too hard with them, was enthusiasm for therapy , and I was just thinking I'm going to have to change… because I can't do this because I'm so exhausted, you know, this is ridiculous, I can't go on like this* (Lucy)

> Ext3: *The impact on me has been that I have got close to burning out* (Nancy)

> Ext4: *I would take the world on my shoulders and I would want to find solutions for everybody… So in terms of dealing with people and not taking their issues on board, now I am much better about that when they go out of the door… Sometimes I do feel drained* (Clair)

> Ext5: *I've always found it difficult to look after me… where actually now what I've learnt to do is, is to offer them support to protect themselves, I've learnt a lot, about how I can look after me and how I'm important* (Peggy)

Being more aware of their boundaries and the importance of paying attention to their self-care, several participants described how they do things differently now:

> Ext6*: For me I think it's very very important that I look after myself, which is why I never see more than five people in a day, try and keep it to four people a day, five is too much, especially if its trauma* (Nancy)

> Ext7*: I think that it taught me that not always trying to fix, and to cure, and to heal, and you know sometimes I can't… I'm really starting to understand that the client has to do some of the work … and then I started*

to pull back and I started to feel better… I tried to balance it so that I don't have too many people bringing too much heavy stuff (Lucy)

Ext8: *So now I'm that tuned into my body that I know I'm looking after myself and I now give myself permission to rest and I give myself permission to have fun and just give myself permission for time off* (Peggy)

Ext9: *In terms of mentally taking on their issues and fretting and worrying, that's not an issue for me any more… I've learnt to leave it at the door* (Clair)

4.1.2. Re-connection

The majority of participants talked about the importance of re-connecting with themselves and their bodies, often through walking and other types of physical activity, being in nature, engaging in creative and expressive pastimes, or spending time with significant people in their lives. For example:

Ext10*: I think if you're working with traumatised people the key thing is to find a way to reconnect to yourself so I reconnect to me by being very physically active … but I also reconnect to me by talking to friends because they of course have known me a long time and somehow that's a way of grounding myself in who I am* (Diane)

Portia, Jude and Clair described walking and being in nature as one of the important ways of grounding and connecting with themselves:

Ext11: *I like to walk, I find walking is a time of contemplation and putting things in order, it's something that really works for me* (Portia)

Ext12: *Sometimes I try to get to be on my own and do the garden and go for a walk around the woods, gardens around the corner and that's getting nature, getting some fresh air… I've insisted that we go to the States and go round the canyons - to me insisting that I connect with nature is a form of self-care (*Jude)

Ext13: *I enjoy the countryside… there is lots of natural glacial lakes… and I live very near, and I do find going down there, being near water and on a windy day, on a clear day… I'll go down there and sit, that always, always makes me feel really re-charged in many ways* (Clair)

Diane explained the importance of physical movement and especially dance for her, in helping to mediate the somatic effects of working with trauma:

Ext14: *What I do is quite a lot of physical things, I do tap, I dance … and I go to the allotment that's a very good place for me to let go of it* (Diane)

Creative activities were identified as important by several participants. Max mentioned playing music and singing in a choir, Portia talked about the feeling of *"getting out of everything"* whilst kneading bread dough, and Lucy described her enjoyment of pottery:

Ext15: *I have a pottery course… its two and a half hours a week and its really fun because I don't care how well I do … that's been really fun* (Lucy)

Diane, Jude and Peggy talked about the joy of spending time with their grandchildren, recognising how important it is as part of their self-care:

Ext16: *I've got a little granddaughter now and I get a lot of happiness and joy in being around my granddaughter, she keeps me busy, and I walk my daughter's dog and I garden* (Peggy)

4.1.3. Looking after the body

Many participants talked about the importance of taking care of their body, including good healthy diet, regular exercise, sleep. Some described particular routines of self-care to get ready for the day or to settle down in the evening:

> Ext17: *It's nothing amazing, but it's just I always have breakfast first thing, have coffee, say my prayers, meditate a bit and then I go off and do some cycling or something on a machine… then I have my shower and everything and then I feel ready for the day* (Nancy)

> Ext18: *Exercise - minimum half an hour a day… minimal processed food, most food is made from raw ingredients…. Although I haven't for a while, martial arts* (Max)

> Ext19: *I get up in the morning I have my shower, I make sure I take my vitamins… I eat well … I eat organic, mostly, and making sure that I have lots of vegetables and green things…. and I also do some exercises every morning … I just do some Pilates and some upper body strength exercises so my body is strong* (Jude)

> Ext20: *Before I go to sleep at night I have a routine where I read a totally trivial book, I never read anything serious at night, so my mind can just switch off* (Diane)

4.1.4. Tools and rituals

Several participants mentioned a number of techniques, tools and rituals other than EFT which they use in their self-care, including mindfulness, Donna Eden's energy medicine (Eden & Feinstein, 2000), different types of visualisation, Reiki and acupuncture.

Some of these were used as a regular daily practice:

> Ext21: *I do mindfulness in the morning before I go to work… and I do Donna Eden's energy medicine… and I just try and plan my day ahead... I'll do a meditation before I go to bed at night and I try to practise mindfulness as I go about my day* (Peggy)

Other techniques are used as and when needed, for example when preparing for a client session:

> Ext22: *I visualise an energy field around and that's partly as protection and partly building a positive energy around me… … I'm sending energy out in a positive way, but not actually letting their energy get in at me* (Portia)

Several participants mentioned rituals of spiritual nature, including prayer, meditation, connecting to the higher wisdom. For example, Portia described what she does in her "pre-therapy space":

> Ext 23*: I also do a thing … where I just stay in my room and calm myself and enter a space where I ask for the wisdom, to do the best thing for the client I'm about to work with and also for me, so there's that kind of balance about it and that just takes a second or two…and just have that, pre-therapy space, I find it works particularly well* (Portia)

All participants also gave examples of using EFT specifically as a self-care tool, which will be described in more details in section 2.

4.1.5. Professional and peer support

Five out of eight participants mentioned clinical supervision as an integral part of their self-care, and some also commented on the importance of peer support:

> Ext 24*: I do of course have supervision… and I have peers, with whom I have regular Skype supervisions… I've got about four colleagues that I've got to know over the years who are very dependable people, so if I'm worried about a client, even if it's not officially arranged I just ring one of them up and they'll do the same for me and that's really helpful I find* (Diane)

Accessing personal or complementary therapy when needed, including EFT provided by another therapist, was mentioned by several participants as another aspect of self-care:

> Ext25: *I have therapy once a week when I need... I also have supervisions regularly and sometimes… just to talk about myself and my work* (Lucy)

> Ext26: *I've got friends who are complementary therapists and so we share and I'm in the* [EFT peer support group]*… and when I've needed I've paid privately for EFT* (Peggy)

4.2. EFT HELPS THEM AND IT HELPS ME

The second main theme identified was the apparent positive impact on practitioners themselves of using EFT for themselves, as well as a therapeutic tool with their clients.

4.2.1. The energy goes both ways

The majority of participants referred to the beneficial effects they themselves experience during a client session where they were using EFT as a therapeutic tool for their clients. This is due to the need for the therapist to also tap with the client during the session, and therefore receive the benefits of the technique for themselves as well as leading the client (Fig.2):

> Ext27: *There is probably a synergistic effect in tapping together, that's a possibility... I think in that tapping along on myself as a demonstration for the client I am automatically discharging any emotional responses that I might be getting... So it discharges before it develops, before even I am aware of it* (Max)

> Ext28: *If I go into a session feeling pretty ok , sometimes we will do tapping around the clients issues and then I leave the session feeling slightly euphoric and I can't really tell you why, but I think it's the tapping sort of feeling, you know, life is great, this is really good, and there are other times when I feel really nervous going into a session and tapped with a client and come out feeling a lot calmer and a lot more like my brain is switched on in a way* (Lucy)

> Ext29: [When I tap with the group] *I feel that I'm clearing my own energy on some level for me* (Peggy)

> Ext30: *If I've used EFT during a session funnily enough my energy is better after the session, I'm less drained and more satisfied, because there is always a result, there's always an outcome which is satisfying, that is really all I can say* (Jude)

Nancy made a comparison between EFT and Reiki:

> Ext31: *I enjoy doing it because it's like doing Reiki or something because the energy is coming through you, and you know it goes both ways and I'm thinking EFT has that same effect when I'm working with a client, and the energy is in the room… And my tapping with them, whatever I'm saying to them it helps, it helps me* (Nancy)

Diane noted that tapping jointly with the client in helped enhance her therapeutic intuition:

> Ext: *I do think my tapping on me enhances the impact on the client because… my energy system is joined with that of the client, which is why I think I get those intuitions sometimes, it's almost like I'm in their energy system and sometimes I know before they say something what they're about to say* (Diane)

Some participants commented that EFT appeared to have a protective effect in reducing the impact of the client's traumatic material on themselves:

> Ext33: *It helps me with client's trauma if I'm tapping, because if the client has told me about the trauma then clearly it's affecting me, I think trauma has gone into my head and become part of my memory system and the tapping would help me with that* (Jude)

Jude went on to give an example of where the client's story impacted on her but after tapping on different material presented by client later on she felt it was spontaneously resolved for her:

> Ext34: *Some very, very traumatic thing happened in the room with her father and from that her whole life had been affected by this one trauma, and I had a very vivid memory of it, and I found the event quite traumatising, we did the Rewind Technique*[4] *on that particular one, but she was left with some residual problems going further back so we tapped on that and I found it was very peaceful for me that tapping, I felt that the representation of her trauma in my brain was being tapped out by the final tapping… I felt it was resolving in my head as well* (Jude)

4.2.2. Before and after sessions

The majority of participants had used EFT before and after client sessions which they perceived as challenging or difficult in some way. For example, Lucy employed it for dealing with anxiety about working with a particular client:

> Ext35: *He was bright and so clever and I felt like he was running rings around me and I was so anxious about having sessions with him… I especially used to get into the office early to use EFT on myself* (Lucy)

Jude used EFT to enhance her openness to the client and their experience, and to manage her own need to be of assistance:

> Ext36: *I don't know what is going to happen during this session, where I can be of service, I just have no idea… so I tap to be very open to their experience to try and find something maybe that will be of use to them* (Jude)

[4] Rewind Technique - trauma processing technique in Neuro Linguistic Programming and Human Givens therapy, involving manipulation of the imagery

Nancy described using EFT on her feeling of being "stuck" with certain clients:

> Ext37: *If I feel stuck with a client it's very useful because if they are stuck it's me who's stuck, it's a parallel process, so therefore, that's something that's very useful to unstick… if I tap on "even though I feel stuck"… I just feel that thoughts come in as ideas as they are released into my energetic field as it were… at times I've found that to be very useful* (Nancy)

Many participants reported that they may use EFT after a difficult session, to ground themselves, or where they feel they may have picked something up from the client. For example, Portia mentioned her work in a palliative setting:

> Ext38: *The other time I might tap afterwards is because some of the work I do at the hospice … sometimes when someone is near the end of life. There are times I find it very difficult and sometimes I'd tap for that* (Portia)

Nancy talked about how she regularly used EFT for grounding[5] in between client sessions:

> Ext39: *I really do find EFT helpful at the end of a session and I always have a half hour break… and that really brings me back into my body, because sometimes I can 'fly off'* (Nancy)

Portia felt that when she wasn't using EFT during a session with a traumatised client, she was "more likely to carry more trauma", in which case she may choose to use EFT for herself afterwards. She gave a specific example where EFT helped her with some of the secondary trauma symptoms following her work with a client who had escaped from a sinking ship:

[5] Grounding - term referring to being able to stay in the present moment and in their body

Ext40: *It was back when I was training, so we were using CBT, and I found that we worked with* [the incident] *so closely that I actually took on some of her trauma… I had all details of her experience in my head, I later did some tapping on that, that went very nicely thank you* [smiling] (Portia)

4.2.3. Emotional first aid

All participants reported using EFT for themselves on day-to-day issues, for self-soothing and emotional regulation, though some used it more frequently than others.

Ext41: *I use a lot of tapping on the daily basis, to release anxiety, release tensions, release frustrations, and let it go.. I use EFT for everyday little issues… and for bigger issues as well.. It helps me to keep my perspective of the big picture of what I want to achieve in life* (Clair)

Ext42: *If I get an emotion which I find unpleasant, which feels unhelpful in the moment, like fear or anger or something like that, I will automatically fling into tapping on that… I don't want it to go away, because the emotion is important and needs to be heard, but I just want to bring it down to a level which is manageable. I also use it to self-soothe if I breach my own perfectionist standards* (Jude)

Ext43: *If I'm feeling disturbed in any way, I will usually do a few rounds[6] of tapping… If I didn't use it for myself I don't think I'd be so fit for purpose, I don't think I would be able to work with the clients who come in the next day and I probably wouldn't get as good as night's sleep as I do* (Diane)

A few participants commented on the immediacy of the calming effect of tapping for themselves, with Jude describing it as *"instant self-soothing and instant centering"*. Nancy, whose toolbox is very extensive, echoes that among all her

[6] Round of tapping - refers to tapping a standard set of EFT acupressure points once (either the full or abbreviated version)

therapeutic approaches *"EFT is just the one that works the fastest, it's really fast, the results are instantaneous"*. Clair's experience is similar:

> Ext44: *I'm always in a better place after I use it, always!… Yesterday I did it… It literally about two or three rounds, and I wasn't even that specific, it just made a difference… It just does, every time (Clair)*

Whilst most participants gave examples of EFT having a soothing rather than energising effect, Nancy also described how she used it to counteract the overwhelming feeling of tiredness during a training course:

> Ext45: *I just tapped, and I just had that feeling of my eyes opening up and just being alert and awake, it was extraordinary* (Nancy)

Both Jude and Clair found EFT helpful in preparing for delivering trainings and presentations:

> Ext46: *I would use it before trainings if my mind is blank or I have to confrontgoing out into a room full of people who I know are there to learn and also to judge the trainer… I will tap so that I can just be in my material flow* (Jude)
>
> Ext47: *I think I would tap tonight before the presentation, so that I am calm and I don't "umm" and "errr"… and I don't forget what I am trying to say… I would tap like that so that I go in as calm as I can be* (Clair)

Max noted that he didn't feel the need to use EFT for himself often, but gave one example of an occasion where it was helpful:

> Ext48: *I can think of one instance where specifically I did* [use EFT]… *That was at my father's funeral… where I was giving a soliloquy at the funeral*

something that I had written about him… I prepared for that by tapping as we were waiting for a particular time… (Max)

Apart from the frequently quoted benefits of EFT for day-to-day emotional regulation, some participants described significant and long-lasting shifts in their belief systems and their emotional reactions and behaviours, which they attributed to the use of EFT. For example, Jude spoke of one of her early experiences in EFT, where she appeared to have permanently transformed her response to a situation in which she would have typically felt a sense of powerlessness:

Ext49: *Suddenly I felt I wasn't powerless - and I had tried everything else, everything! - NLP, anchoring, this, that, to deal with this particular way of being in a situation … It kind of startles me to some extent how brave I can be in situations where I normally would have been taking a back seat* (Jude)

4.2.4. I am more in touch with me

Several participants noted how EFT was helpful in grounding, centering, and re-connecting with themselves and their own needs. This is directly relevant to Sub-theme 1.2 which also addresses re-connection, but as these examples refer specifically to the use of EFT they are presented here under the '*EFT helps them and it helps me*' theme for greater clarity.

Ext50: *I feel when I use it I don't suddenly become this perfect person, sadly, but I'm in a calmer place, I think the big difference is I'm more in touch with me* (Portia)

Portia went on to give a recent example of how EFT helped her to get in touch with her need for rest:

> Ext51: *I was meant to be going out with friends… but I was exhausted so I thought I'm just going to do some tapping on this, my hope was that the tapping would move the tiredness, but it didn't, but what it did do was to bring in a really stark thing, "you don't have to go, you could cancel this"… in terms of actually looking after me and my energy it was definitely the right decision, but before I tapped that option hadn't almost occurred to me* (Portia)

Similarly, in recognising her tendency to disconnect from herself, Nancy repeatedly referred to the helpfulness of EFT in grounding and bringing her back into her body, as well as helping to separate self from the other person, whether in work or personal context:

> Ext52: *I know I can dissociate, I can daydream… think about other things and not be present in my body… and really it brings me back… and if I'm upset about something or somebody, it's really good for that, it brings me back into my own space, because it separates me from the energy of the other person, that for me probably is the most useful… Again it does that separation thing, and it grounds me and it makes me feel centred, that's the thing, it's very centring* (Nancy)

4.2.5. The Joy of Helping

A subtle but prominent thread could be identified from the EFT stories shared by most of the participants, in that they seemed to derive much joy and satisfaction from being able to use EFT with their clients, and it appeared that moments of delight and sometimes amazement at how well it worked were still a regular occurrence in their clinical practice despite some years of experience with this technique.

Whilst thematic analysis does not typically look at intonation and emotional expression of the participants' speech, in conducting interviews and listening to the recordings it was impossible not to notice the apparent feelings of deep satisfaction and a sense of wonder, not only in the use of words of "amazing" and "extraordinary", but in the tone of voice and the facial expressions of the participants, who often appeared moved when recounting their experiences with using EFT as a therapeutic tool with clients.

Some of the specific attributes of EFT work which the participants seemed to appreciate most included: the speed of efficacy, its gentleness, practical usefulness in work with traumatised clients in particular, as well as being able to bring humour into it.

The unusually fast impact that EFT seems to produce in clients was mentioned by the majority of participants:

> Ext53: *I don't think there's anything else like that... it's just the results, they are so fast and so amazing… it's just such a simple technique to be able to get right to the core of things and I think it's fantastic because sometimes people can't find the right words but they can find the feelings or they can describe it in a colour, or a shape or a sense and you can tap on that* (Peggy)

> Ext54: *This woman was really, really in a lot of* [emotional] *pain, so I said well let's try a round of tapping on …. It's 10, and we got it down to 0, in two rounds, she said I don't feel any pain at all, it's gone… It was just extraordinary* (Nancy)

Portia also noted that the unusual speed with which EFT works can be a disadvantage, as it may be difficult for clients to comprehend or accept:

> Ext55: *Sometimes it works too well too fast… I've certainly worked with people where they really struggle with, they had this thing and it's gone… although they kind of wanted to get rid of it, because that's why they're here, I think, then actually, it's just gone, is a weird step too far* (Portia)

A number of participants compared the efficacy of EFT with other therapeutic approaches in their toolboxes. Max stated that, unlike most talking therapies, EFT seems to directly effect change:

> Ext56: *It has a change agent.. I don't quite know what that is, but it changes things… A psychodynamic approach, it explores the past, so people can understand why they are like they are... "but so what?" - that's the typical response you get... "I still feel like that, nothing changed" but with EFT people feel differently, and they usually feel it immediately* (Max)

Lucy compares EFT to EMDR:

> Ext57: *I think it can take away a lot of the emotional punch of a trauma in the same way EMDR can but I think its gentler than EMDR so although I'm trained in EMDR… I actually think EFT is much gentler* (Lucy)

Clair who was trained in hypnotherapy before she came across EFT, put it quite bluntly:

> Ext58: *The way it works is so amazing.. Why would you want to bother with hypnosis, when you gonna get this kind of result that much quicker with EFT?* (Clair)

On the other hand, Lucy, Clair and Diane all emphasized that their skills in counselling/ psychotherapy were an important foundation for using EFT more effectively.

A number of participants pointed out how helpful EFT was even with severely traumatised clients:

> Ext59: [Client] *worked through some phenomenal traumas… just using EFT, and she just knew where to go with it… it was quite fierce… she was just like, "I need to tap on that", "I need to tap on that" and she cleared so much… She wrote to me afterwards and said that she just doesn't feel any of the trauma from the past* (Nancy)

> Ext60: *There was a lady… it was abuse we were looking at… and her state was really quite extreme when she talked about this, very much in a high anxiety state, and visibly very evident, but when she came back the week later… whilst she still could clearly remember the event she had forgotten the trauma…* (Portia)

> Ext61: *Years ago I had a client who was a survivor of horrendous abuse... I'd tried all sorts of things with her in regular counselling… Nothing worked at all… there was no demonstrable improvement in her emotional state for years* (Max)

Then some years later Max found EFT and incorporated it into work with this client:

> Ext62: *She actually started to show some improvement… in all sorts of different ways… and it got to the point where she was ready to go and disclose* (Max)

Lucy and Diane remarked on the safety and gentleness of EFT as a trauma processing approach:

> Ext63: *Because trauma is lodged in the body … I don't see much point in not working with the body and EFT goes straight to the body doesn't it?… I use other approaches to make sense out of it… but to actually release it, I think EFT is probably the safest approach I know and the most rapid* (Diane)

> Ext64: *I guess the gentleness of it is the thing I always come back to, that I really like, it's really gentle and it's not frightening, sometimes people think it's really weird but I don't think they are frightened of it* (Lucy)

Diane mentioned how EFT as a therapeutic approach lends itself to using humour:

> Ext65: *I also believe in laughter in therapy and I suppose it's quite surprising in a way, how often, even people who are quite traumatised can find something to laugh about, usually with EFT.. I think with EFT the great thing is we can incorporate quite a lot of humour, I think it's very healing* (Diane)

4.3. ETHICAL ISSUES AND REFLECTIVE PRACTICE

A number of issues relating to ethics and safety of client work were raised by participants during the interviews, emphasizing the significance of self-awareness and reflective practice for therapists. These included concerns about the potentially unsafe and premature use of EFT by people with little experience or training in mental health; significance of recognising own countertransference responses; and helping yourself before helping others.

4.3.1. Opening the Pandora's box safely

Several participants noted the importance of the therapist being sufficiently prepared and experienced, in order to manage and contain the situations where EFT triggers the release of intense emotions or accesses trauma, and expressed concerns about the lack of mental health experience among many EFT practitioners

who do not heed the EFT originator Gary Craig's warning "do not go where you do not belong" which he repeatedly emphasized in his talks and seminars (Cayer, 2011, p.1).

> Ext66: *I think we have to be aware of the power of EFT in releasing things from the body and know that we can handle it… Once somebody's experience of trauma starts travelling around the body and different experiences are happening and different parts of the body are responding… It could be very frightening* [for the therapist] *if you're not very confident in your ability to help them resolve it* (Diane)

> Ext67: *When I was learning it,* [the trainer] *doesn't directly say this but kind of implies… that you can just use EFT* [on its own], *which I don't believe any longer… I have to use psychotherapy as well as EFT and I am worried that people that are just EFT practitioners and not counsellors or therapists using it and maybe stumbling into something that's really, really traumatic* (Lucy)

Clair and Diane were also concerned about the common assumption among EFT practitioners that it is best to start tapping with a new client almost straight away, and talked about being careful in not introducing EFT too quickly to an individual who is vulnerable and potentially traumatised:

> Ext68: *You get somebody who comes to you who is feeling vulnerable, who is feeling unsure, to just say let's go into it… To just start saying, let's tap... For the client, they are still trying to get comfortable… and to sit and be relaxed, and I just listen, most people just wanna be heard...* (Clair)

> Ext69: *If I start using EFT straight away with people, if they've had quite deep profound traumas… if I use the EFT too quickly I don't know what's going to emerge, so if I have quite a bit of time talking with them first and really assessing the level of trauma they've experienced and how they're experiencing it in their bodies, then I feel I'm more prepared for what*

might be going to come out when we start using EFT. Because I know using EFT is like opening Pandora's Box really (Diane)

4.3.2. Know your stuff from client's stuff

Several participants emphasised the importance of understanding their own countertransference[7] responses and triggers, and the role of EFT in that awareness.

Clair used a metaphor to describe the apparent power of EFT to access the unconscious mind, *"getting over the drawbridge to the castle"*, and recognised that when used in a session with client it has a potential *"open doors"* in the practitioner as well:

> Ext70: *It has made me aware, very conscious… when I am tapping… If I start feeling something myself - because it does open doors in yourself as well… it makes me aware if I hit triggers that resonate… And if it is an issue after the client's left … Let's look at it again, for myself, why did it trigger me, where is this coming from for myself?* (Clair)

Peggy gave an example where she became aware of her triggers in relation to a challenging work situation, and how she felt EFT helped to enhance that awareness:

> Ext71: *I couldn't understand why I felt so anxious* [about the work situation] *… so I came home and I wrote it down and I tapped on it… Doing EFT made me so much more aware of stuff because I knew it wasn't anything to do with* [the work situation] *… it was some thing in me that was being triggered* (Peggy)

[7] Counter-transference - term referring to the therapist's unconscious reactions to the client, typically based on therapist's own early life experiences

Diane described how she may notice and process some of her own bodily responses during and after a session:

> Ext72: *I might feel it in my body and it might take a while to settle down after the session… so usually I' d tap on it, so I'd ask myself… ok what's my body trying to tell me to stop worrying about … because I do respond kinaesthetically to my clients, I pick up the transference in my body so naturally… and with somebody who is very traumatised their feelings are more intense really, and I'm always interested if I don't feel very much in my body, and occasionally I don't, and I think hmmmm I wonder what that's about?* (Diane)

In talking about the importance of reflective practice for therapists, Max described what reflexivity meant to him:

> Ext73: *Awareness of how I feel and noticing what I feel - and tracking that - is that my feeling, or is it somebody else's feeling? If it is my feeling, why am I feeling that and what do I need to do about it… If it is not my feeling how come I picked it up, again do I need to do something with it?* (Max)

4.3.4. Put your own oxygen mask on first

All participants recognised the importance of good self-care for their functioning as a therapist, and several emphasized their sense of responsibility for their own healing and personal development in the context of working with vulnerable clients:

> Ext74: *I just believe my clients need a therapist who is whole and well and potent and where her energy is clear so that I can meet them as a fresh person rather than someone impacted by everybody else's difficulties* (Diane)

Max summarised the importance of personal healing and ability to self-reflect, especially for therapists working with trauma:

> Ext75: *I think that [personal therapy] is essential… and from that to develop awareness… reflective practice, be able to reflect on your own process… Because that's how you develop the resilience to work with some of the horrendous things* (Max)

5. DISCUSSION

This was the first qualitative study investigating the use of EFT as a self-care tool by therapists working with psychological trauma.

This main findings of the study were categorised in the following way: (a) the importance of therapist self-care from a holistic perspective; (b) indirect benefits of EFT for the therapists who use it in sessions with clients; (c) direct benefits of EFT for the therapist when applied as a self-care tool; (d) ethical concerns relating to therapists' self-awareness, self-care and personal/professional development. Different aspects pertaining to these areas will be discussed with reference to relevant existing literature.

5.1. Self-care and self-awareness are ethical issues

The findings of the study suggest that a trauma therapist's self-care skills and their level of self-awareness are important issues, potentially affecting the therapists' capacity to offer effective and safe service to their clients, and are thus essential to ethical clinical practice.

All therapists participating in the study showed awareness of the holistic[8] nature of self-care, and described how they made efforts to nurture themselves in different areas of their being. Looking after the physical body in the form of exercise and nutrition (Ext. 17, 18, 19) as well as good quality sleep (Ext. 20), connection with self in form of creativity (Ext. 15), dance (Ext. 14), spending time with family and friends (Ext. 10, 16), being in nature (Ext. 11, 12, 13) were all examples of

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Holistic - referring to 'whole person' in this context

participants' ways of taking care of themselves. Additionally, the importance of the need to maintain healthy and ethical personal boundaries featured in many of their contributions. Many commented on being aware of their own tendency to rescue others, including clients and colleagues (Ext. 4), overworking (Ext. 1), and not looking after themselves (Ext 5). Some mentioned the consequences of neglecting their own needs in the past, which had resulted in exhaustion and burnout (Ext. 2, 3).

The ability to reflect on these experiences and to pay attention to developing their self-awareness skills was described by some of the participants as having helped them to strengthen their boundaries and attend to their own needs more consistently. The ways that they described doing this were in allowing themselves more balance between work and rest (Ext. 6, 8) and not taking on their clients' issues (Ext. 7, 9). An example was Diane, who eloquently summarised the importance of self-care as an issue not only for a therapist's own health and wellbeing, but also as being fundamental to their ability to be present with their clients: *"my clients need a therapist who is whole and well and potent and where her energy is clear"* (Ext. 74). These qualities enable a therapist to hold a safe therapeutic space for a client and to offer them most appropriate and effective treatment.

Whilst there are many commonalities between the strategies identified by the participants in this study, and those suggested in previously published research (Figley, 2002; Radley & Figley, 2007; Sommer, 2008), it is likely that an effective and holistic package of self-care will be unique to each particular individual working in a helping profession. Rothschild and Rand (2006) encouraged each therapist to experiment in order to discover which strategies are most helpful to

enable them to continue working effectively and safely with clients. As use of EFT was one of the inclusion criteria for this study, it is not surprising that all of the participants incorporated EFT as a tool in their individual holistic self-care 'packages', albeit at different frequency and intensity.

5.2. EFT as an 'inoculation' against compassion fatigue and vicarious trauma

One of the most intriguing and unique features of EFT is its apparent ability to protect the therapist from the impact of the potentially distressing client's material, without compromising - and possibly enhancing - the level of empathic connection. A typical effect experienced by EFT practitioners, summarised by Max, is that any strong emotional responses triggered by the client material in the therapist appear to be automatically discharged as they are tapping together with the client (Ext. 27). Standard EFT procedure involves the therapist stimulating their own acupressure points as a demonstration and guide for the client who is tapping along simultaneously (Fig.2). The therapist also repeatedly echoes the clients words related to specific aspects of the distressing issue. The fact that the treatment protocol is applied by the therapist for themselves at the same time as it is used by the client, appears to be unique to EFT and related energy psychology approaches such as Thought Field Therapy (TFT) (Callahan, 2001).

It is not unusual for therapists to report that they feel better after the session than before the session if they have used EFT as the main treatment tool (Ext. 28, 30), even though they may have been witness to client's intense distress and have listened to harrowing details of their trauma. This unusual phenomenon of the

therapist getting an indirect benefit from tapping for themselves alongside another person tapping on own their issue, is known in the EFT literature as 'Borrowing Benefits' (Craig, 2011). This phenomenon is often described in relation to group workshop participants observing an EFT demonstration and tapping for themselves at the same time (Chuch & Brooks, 2010), however there has been no previous empirical research on the relevance of this for the therapist working one-to-one with traumatised clients. The findings of this study, suggesting that the use of EFT in a therapy session can be simultaneously beneficial for the client and the therapist, can have wide-reaching implications in the effort of preventing stress-related conditions and enhancing wellbeing in health professionals, and merits further investigation.

5.3. EFT as a tool for reflexivity and self-awareness

Reflexivity, as described by participant Max, related to "noticing what I feel and tracking that - is that my feeling, or is it somebody else's feeling?… Why am I feeling that and what do I need to do about it?" (Ext. 73). Whilst traditional training in counselling and psychotherapy of many modalities does pay attention to counter-transference responses, the findings of this study suggest that EFT can also be a useful tool to enhance therapist's awareness and ability to reflect on their own responses to client's material (Ext. 70, 72) or other work-related situations (Ext. 71). The mechanism of this is not clear, but it is possible that through helping therapists to connect to their body (Ext. 52) and the 'inoculation' effect that somehow affords protection against the impact of client's trauma (Ext. 33, 34) facilitates clearer thinking and ability to reflect.

On the other hand, EFT also helps to "open doors" in the therapist themselves (Ext. 26), allowing them to identify their own triggers and the possible predisposing vulnerabilities that those triggers link into from their earlier life experiences. It is not clear what the EFT mechanism is for bringing unconscious material into consciousness, but it is likely that use of the physical stimulation is helpful to 'tap into' the 'body memory' of the person who uses it. Developing awareness of their own triggers, 'blind spots' and vulnerabilities, can help therapists to recognise their own need for healing and personal development. Where this becomes more a part of a therapists' conscious awareness, it makes working on those areas of vulnerability in supervision or personal therapy more possible. This is another aspect of both personal self-care and ethical practice that is important for therapists of all disciplines to consider. Participants in this study described taking responsibility for this, for example through using EFT for themselves independently (Ext. 37, 40, 71), or through accessing personal therapy - whether more conventional talking therapies or EFT specifically (Ext. 25, 26).

It is possible that the regular practice of EFT for self-care, which involves observing and describing one's internal experience, may help to strengthen the 'observing self' (also known as the 'witness' in Buddhism), referring to the part of human consciousness that is able to look upon our experiences, including distressing ones, with compassion and detachment at the same time. It is also suggested that using EFT regularly for self-care can expand the individual's capacity for dual awareness - ability to attend simultaneously to both internal and external stimuli. These qualities have been identified by Rothschild and Rand (2006) as vital to the emotional health of helping professionals and their clients. The therapist has to be able to notice and manage their own internal experiences (feelings, thoughts,

intuitions) at the same time as observe the non-verbal cues from the client, listening and responding to them, in order to be in the best position to assist the client safely and effectively.

5.4. EFT helps therapists to connect with themselves

One of the reported effects of using EFT that therapists in this study, was its benefits as a means of grounding, centering, and re-connecting with self and the therapist's own needs (Ext. 50, 51, 52). Most of the participants also discussed having used a range of other means of grounding and reconnection with themselves, such as being in nature (Ext. 12, 13), engaging in creative activities (Ext. 15), or spending time with people important to them (Ext. 10, 16). However EFT was also described as a practical and simple additional tool which can be used in the moment, especially when other environmental resources were not easily available, or where time was limited, for example during the short breaks between client appointments (Ext. 39). Therapist's ability to be centered and grounded is essential for their capacity to be present for the client and give them the most appropriate support in the moment.

5.5. EFT as an emotional regulation and stress management tool

The findings of this study indicate that therapists who work with trauma often used EFT as a stress management and an emotional regulation tool, for day-to-day stresses, anxieties and upsets. Many of the therapist-participants described using EFT on a regular basis as a mainstay of their self-care (Ext. 41, 42, 43), which can

be a standard daily practice, similarly to a meditation practice, plus as and when required when facing stressful events, upsets and frustrations. Other participants described only occasionally using EFT at particular times when needed, as in Max's examples of preparing for his father's funeral (Ext. 48).

One surprising finding which was not highlighted in previous literature on the benefits of EFT for therapists was that one of the participants in this study described EFT as helped improve energy levels when she was feeling exhausted during a training event (Ext. 45). This can clearly be a very helpful application of EFT for busy health professionals, for whom tiredness is not an unusual occurrence. It is interesting to note, though, that EFT does not appear to 'go against the best interests' of the individual and will not over-ride the basic need for rest and recuperation, as in the example of Portia who tapped to help her with exhaustion to enable her to go out with friends, but instead had a realisation that she can allow herself to rest instead (Ext. 51). The important implication of this is that the use of EFT may help to remind the therapists of their needs which could be ignored or neglected within a busy therapy practice.

5.5.1. Preparation for sessions

An additional application of EFT for some therapists was managing their own emotional state in preparation for sessions with clients perceived as difficult or challenging in some way, for example where Lucy felt anxious with a particular client (Ext. 35), or where Nancy experienced a sense of 'stuckness' (Ext. 37). Therapists expressed their awareness of the importance of being open and 'getting themselves out of the way', which refers to open to what client brings without having pre-conceived judgements or assumptions, or expectations of how the client

may respond, and Jude commented specifically on the helpfulness of using EFT for herself in preparation for a client session as a means of accomplishing this (Ext. 36). It appears that use EFT can be a valuable strategy for helping therapists bring themselves into an optimum state emotionally and psychologically, to be able to be open to the client's experience and offer them the best support and treatment.

5.5.2. Clearing after the session

This study also found that EFT can be helpful to therapists after a client session, especially if the session was perceived to have been challenging or upsetting in some way, for example when working with a client at the end of life (Ext. 38). One of the reasons that the use of EFT in these situations can be really effective for regaining psychological and emotional equilibrium for the therapist after a difficult session is the rapid soothing effect, typically noticeable within one or two minutes of commencing the procedure.

Another post-session use of EFT mentioned by participants, was in situations where the therapist felt that may have 'picked something up' from the client (Ext. 40), which could refer to residual feelings, sensations or intrusive images that may remain with the therapist after the session. Rothschild & Rand (2006) talked about 'cleansing rituals' that some practitioners engage in after sessions with certain clients, "as if the client's are still sticking to their skin" (p.195), and go onto recommending a range of cleansing techniques, such as washing hands, airing the room, visualising cleansing energy of wind or water, etc. It appears that some therapists purposefully use EFT with a similar intent, to clear any residual energy from the client after the session.

Finally, participants also mentioned a beneficial post-therapy use of EFT for self care when there had been a sense of disconnection from themselves and a feeling of needing to be more grounded (Ext. 39): this is particular relevant to therapists working with clients suffering with severe trauma and dissociation, as the therapist needs to be fully present in the session in order to assist the client who may feel that it is unsafe to "stay in their body" because of their traumatic experiences.

5.6. EFT in Compassion satisfaction

The joy, pleasure, sense of wonder and sometimes amazement that therapists in the study apparently derived from the use of EFT as a tool with their clients (Ext. 53, 54) could be linked to the concept of compassion satisfaction, which relates to positive affect professionals derive from being able to help (Figley, 2002; Radley & Figley, 2007). It could be suggested that the joy of helping with EFT is one of valuable aspects of having this technique in the therapeutic arsenal of a trauma therapist.

All the participants of this study enthusiastically reported on how effective and rapid EFT was in their practice, especially for working with traumatised clients (Ext. 53, 54), and compared it favourably to other therapeutic approaches (Ext. 65, 57, 58). These reports of efficacy are supported by the growing research on EFT treatment for PTSD with wide-ranging populations such as veterans (Church et al., 2013; Church et al., 2016); survivors of sexual violence (Nemiro & Papworth, 2015) and natural disasters (Gurret et al., 2012), including some studies where significant reduction in traumatic memories was achieved after a single session treatment (Church et al., 2012). It may be reasonable therefore to conclude that their use of

EFT in therapy with clients may have been a significant contributing factor to these therapists' experience of compassion satisfaction, which in itself can offer protection against stress-related conditions such as compassion fatigue and burnout in health workers (Murray, Logan, Simmons, Kramer, Brown, Hake, & Madsen, 2009). The suggestion that using EFT enhances satisfaction has also been reported in the findings of a study by White (2014) on the use of several different energy psychology approaches by trauma therapists, with the title of the paper announcing, "It helps me to love my work".

The speed of efficacy in reducing the intensity of negative emotion appears to be one of the most useful features of EFT reported by the therapists who took part in the study: just one or two 'rounds' of the standard EFT procedure, typically taking no more than one or two minutes, are sometimes enough to produce a significant calming effect in the client (e.g. Ext 53, 54, 56). The relaxation and calming response is typically evident very quickly - either during or immediately after carrying out the procedure, which was also found in previous studies on the experiences of EFT therapists (Chalmers, 2015; Mason, 2012; Schultz, 2007; White, 2014).

The evidence of this study suggests that incorporating EFT as a therapeutic approach in work with clients can indeed enhance the levels of compassion satisfaction in therapists, with the participants using terms such as "amazing" (Ext. 53, 58), "extraordinary" (Ext. 54), "gentle" (Ext. 54), "the safest approach I know and the most rapid" (Ext. 63). EFT being conducive to the use of humour in therapy has also been mentioned (Ext. 65).

5.7. Implications of this study

Clinical applications of EFT for a range of symptoms in clients in mental health, for PTSD (Church et al., 2013; Karatzias et al., 2011; Sebastian & Nelms, 2016), anxiety (Clond, 2016), depression (Nelms & Castel, 2016), food cravings (Stapleton et al., 2016) are becoming better known and embedded in some health services, with the increasing volume of research. The findings from this study indicate that EFT as a therapeutic approach has additional value in enhancing the well-being of therapists and counsellors, especially those who work with trauma who may be subject to vicarious traumatisation and compassion fatigue. This is due both to its effectiveness as a way of potentially 'inoculating' the therapist against some of the possible deleterious effects of working with traumatised clients through the phenomena of 'borrowed benefits' and in its use as a deliberate self-care tool in general day to day use or specifically prior to and/or post sessions with clients.

Below is a summary of potential self-care applications of EFT by therapists:

Day-to-day use of EFT:

- Stress management, self-soothing and emotional regulation
- Getting in touch with own needs, grounding, re-connecting with self
- Healing and personal development - either through a self-applied treatment, or through accessing services of a trained EFT therapist

Work-related use of EFT:

- Preparation for client sessions
- Enhancing empathic connection and intuition

- Awareness of own triggers and counter-transference responses (with clients and/ or colleagues where working for an organisation)
- Protective ‘inoculation’ against picking up aspects of client’s traumatic and distressing material
- As a ‘clearing’ technique after the session, to clear the therapist’s energy and their therapeutic space
- For self-supervision and self-reflection

5.8. Concerns about unsafe use of EFT

Findings of this study also raised a number of concerns from participants about the potentially unsafe use of EFT. Participants reported that as EFT appears to be such a powerful tool that allows quick access to client’s inner world, there is a potential to reach traumatic material early in therapy process (Ext. 66, 69). With a therapist who is inexperienced in work with trauma there may be a risk that they cannot contain the client's distress safely, with the potential of severe abreactions[9] and even re-traumatisation to the client, and possible impact on the therapist's own wellbeing.

There was also concern expressed by some participants that there may be a level of complacency among the EFT community, including some EFT trainers, who advocate the use of EFT in early stages of the first session (Ext. 68), and espouse the belief that EFT is better than any other treatment and can be used as a stand

[9] Abreaction - an intense emotional response, typically due to connection to traumatic material

alone therapy (Ext. 67). Whilst the findings of this study do suggest that EFT is a safe and gentle therapeutic technique, and previous research has found that incidence of abreaction is low when delivered by qualified psychotherapists (Shultz, 2009; White, 2014), the apparent ease with which EFT helps to bring up traumatic material raises some causes for concern, especially where the practitioner has no mental health background or specialist trauma training (Ext. 66, 67, 69).

This emphasizes the need for proper ethical and practice guidelines of professional EFT organisations and education providers, and the importance of EFT practitioners acquiring specialist training necessary for working with the client groups of their niche. Whilst all the therapists who took part in this study were enthusiastic about EFT as a therapeutic tool, several of them noted the importance of their skills in talking therapy and how that foundation supported their use of EFT to make it more effective.

5.9. Study limitations

This was a small scale study, with only 8 participants, and as such was limited by its scope. Participants were self-selecting, and were likely to more enthusiastic about EFT applications in their practice and as a self-care tool than some of the therapists who would have been eligible but did not choose to take part in the study. The researcher's personal experience of EFT as a therapeutic and a self-help tool is likely to have had some influence on the way she identified the emergent themes from the collected data.

6. CONCLUSION

6.1. Concluding remarks

This study highlighted that, in addition to offering an effective and gentle tool for trauma processing work with clients, EFT's apparent benefits for therapist well-being merit much further attention in the field of mental health. The main beneficial effects include the apparent protective "inoculation" of EFT against the impact of clients traumatic material on the therapist; ease and efficacy of EFT application for stress management and emotional regulation; and its qualities in

enhancing self-awareness and reflexivity. These features of EFT place it as a helpful therapeutic approach not only in supporting clients suffering from trauma and other types of psychological distress, but as a unique and valuable self-care tool for mental health professionals who may be at risk of stress-related disorders due to the nature of their work . It can be concluded that EFT deserves to be much more widespread among mental health professionals, and should ideally be widely integrated in training programmes for counsellors, psychotherapists and psychologists as a standard therapeutic tool.

6.2. Future research

The following additional areas of research could be usefully investigated to build on the findings of this study.

EFT for therapist's own trauma

The findings of this study show that EFT was perceived as a highly effective and gentle tool for trauma work by therapists (Ext. 53, 54, 55, 63), a view has also been suggested by previous studies looking at therapist experiences in the use of EFT (Schultz, 2009; White, 2014). With a significant volume of research supporting the therapeutic use of EFT for treatment of PTSD (Church et al., 2013; Nemiro & Papworth, 2015; Boath et al., 2014; Gurret et al.,2012), it is highly likely to be helpful to therapists and other mental health professionals for healing their own traumas. Whilst normally this would require therapy with a trauma-informed practitioner, it is interesting to note that EFT has a number of trauma protocols that can potentially be used for self-treatment, including the Movie Technique, Tearless Trauma Technique (Craig, 2011), Matrix Reimprinting (Dawson & Allenby, 2010), Picture Tapping Technique (Davis & Sutton, 2014) and Identity Healing (Hunt,

2016). Future research could help evaluate whether EFT is helpful in reducing the impact of previous trauma in mental health professionals, and in particular trauma therapists, and how this affects their wellbeing overall, as well as their capacity and efficacy in working with traumatised clients.

EFT in supervision

Another area that hasn't been touched upon in this study was the use of EFT in clinical supervision. Anecdotally, many EFT practitioners and their supervisors (sometimes known as "mentors") use EFT tapping during supervision sessions to enhance self-awareness and intuition, as well as tapping during self-reflection, in a way of 'self-supervision'. It would be valuable to explore whether incorporation of EFT into clinical supervision could improve the experience of both therapist and supervisor, in raising awareness of counter-transference reactions and simultaneously soothing any negative affect from discussion of distressing and difficult client cases.

Tapping with the client or on the client?

Some variations of the standard EFT procedure allow the therapist to physically tap on the client's acupressure points, which is less common among EFT practitioners whose professional background is counselling and psychotherapy, rather than body therapies such as massage, reflexology, acupuncture, where it is a normal expectation for the client to be touched by the therapist. It can be hypothesized that the therapist who taps directly on the client rather than on themselves during

the EFT procedure is less likely to benefit from the 'inoculation' effect, even though it can be argued that the acupressure points on the therapist's fingers that are used for the percussive action of tapping will be stimulated in any case. It would be for the benefit of both clients and practitioners to investigate whether the apparent protective effect of EFT differs between therapists using it "on" the client and "with" the client, which would help inform the best practice in the use of EFT for trauma.

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APPENDIX I

DSM 5 Diagnostic Criteria for Post-Traumatic Stress Disorder (adapted from APA, 2013).

Criteria satisfied by client are marked in blue.

Criterion A: Stressor.

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

1.Direct exposure.

2.Witnessing, in person.

3.Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.

4.Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: Intrusion symptoms

The traumatic event is persistently re-experienced in the following way(s): (one required)

1.Recurrent, involuntary, and intrusive memories.

2.Traumatic nightmares.

3.Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness.

4.Intense or prolonged distress after exposure to traumatic reminders.

5.Marked physiologic reactivity after exposure to trauma-related stimuli.

Criterion C: avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

1.Trauma-related thoughts or feelings.

2.Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

Criterion D: negative alterations in cognitions and mood

Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

1.Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).

2.Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").

3.Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.

4.Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).

5.Markedly diminished interest in (pre-traumatic) significant activities.

6.Feeling alienated from others (e.g., detachment or estrangement).

7.Constricted affect: persistent inability to experience positive emotions.

Criterion E: alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)

1. Irritable or aggressive behavior

2. Self-destructive or reckless behavior

3. Hypervigilance

4. Exaggerated startle response

5. Problems in concentration

6. Sleep disturbance

Criterion F: duration

Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

Criterion G: functional significance

Significant symptom-related distress or functional impairment (e.g., social, occupational).

Criterion H: exclusion

Disturbance is not due to medication, substance use, or other illness.

Specify if: With dissociative symptoms.

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

1. Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).

2. Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

APPENDIX II

Information Sheet

Date:

Dear [Participant],

I am studying a MSc degree in Therapeutic Practice for Psychological Trauma at the University of Chester.

I am about to embark on my final year research project dissertation and would like to invite you to take part in an interview regarding your experiences of using EFT (Emotional Freedom Techniques) as a self-care tool in the context of your work with trauma clients.

I am interested in the potential applications of EFT in helping trauma therapists to ameliorate the psychological, emotional and physical impact of working with clients presenting with issues of trauma and post traumatic stress. The title of the study is *"A Thematic Analysis of the use of EFT (Emotional Freedom Techniques) as a self-care tool in trauma therapists"*.

The results from the findings of my research study will be analysed and then disseminated within the public domain. To protect confidentiality the research will be carried out in accordance with the University of Chester's guidelines as outlined in the Research Governance Handbook, alongside the British Psychological Society (BPS) Codes of Ethics and Conduct. Any information gathered will be stored securely in accordance with the Data Protection Act (1998) and your identity will be kept anonymous.

There will be 10 participants as it is a small qualitative study, which will involve you being invited to attend a one-to-one interview with myself lasting up to approximately 90 minutes, either face-to-face or via Skype. The interview will be recorded and then transcribed so that I can analyse it using a qualitative

methodology called Thematic Analysis, which helps to identify the themes emerging during the interview.

The inclusion criteria for the study are: psychotherapists, counsellors, psychologists and psychiatrists who are accredited/registered with an appropriate professional body (such as BACP, UKCP, HCPC), working in England or Wales, trained in EFT (Emotional Freedom Techniques) to at least Level 2 (AAMET syllabus or equivalent), and have been using EFT with trauma clients as well as a self-care tool for 2 years or more. The exclusion criteria are: those who are not fluent in English, and those who have experienced a personal trauma within the past twelve months - this is to protect them from potential triggers to their own trauma reactions.

You will remain anonymous throughout and your identity will be protected by relevant codes of ethics. In accordance with the University of Chester's Research Governance Handbook, a pseudonym will be used in place of your name, and any quotes from the interview used in the final dissertation and any subsequent publications will be anonymised. There may be a small potential risk of your identity being recognisable through the contents of interview extracts, and to reduce this risk, only short extracts will be used in the thesis and subsequent published material based on the research. Any electronic data gathered in the course of the project will be password protected, and deleted after the research is written up. Hard copy data will be stored in a locked cabinet, and shredded after 5 years in line with the University of Chester's Research Governance Handbook. You have a right to withdraw without giving any reason or explanation at any time, up to the point that the research is written up which is anticipated to be in August 2016. The completed study will be available in thesis form, and will be accessible in electronic format.

The possible benefits of the study for you are that it will offer an opportunity to reflect on your experience of self-care and specifically use of EFT as a self-care tool in the context of working with trauma, enhance your awareness of your current strengths in looking after yourself, as well as potential points that could be further developed, whilst at the same time sharing your knowledge and experience and bringing valuable insight to this subject where there has been relatively little study. I anticipate that this research study will be of a low-risk nature, however some aspects of this topic may be potentially distressing, and you are advised to

seek personal support and supervision if necessary, which would be at your own expense if required. Information on and contact details of organisations offering support in the event of any adverse reaction to the participation in the project will be provided.

My research has been approved by the University board of ethics and my work will be monitored by an academic supervisor throughout the study. Any concerns or complaints will be met firstly with me, my supervisor Dr Nikki Kiyimba at n.kiyimba@chester.ac.uk or the Dean of the Faculty Mr David Balsamo at d.balsamo@chester.ac.uk for any issues which you may have.

If you have any questions at this stage regarding this proposed research study, please do not hesitate to contact me on 0618258@chester.ac.uk or over the phone 07887 617558.

Thank you for your time.

Yours sincerely,

Masha Bennett

Support organisations

Samaritans
Address: Freepost RSRB-KKBY-CYJK, PO Box 9090, STIRLING, FK8 2SA
Telephone: 116 123
Email: jo@samaritans.org
Website: www.samaritans.org

BACP (British Association for Counselling and Psychotherapy)
Address: BACP House, 15 St John's Business Park, Lutterworth, Leicestershire LE17 4HB
Telephone: 01455 883300
Email: bacp@bacp.co.uk
Website: www.itsgoodtotalk.org.uk/therapists/

UKCP (United Kingdom Council for Psychotherapy)
Address: 2nd Floor, Edward House, 2 Wakley Street, London EC1V 7LT
Telephone: 020 7014 9955
Email: info@ukcp.org.uk

Website: www.psychotherapy.org.uk

APPENDIX III

Interview Schedule

(Prompts in italics)

1.Tell me about your therapy practice in the context you work in?

How many days
How many clients
What are typical clients

2.Tell me about your work with clients who have experienced trauma?

How do you define trauma?

3. In what ways has working with trauma clients impacted you?

Emotionally
Physically
Beliefs about world / self

4. In what ways do you attend to your own self care?

Physically
Emotionally
Socially

5. How did you start using EFT?

For self
With clients

6. How does EFT compare with other approaches in working with clients with trauma?

Advantages
Disadvantages
What is your hypothesis on how EFT works and what is the mechanism?

7. How do you use EFT for self-care in the context of working trauma?

Before session
After session
During session
Day-to-day

8. What difference does it make when you use EFT for yourself versus when you don't use, e.g. when you don't have the time?