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THE EXPERIENCE OF LEARNING EMOTIONALLY FOCUSED COUPLES THERAPY

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This study examined the process of learning Emotionally Focused Couples Therapy (EFT) as reported by 122 EFT therapists and therapists-in-training. Participants completed an online questionnaire assessing their experiences of learning EFT, with particular emphasis on EFT theory, alliance, interventions, perceived impact on clients, and impact on self. Findings suggest that therapists are drawn to the attachment-based model of EFT, appreciate the EFT framework and structure, that clients endorse the usefulness of the model and that learning the model has contributed to personal healing and improved relationships for the trainees. Results also show that the transition to EFT from another model can be taxing and requires time, support, and additional supervision/training to increase comfort level and competency with EFT. Nevertheless, results also highlight that learning EFT can be a rewarding and worthwhile endeavor.

The need for empirically supported and effective approaches to couples therapy has been emphasized in the research literature (e.g., Christensen, Doss, & Atkins, 2005; Northey & Hodgson, 2008). One approach that has received increased attention and popularity in recent years is Emotionally Focused Therapy (EFT; Johnson & Greenberg, 1985; Johnson, 2004). In addition to its popularity, EFT has also been found to be one of the most effective approaches for working with couples experiencing relationship distress (Johnson, Hunsely, Greenberg, & Schindler, 1999). Two meta-analytic studies of couples therapy research, both conducted by researchers with no formal EFT training or affiliation, have concluded that EFT is as or more effective than Behavioral Couples Therapy for marital distress (Byrne, Carr, & Clark, 2004; Wood, Crane, Schaalje, & Law, 2005). As such,

> EFT combines experiential, systems, and attachment theories with the goal of fostering the development of safe contact, accessibility, and responsiveness in both partners and making them aware of their attachment needs. To attain this, the couple has to deal with the powerful emotional responses that organize their interactions and access and restructure elements of their inner working models, if these are problematic. They then can engage in new attachment behaviors. (Johnson, 1996, p. 24).

To accomplish these therapeutic goals, EFT moves through a relatively structured nine-step approach. The nine steps are as follows: (1) delineating conflict issues in the struggle between the partners, (2) identifying the negative interaction cycle, (3) accessing unacknowledged feelings underlying interactional positions, (4) redefining the problem(s) in terms of underlying feelings, (5) promoting identification with disowned needs and aspects of self, (6) promoting acceptance by each partner of the other partner's experience, (7) facilitating the expression of needs and wants to restructure the interaction, (8) establishing the emergence of new solutions, and (9) consolidating new positions (Greenberg & Johnson, 1988).

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Although the effectiveness of EFT has been demonstrated, very few studies have focused on the process of becoming an effective EFT therapist (Montagno, Svatovic, & Levenson, in press). The process of learning and mastering EFT requires intensive training and supervision. This process may be particularly difficult for seasoned therapists who have used theories requiring little or no structure. To better understand the intricacies of learning EFT, the current study aims to explore the lived experience of therapists learning the EFT model.

PROCESS OF LEARNING EFT: WHAT WE KNOW SO FAR

Little information is available in the current research literature regarding therapists' perception of the process of learning EFT. It has been suggested that learning how to do couples therapy, regardless of the type of model, is more of an art than a science (Palmer & Johnson, 2002). Further, working with emotions is a main focus of EFT, and some therapists may not feel comfortable engaging the couple and self in the emotional exchange that is central to the work of EFT. In what follows, and as outlined by Greenberg and Johnson (1988), the different components of the EFT model that may be particularly relevant, and at times challenging, to those in training will be discussed.

First, it may be challenging for new trainees to focus on the interactions between the couple instead of only intrapsychic factors. Second, trainees have to learn how to focus on the couple's emotional experiences in session. Third, the beginning EFT therapist has to learn how to remain nonjudgmental throughout the therapy process. Fourth, it can also be challenging for the EFT therapist to learn how to maintain a focus on both interpersonal process and intrapsychic information. Fifth, EFT trainees, as well as other couples therapists in training, face the challenge of having to learn how to structure a session and how to work with alliances (Greenberg & Johnson, 1988).

Areas of particular interest in this investigation include the therapeutic alliance and a focus on attachment theory. Research has shown that the therapeutic alliance in EFT is a strong predictor of therapy success (e.g., Johnson & Talitman, 1997). Palmer and Johnson (2002) noted that the therapeutic alliance may be in and of itself healing. As such, beginning EFT therapists will have to learn how to establish a close working relationship with both partners, being equally compassionate and nonjudgmental. Regarding attachment theory, EFT therapists will have to learn how to address each partner's need for a sense of security. This involves becoming aware of each partner's attachment strategies and tailoring the therapy process to create and increase connection between the couple (Palmer & Johnson, 2002).

Palmer-Olsen (2009) stated that, perhaps, the most difficult aspect of learning EFT is to unlearn previously learned therapy models. She goes on to say that learning EFT becomes easier as therapists are willing to move away from previously learned models, allowing themselves to experience a "clinical paradigm shift" (p. 13). Palmer and Johnson (2002) suggest that the prerequisite for becoming a successful EFT therapist is to find the model personally appealing. The authors suggest that therapists' level of comfort with the EFT model will largely depend on where they are in their personal and professional development and how aware they are of themselves.

Finally, a study investigating therapists' experience with EFT training and supervision led to a proposal for an EFT Training and Supervision Model (Palmer-Olsen, 2007). The author suggests that there is a need for effective training and supervision when learning EFT. Although an EFT certification model exists, until the publication of this special section, the field has lacked a fully articulated model of supervision that explains the process by which a trainee gains EFT competence. The findings from Palmer-Olsen's original study identify six principles that may be helpful to those in EFT training as well as to those who provide supervision to EFT trainees. In what follows, Palmer-Olson's EFT Training and Supervision Model will be briefly discussed.

First, EFT supervision and training should be based on a strong supervisory alliance. Effective EFT supervisors were described as "warm, accessible, and transparent" (p. 60) by most study participants. Second, EFT supervision and training was perceived as most effective when the EFT supervisor incorporated "self-of-the-therapist" issues into supervision and

modeled how to appropriately deal with personal issues when they arose. Third, EFT supervision and training seems to benefit from the use of EFT written materials during supervision. It has been suggested that using the ''treatment manual'' (Johnson, 2004) and workbook (Johnson et al., 2005) may increase supervision effectiveness. Fourth, modeling and practicing EFT concepts and interventions may make supervision sessions more effective. Specifically, role-playing EFT techniques was found to be most effective for the participants in the Palmer-Olson study. Fifth, EFT supervision and training should include observation of clinical work via live supervision and the review of audio and video tapes. As was suggested, observation of clinical work may help increase the supervisee's delivery of the EFT model. Sixth, EFT supervision and training should include goal setting and evaluative elements for supervisor and supervisee. Structure, goals, and an open supervision process may help to maximize the effectiveness of EFT training and supervision.

Emotionally focused therapy has been found to be one of the most effective approaches to couples therapy (Johnson et al., 1999); yet, little is known about the process of learning EFT and the ease and/or difficulty with which it is learned. This study was designed to advance the literature on the process of learning EFT by examining therapists' draw and appeal to EFT. Specifically, this study focused on examining therapists' draw to EFT theory, perceived impact on clients, and impact on self.

METHODS

Procedure

Once IRB approval was received for the project, participants were recruited from a listserv designated for an international body of clinicians that had previously completed official (International Centre for Excellence in Emotionally Focused Therapy—ICEEFT) EFT training. In the month following the initial request, two additional calls for participation were sent out on the same listserv. If interested, clinicians were directed to a website where they could complete a consent form and fill out the questionnaire.

Sample

The sample for this study includes 122 clinicians recruited from an EFT listserv consisting of therapists around the world that have participated in EFT training. The sample is largely women (81%), White (90%), and middle-aged (mean, 52.3 years). Fifty-two percent of the sample described themselves as religiously affiliated, with Judaism as the largest affiliation (22%). Twenty-six percent of the sample described their religious affiliation as strong, 29% as moderate, and 45% as not religious.

Thirty-eight percent of the sample classified themselves as Marriage and Family Therapists, 23% as Clinical Psychologists, 16% as Social Workers, 11% as Counseling Psychologists, and 7% as Mental Health Counselors. Thirty-three percent of the sample had obtained a doctoral degree, 58% a master's degree, and 9% ''other.'' Seventy-two percent of the sample listed private practice as their primary clinical setting. The most common response to the question ''What percent of your practice is couples therapy,'' was 50%. Eighty-eight percent of the sample stated they draw upon EFT techniques ''most'' or ''all'' of the time when working with couples, 74% when working with individuals, and 58% when working with families. When asked about their level of EFT training, 51% stated they had completed the 4-day EFT Externship, 21% stated they had also completed advanced training and EFT supervision, 11% stated they are Registered EFTs, and 10% stated they are also EFT supervisors (for more information on the EFT registration process, go to http://www.icceft.com or http://www.eft.ca).

Measures

The questionnaire was created specifically for this study. As stated previously, the purpose of the study, and the accompanying measure, was to gather data describing the process of learning EFT. Accordingly, the survey consisted of both quantitative and qualitative questions across the following sections: (1) demographics, (2) the appeal of EFT, and (3) the experience of change to EFT. The demographics section consisted of questions regarding standard

personal and professional identifying information. The section on the appeal of EFT focused on major domains in the EFT literature (theory, alliance, intervention) that may have influenced a clinician's decision to learn EFT. The quantitative questions in the appeal section were based on a 6-point likert-type scale ranging from inaccurate to accurate. In addition, this section included questions regarding the impact of practicing EFT on clients and on the therapist her or himself. The change to EFT section consisted of open-ended questions regarding previous clinical experiences, as well the actual process of learning and practicing EFT. (for a complete copy of the questionnaire, please contact the authors).

Results from Quantitative Data

A series of simple statistical analyses (regression, ANOVA) were conducted to determine whether significant associations existed among any of the demographic variables (see Table 1 for descriptive statistics) and the five key areas in section ''Methods'' of the questionnaire (theory, alliance, intervention, clients, self). Table 2 lists participants' mean and standard deviation scores for each question (6-point likert-type scale ranging from inaccurate to accurate) in section ''Methods'' of the study. Owing to the small numbers, an analysis among groups in the categories of race, theoretical orientation, and religious affiliation was not possible. Specifically, no participants in the study described themselves as American Indian–Alaska Native, Native Hawaiian or Pacific Islander, or Black or African American. This problematic response bias, and accompanying implications, will be discussed in the limitations section. In addition, no participants described themselves as behavioral or strategic therapists. Among religious affiliations, no participants described themselves as Pentecostal, Seventh-Day Adventist, or Muslim. In addition, owing to cell-size limitations, we did not test for intercorrelation between predictive variables in a multiple regression or MANOVA model. The implications of this constraint will be discussed in the limitations section. A report on quantitative findings, by section, follows.

Draw to EFT—Theory. A question relating to therapists' understanding of systems theory was significantly ($p < .001$) related to their academic background. Specifically, results from the ANOVA procedure showed that Clinical Psychologists rated their prior knowledge of systems theory significantly lower than all other groups of mental health professionals in the study. Similarly, a question about experiential–humanistic theory was significantly related ($p < .05$) to academic background. Results show that Counseling Psychologists in this sample scored significantly higher than Marriage and Family Therapists when asked to rate the impact of a humanistic–experiential approach on their ability to understand relationships in a new and meaningful way. This question was also significantly related to therapists' age ($p = .001$). The results of a regression analysis suggest that older therapists report less appreciation for an experiential–humanistic approach. A question relating to attachment theory was significantly associated ($p = .05$) with religious affiliation. This result highlights therapists who define themselves as ''religiously affiliated'' were more likely to claim a prior ''solid understanding'' of attachment theory than those clinicians who did not.

Draw to EFT—Perceived impact on clients. There were no significant associations between the key demographic variables and questions in the ''alliance'' or ''intervention'' sections; however, academic background and therapist age were related to questions regarding the perceived impact of EFT work on clients. When responding to the question ''My clients have expressed that their lives have changed for the better as a result of our EFT work together,'' Social Workers scored significantly ($p < .012$) lower than Mental Health Counselors (the highest mean score on this item). Therapist age was significantly ($p < .009$) related to this question as well; older therapists were less likely to respond affirmatively to this client change question.

Draw to EFT—Impact on self. Therapist age, professional license, and/or level of EFT training were significantly associated with three different questions in the ''Impact on self'' section of the study. Specifically, therapist age was significantly associated ($p < .05$) with a question about EFT training providing a meaningful and life-changing understanding of one's own life experiences. The results of the regression analysis suggest that as therapist age increases, the ability of EFT to provide a meaningful and life-changing understanding of one's own experiences decreases. Professional license was significantly associated ($p < .05$) with a question regarding the impact of learning EFT on forming deep, secure attachments outside of the

Table 1
Demographics

Variables	Mean	*SD*
Age	52.32	9.38
Years since graduation	13	10.6
	N	%
Gender		
M	23	18.9
F	99	81.1
Race		
American Indian–Alaska Native	0	0.0
Asian or Asian American	3	2.4
Native Hawaiian or Other Pac Islander	0	0.0
Black or African American	0	0.0
White	111	89.5
Consider myself more than one race	5	4.0
Other	5	4.0
Religiously affiliated		
Yes	62	52.5
No	56	47.5
Religious affiliation		
Roman Catholic	6	7.7
Protestant	10	12.8
Baptist	3	3.8
Episcopalian	2	2.6
LDS	3	3.8
Methodist	2	2.6
Presbyterian	4	5.1
Pentecostal	0	0.0
Seventh-day adventist	0	0.0
Jewish	17	21.8
Buddhist	7	9.0
Muslim	0	0.0
Other	24	30.8
Consider yourself		
Strongly religious	30	25.6
Moderately religious	34	29.1
Not religious	53	45.3
Academic background		
Clinical psychology	28	22.6
Counseling psychology	14	11.3
Marriage and family therapy	47	37.9
Social work	20	16.1
Mental health counseling	7	5.6
Other	8	6.5
Highest degree in any mental health field		
MA/MS	47	38.2
MSW	22	17.9
Ed.S	3	2.4
Ed.D	3	2.4

Table 1
(Continued)

Variables	Mean	*SD*
Psy.D	4	3.3
PhD	33	26.8
Other	11	8.9
Primary clinical license		
Psychologist	29	24.6
Marriage and family therapist	44	37.3
Social worker	20	16.9
Mental health counselor	13	11.0
Other	12	10.2
Primary theoretical orientation		
Behavioral	0	0.0
Cognitive-behavioral	5	4.2
Interpersonal	9	7.6
Humanistic/Existential	8	6.7
Eclectic	21	17.6
Systems	8	6.7
Emotionally focused	45	37.8
Contextual	1	0.8
Strategic	0	0.0
Experiential	6	5.0
Other	16	13.4
Primary work setting		
Private practice	85	72.0
Community mental health center	8	6.8
Student counseling center	8	6.8
Medical setting	3	2.5
Religious/church setting	2	1.7
Other	12	10.2
Level of EFT training		
5-day EFT externship completed	60	50.8
Advanced Training/EFT Supervision	25	21.2
Registered EFT therapist	13	11.0
EFT supervisor	12	10.2
Other	8	6.8

therapy room. Results of the ANOVA suggest that Clinical Psychologists scored lowest on this question and Mental Health Counselors scored the highest; the difference between these scores was significant ($p < .05$). Level of EFT training was significantly ($p < .05$) related to a question regarding how therapists approach their own relationships outside of the therapy room. Clinicians who had completed only the EFT externship scored significantly lower on this question than those who had also completed the advanced externship and some supervision.

Results from Qualitative Data

At the conclusion of the quantitative questions in the survey, participants were asked to respond to open-ended questions. These questions addressed the same five areas (theory, alliance, interventions, perceived impact on clients, and impact on self) as the previous quantitative questions, but the open-ended nature allowed participants to share "any additional insights and

Table 2
Means and Standard Deviations

Appeal of EFT	Mean	*SD*
Theory		
Question 1	3.45	1.51
Question 2	4.78	1.23
Question 3	4.77	1.22
Question 4	5.68	0.54
Question 5	5.13	0.94
Question 6	5.06	0.97
Question 7	5.79	0.45
Question 8	5.26	1.06
Question 9	5.39	0.95
Question 10	5.69	0.59
Question 11	5.50	0.80
Question 12	5.31	0.87
Alliance		
Question 1	5.14	1.31
Question 2	5.09	1.23
Question 3	4.79	1.55
Intervention		
Question 1	5.12	1.03
Question 2	5.23	0.90
Question 3	5.28	0.86
Impact on clients		
Question 1	5.56	0.62
Question 2	5.25	0.70
Question 3	5.14	0.94
Question 4	5.07	
Impact on self		
Question 1	5.56	0.89
Question 2	5.38	0.98
Question 3	5.31	1.05
Question 4	4.80	1.28
Question 5	4.95	1.23

experiences'' regarding these five key areas. The responses to these questions were sorted by topic and analyzed separately.

Analysis. A team of four researchers, all MFTs, independently reviewed the written responses to each question. Therapists' comments were analyzed by question/topic area; each researcher attempted to group the responses according to similarities and differences among descriptions. These initial codes represented simple groupings of similar incidents, phenomena, or experiences (Corbin & Strauss, 1990) described by the therapists. The ''naming'' of similar phenomena or coding helped to ''label, separate, compile, and organize data'' (Charmaz, 1983, p. 111). For example, a response to the open-ended question regarding theory, ''Helping couples connect and express their attachment needs'' was placed in the ''Attachment Theory'' grouping. The response to the alliance question, ''EFT gave me real-life skills for making a stronger alliance,'' was placed in the initial grouping ''Stronger Alliance.''

Once this initial and independent sorting and grouping process was completed, the two authors discussed each researcher's conceptualization of key phrases and concepts. The two lead researchers–authors then compared the four sets of initial coding for exceptions and/or

redundancies, often called constant comparison (Corbin & Strauss, 1990). In these discussions, the authors frequently referred to the transcripts and attempted to honor and highlight therapists' own language in the naming of codes (Constas, 1992). At this point, the authors collaboratively worked to re-group the initial codes into more theoretically dense groupings, often combining initial codes of similar theme. For example, the previously cited quote regarding a "Stronger Alliance" was combined with other similar quotes to form the broader, more dense "EFT alliance" grouping. As a result, the newly labeled codes provided a more complete or "thicker" description of the therapists' experiences and perceptions (Geertz, 1988). This process was repeated until clear and consistent patterns emerged from the data, a process often referred to as saturation (Bowen, 2008). The results that follow represent the most frequent and consistent responses across therapists to the five open-ended questions.

Theory. Four primary themes emerged from responses to the question "Please share with us any additional insights or experiences regarding certain aspects of EFT theory that pulled you toward the study and practice of EFT." Therapists most frequently spoke of *attachment*-related concepts when answering the theory question. Specifically, therapists seemed to appreciate an attachment-based framework for understanding and treating couple–marital problems. For example, one participant noted:

> the unmet attachment-based needs are key to understanding WHY couples continue to seek connection, even when the relationship is filled with bitterness and fighting.

Others spoke of the practicality of attachment theory and its value in explaining the universal need to connect with others:

> I recognized immediately that the attachment dynamics with which I was working in dyadic sessions with children and parents were also present in my own marriage and family, as well as in the lives of friends.

> Attachment helped me refocus on the vulnerability that all people want to express.

The second most common set of responses to the theory question were related to EFT's focus on *emotion* in therapy. Therapists described the practical in-session value of focusing on emotion and using it as a vehicle to foster connection between partners. One therapist described

> using the power of emotions to move people out of rigid positions and facilitate reconnection.

Another described how effectively working with emotions helped make other learning possible,

> clients have no problem implementing what they learned in cognitive/behavior therapy AFTER their emotional turmoil has been dealt with.

Others spoke positively of how the model helps them feel more effective when dealing with strong emotion:

> previous training was inadequate when strong emotions were involved.

> EFT helps me get out of my. . .head and focus on emotion. . .to slow things way down.

The third most frequent set of responses relate to having a *map/frame* to guide therapy. Quite simply, participants appreciate the clear direction and focus EFT provides in therapy. One response is exemplary of others in this group,

> EFT is invaluable to me in knowing where to focus to help a distressed couple.

And fourth, therapists simply, but frequently, stated that *EFT works*. In their statements, the majority of participants were not referring to the outcome research on EFT, but instead their own experience with EFT in session.

> The simplicity and elegance of the theory worked. . .in my experience. . .nothing works better.

Overall, therapists most frequently described a draw to the attachment and emotion-based aspects of EFT. Once they began experimenting with EFT, they seemed to appreciate the practical utility and effectiveness of the model.

Alliance. Three main themes emerged from therapist responses to the question regarding additional insights or experiences with therapeutic alliance that may have pulled them toward EFT. The first and most consistent response related to *prior knowledge of or skill in the alliance area*. The first subgroup of responses in this dense code is represented by the following quote:

"I was already very aware of the importance of alliance but the EFT training underlined it in a very powerful manner." For these participants–clinicians, alliance had long been an important aspect of their work, but *EFT's focus on therapist—client connection further strengthened* prior abilities. As one participant stated, "I had excellent connections with my clients. EFT just helped explain it." The second subset of responses simply stated that forming a strong therapeutic alliance was *a skill they already possessed*; for example, "creating alliance was my strength before EFT training."

The third and final grouping of responses, although less frequent, spoke clearly of the *unique aspects of an EFT-based alliance* with clients. For these therapists, learning EFT seemed to help them become more empathic, affirming/validating, respectful, compassionate, and understanding toward clients. As one participant described, EFT helped her or him "to authentically and with integrity affirm people even when they made choices in relationship that kept them disconnected." Another participant eloquently described the change s/he experienced in this way:

> I particularly warmed to the no blame approach and seeing behaviour as a way of soothing uncomfortable feelings helps me to feel empathy for each party equally. It also has helped me to develop my language to be more descriptive and non judgmental which in turn gives me a warmer feeling towards a person even though they may be behaving in a way that could be seen as mean spirited.

This last quote speaks, as did others, of how the theory and practice of EFT helped clinicians care more deeply about people that were previously seen as difficult or even mean.

Interventions. When asked to share additional insights and experiences regarding EFT interventions that pulled therapists toward the study and practice of EFT, respondents identified three major themes. First, many clinicians stated they were *too new to EFT to know* how to respond fully to the question, for example, "I am too new to confidently use the interventions." One participant described in greater detail the struggle of therapists-in-training to learn, remember, and apply EFT.

> I am such a newbie in EFT, I really feel I don't know what I'm doing. It's enough for me to decide whether I am in the model, or have slipped back into my old ways. It is too much to figure out where I am with respect to what stage or step I on.

The second most frequent response described learning and applying EFT interventions as *hard or not natural*. Multiple participants described the struggle to change from their previous therapeutic approach to EFT or found the steps and stages hard to remember and apply.

> I believe that the interventions are extremely hard to learn for someone trained in different approaches- structural, strategic, contextual, etc. All of those interventions took us, the therapists, further away from the couple before us as human beings.

> This is the HARD part for me. I understand the EFT interventions—using them with all the complications clients bring is sometimes overwhelming for me.

> I have not found that I am able to do or even remember the steps of EFT in order to do them in order with my clients, other than the first one of de-escalation. What has

helped me do EFT is to keep several mantras in mind: focus on process, not content, go for feelings, recognize secondary emotions and ask about primary emotions.

Others described how some aspects of EFT interventions were *not natural and/or required a consistent effort* to apply:

While these interventions are useful, it is not natural for me to use without constant attention to the model

RISSSC [Repeat, Images, Simple, Slow, Soft, Client's words] is difficult for me, a fast talking, fast moving Northeasterner!

Overall, therapists seemed to appreciate the interventions outlined in EFT and have or are working to implement them. They also described clearly the struggle to learn, remember, and apply these interventions in their work with clients.

Perceived impact on clients. Three major themes emerged from the responses of participants to a question regarding how studying and practicing EFT has impacted their clients. The most frequent grouping of responses to this question related to "Client benefits." The participants–clinicians described uniquely positive client feedback, emotional openings and breakthroughs, less blaming in session, a reduction of fear, increased vulnerability and support/soothing between partners, a clearer understanding of negative cycles, increased confidence and competence, and even improved parenting. A few quotes illustrate the many statements comprising this first theme.

I've had 2 couples in the last week say they got more out of one or two sessions with me than they had in months of recent sessions with non-eft therapists. The greatest impact, of course, is clients' experience of a more engaged, resilient and secure relationship. I think eft is especially useful in what other models refer to as "over- and under-functioning" partners. It helps each partner see the emotional basis for their positions, attitudes. Pointing out how the cycle is the enemy decreases blaming and helps partners gain a broader perspective of their pattern.

One client said I've "seen four therapists and you're the first to go underneath to what's really going on.'

There is more heart connection during my couples sessions, and most report more connection during the week between sessions. I feel the work is heart centered, attachment based, because of all the eye contact and attachment based work that happens during a session. Couples report falling in love again during many of the sessions. Sometimes my next client arrives and says, "there's a couple holding each other in the waiting room. . . you must do amazing work with couples here."

The second most common theme in response to this question is similar to others in previous questions, in that *participants have not yet gained enough EFT experience* to notice a difference in their clients' experience.

My experience is limited. I took my externship 3 months ago. So, my own outcomes have been encouraging, but limited.

I would have been even more positive but I am such a newbie that I am still clumsy with the EFT moves. I think it will get even better over time and with greater practice and supervision.

Other statements in this theme suggest that some clinicians do not feel effective in their practice of EFT, thereby limiting their clients' experience in therapy.

I am not sure the EFT model has actually been helpful as I do not yet feel I am effective at it.

The third theme in this area highlights the concerns of a number of therapists who state *EFT does not seem to work for some clients*. In their descriptions, clinicians seem to highlight exceptions to the overall positive impact of EFT on clients.

> It has been extremely successful with all but my most intellectual/defended and dismissive/narcissistic clients. Otherwise they generally are deeply moved by their partner's expression of emotion.
>
> Most of my clients have greatly benefited from the EFT work I have done with them. There is always the occasional few who have had affairs, and continue to do so while therapy is ongoing (without my knowledge until later) that makes couples work so difficult. The vast majority of my work with couples, has benefited from the EFT framework.
>
> When I meet a couple who is motivated and each person expresses some ownership of their difficulties, I know that because of the model I work from, chances of success are very good. When there is less ownership by one or both partners, I have EFT to help me work through the demon dances and to try and create those bonding moments.

One additional comment describes the struggle to find success while practicing EFT, even after extensive training.

> Basically, I believe in the model, have had lots of training, supervision and conference calls and I still have lots of couples who are not getting better, or better fast. They like me, my work and keep coming, but I can't get them past stage 4 or 5.

Although listing specific concerns and exceptions, therapists generally expressed appreciation for the impact oflearning and practicing EFT has had on the clients they work with.

Impact on self (the therapist). The last open-ended question asked participants to reflect on the personal impact of studying and practicing EFT. Responses to this question yielded two major themes, both related to improved relationship and personal functioning. The most frequently repeated responses focused on *improved relationships* with others. Some of these comments spoke to improved marital–couple interactions. Two quotes highlight the intensity and depth of the comments comprising this theme.

> I note that my marriage of almost 24 years, is now better than it has ever been. I am able to note when either one of us is feeling unsafe as a result of an attachment injury from our childhood or from our past, and find ways to work through it. I am able to let him know what I need, where 5 years ago I would have expected him to know. I am also able to read him more empathically and validate his concerns. Wow, that is a great realization.
>
> It has helped me adjust some of the ways I relate to my husband. I take myself through a similar process that I take the clients and find that if I stop reacting and reach from my own attachment wound, my husband, of course, feels freer to show up in the way he would like, instead of a more defensive way. And of course this is a much better way to be in relationship. He also is more willing to share some of his feelings which in my mind is what I have wanted all along.

Other comments in this theme highlight improved functioning across a number of relationships, including relationships with children and parents.

> I have felt more confident in sharing my vulnerability, knowing that I am not "bad" but that my feelings and even my not-so-admirable actions make sense. I find myself relating to people with much more compassion rather than evaluating them in terms of their impact on me. I feel more confident and safe with people. I feel that what I have to give is valuable, a lot of love. I am less defensive. I can take criticism much better.
>
> The awareness EFT has brought to my own attachment needs has had a vast, lasting and profound effect on my relationship with my parents.
>
> I'm teaching my kids and grandkids things that will help them with their own attachments and heal stuff that comes from our shared past.

The second major theme regarding personal impact relates to *insight regarding personal trauma, and attachment injuries*. Clinicians described how learning and practicing EFT has helped to foster recovery from difficult events in their lives.

During the EFT externship I was finally able to have the language to make sense of an acutely painful ruptured relationship in my complicated stepfamily.

EFT has really helped me understand my own and my husband's attachment wounds in a new and different way. We feel empowered to grow our secure base even more.

EFT has given me incredible insights into my own contributions to my divorce, and has helped me to (hopefully) avoid this devastation in the future.

In summary, participants stated, with great appreciation, that learning and practicing EFT had helped to strengthen their relationships outside of therapy and aided in the process of healing from past trauma and injuries.

DISCUSSION

Quantitative Results

One of the most intriguing findings from the quantitative section of results is that certain groups of respondents (academic training, professional license, and religious) found some aspects of EFT theory and training to be more attractive or helpful than others. Specifically, Clinical Psychologists in the sample reported less previous knowledge of systems theory and less of an impact on personal relationships outside of therapy after EFT training, whereas Mental Health Counselors reported the highest scores when asked about client self-report of positive change and more secure personal relationships outside of therapy after learning and practicing EFT. Social Workers in the sample reported significantly lower scores in terms of client self-report of positive change after EFT, with Counseling Psychologists reporting significantly higher scores on a question regarding the impact of learning about the humanistic part of EFT on their understanding of human relationships. Although difficult to interpret without more information, it likely reflects the fact that training in psychology, particularly in clinical psychology, is less focused on systemic and humanistic principles (e.g., Nevid, Lavi, & Primavera, 1986). It is unclear why some professionals experienced significantly greater personal and professional change (Mental Health Counselors) and others reported no such change in a professional arena (Social Workers). More information regarding past therapy training, prior clinical experience (total hours of therapy vs. couples therapy), as well as perceived competence in professional and personal relationships is needed before we can attempt to understand key differences between professionals.

Religiousness, level of EFT training, and therapist age were also significantly related to key outcome variables. Clinicians reporting higher levels of religiosity were also more likely to report a solid previous understanding of attachment theory. Kirkpatrick and Shaver speak of an attachment-based approach to religion that may help explain this finding; specifically, they suggest that attachment bonds to God may be similar to those of parental figures (Bowlby, 1983; Kirkpatrick, 1992; Kirkpatrick & Shaver, 1992). Kirkpatrick (1992) postulates that God can be thought of as a secure base, providing believers with comfort in stressful times. As with parental figures, these attachment bonds may not only be secure. Religious attachment bonds, as Kirkpatrick and Shaver (1992) suggest, can take one of the three forms as follows: (a) secure, (b) avoidant, and (c) anxious–fearful. Those who view God as a secure attachment figure in their own lives may be more aware of and familiar with attachment-based concepts as related to their work with clients. Additionally, research suggests that those in mental health fields, specifically in psychology, are less religious than those in the general population (e.g., Delaney, Miller, & Bisono, 2007). EFT therapists tend to represent a group of therapists who especially value human connection and some extend this to a sense of connection to a higher power.

Clinicians receiving advanced EFT training were more likely to report a positive impact on their own relationships outside of therapy, providing at least initial support for the concept that EFT training is related to growth and positive change for clinicians (e.g., Rosenblatt, 2009). In addition, older therapists in the sample were less likely to be impacted by humanistic training, less likely to report client change after using EFT, and less likely to report EFT-induced change in their own lives. It appears that some older therapists have already learned lessons or experienced moments that accompany EFT training. Perhaps, some of the gifts of aging (experience, wisdom, understanding) make the impact of EFT training less pronounced (Edmondson, 2005).

When considering these findings, it is important to remember the sample consisted largely of a mature group of therapists (mean age, 52; mean years, since graduation 13).

Qualitative Findings

When given the opportunity to respond in their own words, participants spoke positively and enthusiastically about the pull to EFT training and its impact on their clinical and personal lives. However, participants also spoke openly about the struggle to implement the steps and stages of EFT and the degree of difficulty required to become proficient in its use.

ATTACHMENT AND EMOTION

The clinicians in this study stated appreciation for the attachment and emotional focus of EFT. This growing interest in adult attachment research goes well beyond the clinical realm. Beginning with Shaver and colleagues' groundbreaking work in the late 1980s (Hazan & Shaver, 1987; Shaver, Hazan, & Bradshaw, 1988), there has been a significant proliferation of adult attachment research over the last two decades, across multiple disciplines (Mikulincer & Shaver, 2007). Johnson notes that clinicians are perhaps drawn to attachment because it provides an integrated and practical theory of adult love relationships (Johnson, 2003, 2008). Participants in our study expressed appreciation for the map (emotion as the pathway to attachment which drives the need for connection) that EFT provides when working with couples. This EFT map or framework seems to help clinicians know what to focus on (emotion) and how to handle conflict (promote softening and engagement). Therapists also noted that EFT's attachment-based approach facilitates a deeper engagement among couples that goes beyond content-based conflict to core needs and longings or as one client said to her or his therapist "to go underneath to what's really going on." The results of this study resonate with the voices of many clinicians who now promote and practice attachment-based approaches to therapy (Cassidy & Shaver, 1999; Johnson & Whiffen, 2003).

PROFESSIONAL AND PERSONAL IMPACT

Over the years, numerous clinicians have claimed that their particular model of therapy has a positive impact on clients (Boszormenyi-Nagy & Spark, 1973; DeShazer, 1982; Mandanes, 1981; Selevini Palazzoli, Cecchin, Boscolo, & Prata, 1978; White & Epston, 1990). Some clinicians draw upon clinical research to validate that claim (see Sprenkle, 2002 for a comprehensive review of research on MFT practice). One of the interesting findings of this study is that clinicians, who are neither the originators of the EFT model nor its primary researchers, spoke clearly and positively about the perceived impact of their EFT work on clients. Because the majority of participants were already experienced therapists working from other models prior to EFT training, their statements regarding unique positive outcomes with EFT (e.g., "I've had 2 couples in the last week say they got more out of one or two sessions with me than they had in months of recent sessions with non-eft therapists") are worth noting. A review of therapists' statements regarding the effectiveness of EFT seems to highlight appreciation for the model's emphasis on and efforts to promote deep connection among partners. Also, participants lauded EFT's clear map–framework as a guide for the use of specific, theory-based interventions. Because a number of therapists mentioned that EFT seemed less effective with certain kinds of clients (e.g., highly intellectual, well defended, unwilling to take responsibility for her or his own actions, low motivation for therapy), additional research is needed to clarify why clinicians believe EFT is effective and under what circumstances (see Makinen & Johnson, 2006; Bradley & Furrow, 2007 for examples of this type of process research).

On a personal level, participants spoke openly about the positive impact of learning and practicing EFT on their personal relationships outside of the therapy room. Specifically, participants spoke movingly of resolved impasses, improved connection, and an increased understanding of self and other in their relationships with partners, children, grandchildren, and even parents. Therapists also spoke powerfully about the role of EFT training in resolving their own personal relationship traumas. The positive personal impact of EFT training described by clini-

cians was both surprising and unmistakable. This finding is particularly intriguing because personal growth and development of the therapist is not a stated objective of the EFT model, nor is it mentioned in detail in the core EFT training materials (Johnson, 2004; Johnson et al., 2005).

Although a number of trainers and supervisors are beginning to recognize the importance of self-of-the-therapist supervision, the concept that clinical training is meant to benefit and produce personal growth for the trainee is still disputed (Aponte, 1982, 1994; see Aponte, Powell, Brooks, Lawless, & Johnson, 2009). However, at a minimal level, these findings suggest that the attachment-based principles emphasized in the EFT model and supported by rigorous research are of potential benefit for clinicians as well as for clients. Of course, the idea that therapists are themselves wounded healers in need of healing is not new (see Nouwen, 1970 for a beautiful discussion of the wounded healer construct); however, the concept that clinical training in a specific model of therapy can lead to growth and healing in the trainee is provocative. Clearly, additional research is needed to identify whether and how such healing can occur across a number of unique EFT training settings.

LEARNING EFT: A CHALLENGING PROCESS

From the outset of the study, we wondered whether therapists who had invested time and money in the EFT training process would be willing to talk about the negative or challenging aspects of learning and practicing EFT. With clarity, clinicians did state that learning EFT takes time and practice before one can feel competent, that the model does not seem to work with all clients, that learning the steps and stages can be hard and/or confusing and that using a number of interventions (e.g., speaking slow and softly) can feel unnatural and require significant changes in a therapist's personal style. A number of participants simply stated "I am not very good at EFT," then went on to describe their discouragement. Although learning and becoming proficient in structured models of therapy requires time and practice (Bein et al., 2000; Karekla, Lundgren, & Forsyth, 2004; see Denton, Johnson, & Burleson, 2009 for an EFT specific therapist adherence scale), it appears that the intense emotion and attachment focus of EFT requires significant personal investment. In short, the results of this study suggest that learning and then becoming an effective EFT therapist can be a challenging process (see also Johnson, 2004, pp. 238–241); yet, for the participants in this study, the positive outcomes both in and outside the therapy room were worth the effort.

LIMITATIONS AND AREAS FOR FUTURE RESEARCH

The design of this study, and the actual data, is limited and cannot be generalized across training groups. First, the responses were provided by clinicians who were active on the EFT listserv, had or carved out the time to answer a lengthy questionnaire, and were willing to invest more energy into the process of learning EFT. Because the participants had already invested a good deal of time and money in the EFT training process, it may have been difficult for them to speak honestly about their struggles with the model. Also, as mentioned previously, the sample was largely women, White, and worked in private practice. As a result, the findings cannot be generalized to EFT trained clinicians who are not involved in the listserv community, work in agencies, and are men or clinicians of color. In addition, these results likely do not tell us about the experiences of those clinicians who received EFT training and were left unsatisfied or simply chose a different clinical path thereafter. In short, the findings are likely based on the experiences of pro-EFT clinicians who have the resources to invest in additional and time-consuming training. Although valuable and important because literally no data-based articles exist regarding the experience of learning EFT, clearly more research is needed to highlight the voices of the diverse (in terms of race, ethnicity, gender, and work setting) international group of clinicians now learning EFT and those whose training experience was unfulfilling (see Woolley et al., 2010).

The results were also limited by the questionnaire itself and subsequent data analysis. Because the questionnaire was a one-wave, self-report measure consisting primarily of simple open-ended and likert-type questions, it could not elicit perspectives beyond those provided by the respondents (e.g., clients, spouses) or highlight predictive trends in groups of trainees.

Although the open-ended questions allowed respondents to provide a description of their experience, a face-to-face qualitative interview would be necessary to gain a more rich and accurate understanding of the meaning and personal experience of learning EFT.

Because of the small homogenous sample and accompanying cell size issues, we chose to use simple mean difference tests in our analyses. As a result, we were not able to test for intercorrelations between predictor variables. Because a number of the significant predictor variables were highly correlated (e.g., religiosity and clinical license), we do not know, for example, how much of the significant relationship between clinical license and the impact of EFT on self is actually explained by religiosity. Furthermore, because of concrete, real-life differences between groups (for example Social Work and MFT or community mental health center and academic counseling center), we could not merge or dummy code subsets of responses in a theoretically coherent way, to meet statistical requirements. Therefore, the quantitative results must be interpreted cautiously or replicated with a much larger sample.

Although limited by design and analysis, this study is among the first attempts to understand the qualitative experience of clinicians learning this fast-growing and well-researched model. However, a number of important questions remain regarding the experience of learning EFT, questions worthy of additional research. What motivates a seasoned, mid, or later career clinician to seek out a different model of therapy, especially EFT? What specific aspects of the steps and stages of EFT are confusing or difficult to learn and practice? Which specific components of EFT training lead to the resolution of attachment traumas and facilitate change in the trainee's personal relationships? What gender and racial–ethnic differences (or similarities) exist among the varied experiences of clinicians learning EFT?

IMPLICATIONS FOR TRAINING AND PRACTICE

The results of this study provide practical implications for supervisors and supervisees engaged in EFT training. Perhaps, the most crucial finding in this study is that learning EFT can be frustrating and may require patience. Accordingly, supervisors may need to remember to shower trainees with encouragement and support. This encouragement may be especially vital in those moments when trainees feel inclined to say ''I have not found that I am able to do or even remember the steps of EFT in order to do them in order with my clients'' or ''I understand the EFT interventions—using them with all the complications clients bring is sometimes overwhelming for me'', as did participants in this study. A supervisor's ability to normalize frustration and feelings of failure may go a long way toward helping trainees overcome discouragement and stick with training until competency is achieved.

The findings may also prompt supervisors to ask trainees about the impact of training on their relationships outside of therapy. Supervision can be structured to provide a safe emotional space to discuss the personal growth of the therapist, as well as clinical cases. Aponte et al. (2009; see also Aponte, 1994) have eloquently described a detailed model for person-of-the-therapist training (POTT model) that distinguishes between trainee-centered supervision and therapy. An attachment-centered, personal growth-focused conversation can be fostered in supervision using principles described in the POTT model, or a number of additional supervision approaches (see Todd & Storm, 2002; Chapters 4 and 14 in particular). As supervisors help trainees identify key steps in their own healing and growth process, the trainees will be better able to use those experiences in therapy to benefit clients. As Aponte (1994) poignantly noted, ''the ultimate goal. . .[of therapist-centered training] is not achieved until trainees learn to use the original struggle and the journey to resolution as resources for their work with clients.'' (p. 5)

The results of this study also prompt EFT supervisors to deepen the level of discussion in supervision regarding attachment theory and its application to couples-based work. At least for the trainees in this study, attachment theory was the main ''draw'' to learn EFT. Because an attachment model for couples therapy can represent uncharted territory, particularly for clinicians trained in nonsystemic approaches, supervisors will likely need to spend time discussing basic attachment-based principles and facilitating the practice of attachment-based interventions. EFT-focused supervisors may wish to draw upon the practical questions

and learning activities in chapter two of the "EFT Workbook" when helping trainees to recognize and use attachment language in session (Johnson et al., 2005). The principles and learning activities outlined in Chapter 6 of the workbook can help supervisors teach about the role of emotion in identifying attachment needs, as well as help them to demonstrate how meeting attachment needs within the couple relationship is essential to forming secure bonds.

CONCLUSION

Over the last 15 years, there has been a literal explosion of growth in the number of EFT-related research articles, published clinical training materials, and registered EFT training events (Johnson, 2010). As a result, hundreds of clinicians around the world are receiving EFT training each year (see Woolley et al., 2010). To maximize the effectiveness of such training and its impact for good on clients and therapists, carefully constructed process and outcome research is needed. Not unlike the original process and outcome research that documented the specifics and effectiveness of EFT practice (Johnson & Greenberg, 1988), a new generation of inquiry is now emerging that seeks to highlight the best practices of EFT training. It is our hope that the same passion and insatiable curiosity that prompted the first generation of research will linger into the second and beyond.

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