

FIND YOUR VOICE

Through Emotional Focused Therapy and Attachment Theory

A Field Practicum Report

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By

Leanne Thoroughgood

Regina, Saskatchewan

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Abstract

This final paper is part of the requirements for completion of a Master's Degree in Social Work. This experiential final paper is based on a clinical field practicum focused upon Emotionally Focused Therapy (EFT) with couples. This document presents the practicum student's research into EFT and an exploration of the theoretical basis for EFT. Within the context of the requirements for graduate studies, investigation into the theory, ideology and challenges of this clinical approach was carried out in a private practice clinical environment. The primary goals of this field practicum were to gain knowledge of the process of EFT, and to learn the skills and challenges of this therapeutic process under supervision of an EFT clinician.

A comprehensive investigation into Attachment Theory and its application to EFT was initiated. The field practicum provided a supervised environment to study Attachment Theory, EFT and its processes within the context of the practicum student's personal and professional ideology. Clinical challenges; including student-client, student-supervisor and the student's introspective relationships; are discussed within the framework of EFT. The challenge of Emotionally Focused Therapy for the clinician is the ability to develop a secure therapeutic relationship that provides the appropriate environment for clients to voice their vulnerabilities in order to allow healthy change to occur. The clinician is therefore responsible to insure that any of their own emotional triggers are addressed in order for the therapeutic relationship to be at its optimal functioning. Understanding Attachment Theory and the potential our own history has to influence or impact a therapeutic relationship is paramount in working with EFT.

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Table of Contents

Abstract.....	ii
Acknowledgments.....	iii
Table of Contents.....	iv
Chapter One: Introduction	1
1. Overview of EFT	1
2. Overview of Report.....	3
Chapter Two: Agency	5
1. Clinical Expectations during Field Practicum.....	5
2. Goals and Objectives of the Field Practicum.....	7
3. Challenges.....	8
Chapter Three: Ideology	13
1. Personal and Professional Values and Beliefs	13
2. Humanistic Ideology.....	14
3. Applied Ideology	17
Chapter Four: Theory.....	20
1. Attachment Theory	22
2. Emotionally Focused Therapy	27
3. Relationship Model.....	35
Chapter Five: Values & Ethics.....	39
Chapter Six: Relationships.....	45
1. Client Relationships	45
2. Professional Associate Relationship.....	46
3. Agency Relationship.....	47
4. Professional Relationship.....	48
5. Community Relationship	49
Chapter Seven: Learning Strategies.....	51
1. Co-counselling	51
2. Solo Counselling.....	52
3. Group Process	53
Chapter Eight: Skills.....	54
1. Emotional Focus	54
2. Couple Intervention	55

3. Individual Intervention.....	56
4. Group Work	56
5. Clinical Documentation	58
Chapter Nine: Visions.....	59
Chapter Ten: Conclusion	65
References.....	67
Appendix 1: Attachment Theory.....	76
Appendix 2: Relationship Model	79
Appendix 3: Levels of Intimacy	82

Chapter One: Introduction

The field practicum placement that served as the basis for this report focused on learning about, and practicing, Emotionally Focused Therapy (EFT) for couples. This clinical placement was completed at Arbuthnott and Associates private practice agency from May to August 2011. The utilization of EFT in social work is both a professional interest, and one I feel is necessary to include in a comprehensive clinical practice. The research into, and practicum experience of the application of EFT improved my skills and knowledge of this therapeutic process and confirmed for me that it is a good option for couples who seek counselling for their relationships. EFT is based in research and an ethical framework that is clinically effective. This report outlines the EFT process and demonstrates its application in a clinical practicum environment. This chapter begins with an overview of EFT, and an outline of the remaining chapters of this report.

1. Overview of EFT

Emotionally Focused Therapy, which was developed by Greenberg and Johnson in the 1980s, is a comprehensive therapeutic process (Greenberg & Johnson, 1988). This therapeutic approach was based on Attachment Theory developed by John Bowlby, (Bowlby1969, 1988). Attachment theory is rooted in the premise that, as children we develop significant styles of relationship with our primary caregivers and this attachment is then played out in our adult intimate relationships (Bowlby, 1988). EFT then uses the foundation of Attachment Theory to identify the relationship style and the vulnerabilities each adult has in a couple relationship to address unmet attachment needs (Greenberg & Johnson, 1988). Identifying and addressing unmet needs for individuals and couples requires the formation of a healthy therapeutic relationship, and the necessity of working collaboratively within that relationship (Greenberg, 2010). EFT adheres to a person centered ideology which enhances the therapeutic relationship

with an emphasis on personal growth. Person-centered ideology identifies the significance of the client and their expertise in their own life versus an incorporation of the idea of the clinician as the expert and therapy becomes a collaborative process (Merry & Brodley, 2002). The skills and techniques used in EFT include the process of identifying and describing the negative dynamic demonstrated by a couple and assisting that couple to develop and practice a more positive dynamic, thereby achieving a healthier relationship overall (Greenberg, 2010). Attachment Theory provides insight to a couple in order to help them to understand how the negative dynamics develop within their relationship. These dynamics are subconscious and can be based on a primary relationship in childhood or in previous intimate relationships (Efron & Bradley, 2007). The dynamics were developed to help meet needs of the individual at that time and then were carried into subsequent relationships. These dynamics often create conflict within a couple because each individual tends to believe that their partner is acting out of malice or is acting intentionally to hurt them when, in actuality, each individual is acting without a clear understanding of where the negativity is generated from. Once the insight of where the negative dynamics are generated is learned and understood, most couples are able to develop healthier strategies for communication, understanding, and overall trust and respect to meet the needs of the current relationship. Ultimately, these improved strategies assist the couple to build a closer and stronger bond (Schachner, Shaver, & Mikulincer, 2003).

Greenberg (2010) describes the process of EFT as creating an opportunity for self-reflection for individuals and couples. Self-reflection encourages individuals to search for, and understand, events in their lives that trigger strong emotional responses rooted in past wounds. For couples, self-reflection enables each individual within that couple to understand and clearly communicate these wounds in order to prevent conflict and the creation of negative dynamics.

By clearly voicing these past hurts in a safe environment, and verbalizing how their partner may be repeating or adding to them, individuals are heard and can listen to each other more effectively. Building these more effective listening skills then enables the couple to move forward by changing their actions and their responses to actions by their partner in order to make the relationship healthier. The self-reflection and direct communication techniques that couples develop within this therapeutic approach can help to minimize the ongoing negative dynamics that have possibly impacted upon the relationship prior to the couple seeking counselling support.

Within the framework of EFT, it is the negative dynamics that are considered to be the problem in the relationship, rather than either of the possible deficiencies of individuals involved (Johnson, 2004). Couples seem to respond well to a paradigm shift from seeing the partner as being the problem to focusing instead on the negative dynamics within the relationship. Each person feels stronger, less vulnerable to past emotional wounds, and better able to communicate with their partner about their emotional wounds once the blame is removed. It is the process of learning to share the hurts they experience with each other that enables each individual in the couple to “find their voice.” Neither person needs to remain vulnerable to those hurt feelings as they progress through counselling. The relationship benefits from the development of healthier coping skills and each person feels empowered and stronger to share their hurts and know that their partner will respect and hear their concerns.

2. Overview of Report

Chapter 2 of this Report includes a description of the agency in which I completed my practicum, and Chapter 3 outlines the practice ideology used in the field practicum and my professional orientation. The practice ideology discussed is humanistic ideology which also

compliments EFT. Humanistic ideology emphasizes the expertise of the client in their own circumstance and a clinician's respect of this expertise in conjunction with the expectation of each client having the potential to achieve their individual optimal functioning (Patterson & Joseph, 2007). Chapter 4 explores the theories and models researched for completion of this field practicum and report. The theories researched include Attachment Theory, Emotionally Focused Therapy and a Relationship Model developed within my previous professional practice. As part of my clinical practicum experience, I was able to assess this model, and learn how to effectively apply it within the EFT framework. Chapter 5 provides a review of the values and ethics applied to and practiced in social work as reflected within my clinical practicum placement. Chapter 6 reviews the dynamics of my relationships with clients, my professional associate supervisor and my relationship with the agency, within the profession of social work and the local community. Chapter 7 identifies the learning strategies utilized within this field practicum which included co-counselling, solo counselling and opportunities to engage in group process while utilizing EFT. Chapter 8 specifically discusses the skills of EFT that are required for couple and individual work and how that was applied to group process; which was an important part of my clinical learning experience. Chapter 9 discusses my resulting personal visions upon conclusion of my field practicum that are geared to promote social work within a larger context. Finally, Chapter 10 provides the conclusion for this field practicum report.

Chapter Two: Agency

Arbuthnott and Associates (herein referred to as the Agency) is a private clinical agency located in Regina, Saskatchewan that includes both psychologists and social workers in its practice. As per private practice governance requirements, all therapists are required to be registered with their respective professional associations and all clinicians must have a minimum of a Master's Degree. The Agency employs two full-time psychologists and two part-time social workers. The senior psychologist has been in private practice for over 30 years and is the supervising clinician for the Agency. All therapists at the Agency have clinical practice experience and some have taught clinical courses at the university level. This Agency employs skilled, knowledgeable and well trained therapists who utilize various methods of therapy.

The Agency provides subsidized services for a number of Employee and Family Assistance Programs for companies and civil, provincial and federal agencies within the City of Regina and the surrounding area. The Agency also provides therapy for those individuals who choose private practice over subsidized therapy and pay for services out-of-pocket or through additional private insurance. It is common for the Agency to have wait lists of six to eight weeks.

1. Clinical Expectations during Field Practicum

During my practicum placement at the Agency from May to August 2011, my primary activities were to initially observe counselling sessions led by my professional associate when clients gave permission for me to sit in and observe. This eventually led to my participation in joint sessions with my field supervision, and then progressed to where I could lead sessions or counsel as a solo therapist (which included the video taping of sessions to be reviewed later with my professional associate). Through this combination of observation and supervised practice, I

eventually became the primary therapist for three of the clients I initially saw in conjunction with my professional associate. Becoming lead therapist provided an opportunity to develop my skills within a clinical context and for my professional associate to review taped sessions with me in order to provide feedback on those developing skills. This seemed to facilitate the counselling process so that client needs were met and my professional associate did not have divided attentions (client or student). Having a caseload, though, was not a requirement of the learning process since I had worked as a clinician for years and had effectively managed a caseload during that time. The focus for me within this clinical placement was to learn and build skills specific to EFT. As part of this clinical training process, my professional associate and I spent considerable time viewing my recorded sessions together and she offered me feedback and instruction on technique, review of the stage of therapy that I was in with the clients, and the clinical progress of the clients. Together we planned subsequent sessions.

As part of the practicum field placement, I also provided intake services for the Agency. Intake was not originally part of my learning plan however; the person who normally provided intake had suddenly become ill and was off work for the summer. My involvement in the Agency provided an asset for them and an additional learning opportunity for me. Intake begins when people phone in for initial appointments and provide their name and contact information. Intake allows for a therapist to gather detailed information about specific issues using the ethics and values of confidentiality and privacy. When providing intake services the intake counsellor may ask questions about whether or not the caller had a preference for psychological or social work services; and within the private practice context it is important to inquire about the person's preferred payment method. The intake counsellor is then required to provide the gathered background information to the intended therapist and schedule the client into a session as per the

therapist's availability. The process of assigning a therapist was new for me as clients had a choice whether they preferred social work or psychology and which therapist was available to take new clients. Initially this process was somewhat complicated until I learned each therapist's strengths and clinical priorities. Not having any expectation for intake process, this Agency's process seemed to work effectively for both the clinicians and clientele.

My primary activities for my field practicum were to observe and lead counselling sessions. My professional associate and I also prepared a couples workshop and a community oriented couple's night to further facilitate my learning goals and objectives. The combination of these practices and opportunities did result in meeting my expectations for this field practicum placement.

2. Goals and Objectives of the Field Practicum

All of the original goals and objectives set out for my field practicum were designed to enhance my clinical skills and clinical knowledge base.

My primary goal for this clinical practicum placement was to learn EFT and to have opportunities to practice this therapeutic approach in sessions with clients. Two objectives assisted me in achieving this goal. The first objective was to research Emotionally Focused Therapy and then apply EFT principles and relate them to a therapeutic Relationship Model in sessions with a variety of clients - including both individuals and couples. The second learning objective for this practicum placement was to co-deliver a couple's weekend workshop to provide couples the opportunity to work in a small group atmosphere. The couple's weekend workshop was based on a framework of EFT and utilized the various couple's homework assignments typically given in sessions. The couple's weekend workshop was offered to couples already engaged in counselling, as well as others who had not attended counselling previously.

My second goal for this field practicum placement was to enhance my skills in couples' counselling skills and in group work. The objective that supported this goal was to gather feedback from my professional associate regarding client sessions and use this to improve my skills for both private sessions and through the couple's workshop. Feedback from the couples retreat also assisted in achieving this goal.

Finally, my third goal was to enhance my clinical note taking skills. I accomplished this through focussed attention and feedback from my professional associate. This goal was difficult to measure as there is little evidence-based literature that focuses upon clinical note-taking for therapists. Clinical notes, or managed care as it is referred to in literature, become an extension of the therapy practice and this documentation focuses on client deficits to support ongoing therapies rather than focusing on the strength based empowering progress of clients (Kane, Houston-Vega, & Nuehring, 2002). There does not appear to be a recognized standard of practice for clinical note taking as per national, state or provincial requirements; and various agency requirements for managed care are not often a focus in academic learning (Kane et al., 2002). As in any learning experience, there were challenges to meeting my goals. As discussed in the next section, these challenges did prove to be frustrating during the practicum placement, but were certainly not insurmountable.

3. Challenges

The first challenge that I experienced within this field practicum placement was related to the fact that the summer months are a slower time for couple's therapy and the timing of my practicum placed me at the Agency during those particular months. Similarly we did spend considerable time planning the format for the couple's workshop, but we had difficulty finding couples who were interested in attending a workshop during the summer months.

A second notable, and somewhat surprising, challenge was that many clients chose not to have a student sit in to observe their sessions. In a review of the medical research and literature, it appears that there is ample evidence to support the idea that the more intimate or critical the medical procedure, the more common is the exclusion of medical students by patients. Further, the research shows that this exclusion was usually based on gender (i.e. male medical students excluded from gynecological exams) (Tang & Skye, 2009; Celenza, Li & Teng, 2011). Similarly, a clinical therapeutic encounter is, in fact, an intimate detailing of one's life, and this may account for the tendency of clients to refuse consent for student therapist involvement. In addition, many clients had been long term clients of my professional associate, and were uncomfortable adding someone to the therapeutic experience. New clients to the Agency, when asked for permission to have a student observe their session, cited concerns about privacy and my level of experience as a student therapist. According to the literature, most of which is medically-based, a patient or client-centred approach provides a greater student success of achievement when there is a parallel between the academic faculty advisors and the professional associates approach of 'student-centeredness' (Ripat, Wener & Dobinson, 2013). Without specific knowledge of the professional associate's preparation of her clientele for involvement of a graduate student therapist, it is difficult to suggest what could have improved the outcome for graduate student involvement in therapy. Formal mentoring relationships that account for the attachment styles of the mentor and the protégés can improve the overall success of the working relationship (Germain, 2011). This still provided me with an important learning opportunity in that, if given the opportunity to supervise a graduate student therapist in the future within my own practice, I would be sure to spend the required time with clients in order to remain focused on their needs while still attempting to create opportunities for training for the student therapist.

Specifically, I would focus on clientele that I believe would provide the student with opportunity to improve their skills based on their learning guidelines and identify potential challenges prior to commencement of the student placement.

Another challenge that I experienced within this clinical placement was related to the fact that my professional associate is a part-time practitioner and I was a full-time practicum student. Although discussed prior to the beginning of the practicum, this proved to be more of a challenge than expected due to difficulty finding time to communicate appropriately with one another. However, after some mediation and consultation by my academic supervisor, communication patterns were improved to where expectations could be met and measured. It is through this experience that I personally learned the value of finding your voice and the use of EFT in my personal relationships.

As discussed previously, clients absolutely had the right to allow or decline student participation; therefore, ethical considerations did not create any concerns as clients' rights and confidentiality were always a priority. The team environment in sessions was new to both my professional associate and to me and this created some challenges with clients who were long-time clients of, and already well connected to, my professional associate. As part of the teaching and learning process, some of these long-time clients were asked if they would consider changing therapists. If clients were to transition to see me as the sole (student) therapist only, we spent time working with them as a counselling team and once the clients seemed comfortable with me as the lead therapist, we would then book sessions in the absence of the professional associate. It was not uncommon within the Agency that some clients would see one of the other therapists for individual counselling, while working with my professional associate for couples work. As such, there are times when the Agency's therapists consult with each other in the best

interests of the clients to determine the optimal therapy solution. Following ethical guidelines, discussions between therapists require consent from the clients. This consent is included as initial stage of receiving services with the Agency when clients sign consent forms that include team discussions of cases during supervision sessions. These discussions do not include any identifying information and only discuss the therapist's process and the client's progress and suggestions for addressing issues that may have emerged. These team discussions are described as clinical team meetings held monthly at the Agency as part of supervision in which I participated.

When I participated in the Agency clinical team meetings, I was able to see a team work approach with clients' best interests in mind. Also, when a therapist was struggling either clinically or emotionally with a situation or a client, these clinical meetings were useful for fresh ideas or support through a difficult situation. This process of clinical self-care and team work as an aspect of practice was refreshing to witness and participate in. Much like a client's ability to discuss challenging life situations, the clinical team meetings provided a confidential outlet for all therapists to share their challenges and to have some dialogue with others on suggestions to address their concerns. Some suggestions were clinical regarding patient care and process or the utilization of available resources, but many comments were validating the difficulty of the situation and the particular therapist's challenge in decision-making on therapeutic process. Validating a therapist's particular challenge with clients is helpful and supportive which provides necessary guidance and reassurance in the clinical process. Therapists, who work in isolation, as I have previous to my practicum experience, need to access professional networks for collaboration and guidance in challenging client cases. This availability for professional guidance and support is especially important for private practitioners or rural clinicians who

might have limited access supervision. Although I was invited to participate in these clinical team meetings, the majority of my own clinical supervision came through the one-on-one sessions I had with my professional associate. However, I was encouraged to share during the team clinical meetings about my challenges with couples therapy and specifically learning EFT. The clinical team provided feedback regarding learning a new therapy and offered discussion about how different therapies may address a particular challenging aspect as well. These clinical meetings were very useful and challenged my understanding and incorporation of EFT and its underlying theories and ideology.

Through the Agency clinical meetings and individual supervision sessions during my practicum, I learned more about the methodologies of fellow clinicians of the Agency. As I observed their various practices, clinical orientation and relational process of therapeutic relationships, I was challenged to understand the professional ideology from which I myself have practiced. In the next chapter, ideology and theory of my professional practice will be discussed leading to further emphasis on the specific theory and therapy of EFT.

Chapter Three: Ideology

Ideology functions as the conduit that drives our clinical practice and is rooted in the clinician's values and beliefs. Ideology develops from psychological needs, motives and constraints that are borne through situation and character (Jost, Nosek & Gosling, 2008). While client presenting issues and their focus in sessions determine the end goal for counselling, ideology is the clinician's framework regarding theory of practice and use of therapies to reach those goals (Dillon, 2008). Ideology also directs the relational connection between the therapist and client. There are multiple ideologies that a social worker can relate to, or choose from, for their clinical practice. For the purpose of this paper, humanistic ideology will be reviewed as that best describes my clinical orientation, as well as the orientation which drove the development and implementation of my learning objectives for this clinical practicum placement.

This chapter will provide an overview of humanistic ideology that influences the clinical practice of social work from my personal perspective. This chapter will conclude with an indication of the application of humanistic ideology within the field of social work.

1. Personal and Professional Values and Beliefs

Values, beliefs, and our attitudes, provide the basis and connection to a particular ideological framework as therapists. That ideology is then applied to our clinical context; guiding or directing the clinician to theory that is premised on that ideology (Joseph & Murphy, 2012). Theory then shapes the practice or therapies that clinicians will use within the therapeutic relationship (Mearns, 2003). The therapies utilized then provide a compass for the end goal or destination that the clients have determined for them. Professional ideology in social work informs the clinical practices of a clinician (Joseph & Murphy, 2012). During my practicum experience at the Agency, I learned that ideology is developed through training, and through

regularly reading academic journals, articles, and clinical books. This ideology is then further reinforced and refined through collaboration with other colleagues, supervision and contact with clients. Ideology does not always seem to be a conscious choice of the clinician, but rather is most often an extension of their values and beliefs as they pertain to their social work practice and encompassing empirical evidence to their practice (Peters, 2008). The psycho-social orientation of a therapist is based on a value position rather than on rules (Brodley, 1997). Professional and personal beliefs about ethical practice are reflected in the clinician's methods of relationship with the clients. All of these aspects of the clinician's orientation to practice, from both a personal and professional perspective, influence or guide the clinician towards an ideology that encompasses these various qualities.

2. Humanistic Ideology

I learned through my practicum experience that my practice ideology reflects humanistic ideology and a person-centered approach to practice more than any other specific ideology such as systemic or feministic ideologies. Researching humanistic ideology was somewhat confusing, as articles seemed to use the terms "humanist ideology" and "client centered psychology" interchangeably within the literature. Through more exhaustive research, I learned that the term "client centered" was then replaced with "person-centered" to better reflect that human functioning had implications that could reach far beyond one-to-one therapeutic work (Joseph & Murphy, 2012). The values inherent in humanistic ideology are those of empathy, genuineness, respect, individual dignity, self-worth and strength based growth (Kahn, 1999; Motschnig & Nykl, 2003). These same values and beliefs direct my practice as a clinical social worker. In a counselling environment where people come for assistance with various issues in their life, it is necessary for a clinician to show due respect and compassion as these clients share their personal

histories. Every history a client shares with a counsellor has a significant meaning for the client and requires respect regarding the information shared and the importance of the overall impact in that client's life.

The humanistic ideology of practice guides the clinician towards a client-centered or person-centered theory that believes that all human beings have an inherent tendency toward growth, development and optimal functioning, and self-actualization (Patterson & Joseph, 2007). Kuhn (2001) identified as a central principle of humanistic ideology that humans have awareness to different degrees and that this awareness is essential to an understanding of their experience. Self-actualization is a process that indicates various levels of growth, development or actualization – the premise that humans are always striving for something 'more.' Behaviours significant to the self-actualizing process incorporate values, creativity, choices and expanding beyond one's present self (Kuhn, 2001). Carl Rogers' (1961) work in the 1950s led to the realization that employing a non-directive person-centered approach created an environment which moves towards a self-actualizing process via a humanistic ideology within a therapeutic relationship (Kahn, 1999; Kuhn, 2001; Patterson & Joseph, 2007; Joseph & Murphy, 2012). This non-directivity reflects that the clients are intrinsically motivated toward optimal positive psychological functioning (Joseph & Murphy, 2012).

Based on this humanistic ideology leaning towards a person-centred approach, clients are encouraged to identify their own goals and direction for therapy (Greenberg, 2010). The therapist listens to, and learns about, the client and collaborates with the client to identify an end goal. The client, in this manner, sets goals regarding therapy rather than the therapist 'directing' the therapeutic goals. People attempt to resolve their issues with the knowledge and skills that they have or learn that allows improved internal experiences and interpersonal support (Greenberg,

2010). Some are successful in resolving issues while others seek out therapists to assist them. In some cases, people have resolved their situations only well enough to have it surface again during a difficult or challenging time. Each client comes with his or her unique characteristics, history, issues, challenges and strengths which influence emotional responses (Greenberg & Johnson, 1988). Some clients who present for counselling do not always completely understand what they need or what they are looking for through the counselling relationship. These individuals recognize a need for assistance in order to understand their situation, and to get assistance in addressing that situation. This type of client may require assistance to set counselling goals and may need a more directive clinician initially through validation of the strengths and aspirations (Palmer & Johnson, 2002). This approach employs the empathic abilities of the therapist within the humanistic approach at first, while the therapist aims to eventually assist the client to direct their own counselling needs through a collaborative approach (Merry & Brodley, 2002). Clients determine the direction they want to go and they choose what needs to be addressed, while the therapist emulates a healthy relationship with the client to help assist them in understanding the obstacles that they may not recognize or may have difficulty addressing (Greenberg, 2010). The individuality of clients does not lend itself to a 'one-size fits all' ideology or therapy style. The caution is that while any theory can benefit clients and work for them based on individual preferences, any one theory also has the potential to hinder clients if it is not suited to them. Each therapist is challenged then to work within an applied ideology that fits with the therapist's personal and professional values and beliefs and benefits clients in a respectful and therapeutic relationship.

3. Applied Ideology

The inherent worth of every individual requires that the therapist treat each person with the utmost dignity and respect each situation with the significance required by the client (CASW Code of Ethics, 2005). All people are deserving of our care and therapeutic skills and we, as practitioners, must execute this regardless of our personal or subjective bias. If we are unable to keep our biases at bay, then we must refer the client to another therapist that will be able to meet their clinical needs. As such, my practice ideology reflects the main aspects of humanistic ideology but I find that I am also influenced by other therapeutic ideologies that I have incorporated into my own practice over the years. Within this section, I will therefore further discuss elements of feminist ideology as well as person-centered theory, as both of these approaches have impacted upon my professional therapeutic development.

Learning about feminist ideology and practices during my time in this graduate program has expanded my clinical knowledge although there remain some reservations regarding feminist ideology. One cannot ignore its impact and significance in the progress of women's rights. There remains a struggle with the feminist approach in its method to achieve the primary goal of power equality where this is achieved by negating one person's circumstances for the betterment of women's lives and society (Israeli & Santor, 2010). While I agree with the goal of equality, I have some disagreement with a method that takes societal norms and imposes it on the relationship without looking at the relationship with its unique dynamics and an honest assessment of the health of the relationship. The rights of all people need to be respected which, I believe, is reflected in humanist ideology, thereby providing a voice for both men and women to be heard (Mearns, 2003). Both the humanistic and feminist ideologies provide a therapeutic avenue for self-determination, self-exploration and self-reflection that are very empowering and

rewarding in therapy. However, my personality and practice style is best suited to the humanistic ideology of practice. Also having entered my consciousness through my learning process, person-centered theory suggests the tendency to proactively grow, develop and move toward autonomous functioning when social-environmental conditions are optimal; which is a biological tendency rather than a moral imperative (Joseph & Murphy, 2012).

Reflecting upon how my practice ideology is evident or expressed within my social work practice was a challenging aspect of my field practicum. Clinicians ask their clients to engage in self-reflection as they move through therapy. Conversely, I found that my own self-reflection was required within the practicum experience regarding my practice ideology. Further, this required honest consideration of how clients are respected, how clients would describe their experience in therapy and then this also required me to research different ideologies in order to find the one that best identified with my social work practice and the values and beliefs that are prominent from that perspective.

Patterson and Joseph (2007) identified Carl Rogers's 1961 work of person-centered theory as an approach that offers a dynamic process focused account of personality development and functioning of vulnerability to and development of psychopathology and therapeutic growth. This approach encourages movement towards psychological well-being through relationship. This description of person-centered theory provides the framework for the healthy individual to strive towards, and also explains the drive we all have to reach our individual potential (Rogers, 1961). Rogers believed human development naturally tends towards autonomy and a self-actualizing through our evaluation of experiences in response to our intrinsic needs (Kahn, 1999), but the self-actualizing process does not always result in reaching optimal functionality (Joseph & Murphy, 2012). The social and experiential influences in the process of self-

actualizing can lead to less than optimal situations or circumstances and it is this negative output that can lead to the need for therapeutic interventions to assist individuals to a more optimal functioning capacity (Rogers, 1951; Patterson & Joseph, 2007). It is this person-centered perspective that allies itself to the Emotionally Focused Therapy and the method of its process. Although EFT is largely based in Attachment Theory, which is discussed in the next chapter, person-centered theory and humanistic ideology are both also evident in the methodology of EFT, as partially evidenced by the client directed processes used within its application (Greenberg, 2010).

Chapter Four: Theory

The goal for my field practicum experience was to learn a new therapeutic approach to use in the delivery of couples counselling. My previous training focused on Cognitive Behavioural Therapy (CBT), which seemed to be limiting outside of its skills-based approach to therapy. The primary premise of CBT is that emotional and behavioural responses are not directly related to an experience, but are related to the activation of maladaptive beliefs which are connected to the event or experience (Vonk & Early, 2009). CBT, through the use of homework, provides opportunity to replace dysfunctional interactions with positive ones (Baucom, Epstein, LaTaillade & Kirby, 2008) in order for couples to minimize conflict when it occurs. However, CBT does not directly get to the heart of the issues that led to that conflict. Without resolving the underlying issues, when conflict occurs couples tend to return to their negative behavioural patterns that developed over time, thereby repeating the cycle and never completely ending or resolving it. CBT's premise of changing automatic thoughts and behaviours produces a positive effect (improved interaction); therefore, emotional work is not a significant aspect of the CBT (Beck, 1995).

In my previous CBT training, there was not a substantial means to address emotions or the resultant effect within therapy. My experience with CBT for couples or individuals with emotional barriers to their well-being was that CBT was not overly successful for clients in the resolving ongoing conflict over the long term (Byrne, Carr, & Clark, 2004). Clinician introduction of an emotional component to the cognitive therapy seemed to assist clients to overcome these barriers which seemed to be more effective long-term. The focus of CBT is a psycho-educational and problem-solving approach utilized in couples' therapy (LaTaillade, Epstein, & Werlinich, 2006). In my own earlier practice, prior to enrolling in the MSW Program,

I found that attempting to incorporate an emotional component within the therapeutic work resulted in improved responses to the therapy with less conflict over time, eventually leading to an improved relationship for the couple with no further counselling required. In order to follow best practices, I researched for evidence-based therapies that provided clinical processes for an emotional component. My first introduction to Emotionally Focused Therapy came from a newsletter that I discovered while investigating the availability of training opportunities for couples counselling. This therapeutic model seemed to provide both the framework for emotional work with clients I was looking for and it was founded on evidence based research. Accessing Emotionally Focused Therapy training became a priority for my work and, as such, soon became my focus when pursuing my graduate degree in Social Work.

Researching EFT during both my studies and during my field practicum, I learned that it was based on the work of Carl Rogers (1951 & 1961), who was an experiential therapist who researched and developed a humanistic approach to therapy. Through my research, I learned that the emotional focus within EFT enabled clients and the therapist to address emotional barriers and negative dynamics stemming from emotional wounds (Fisher & Crandell, 2001). These emotional wounds can be rooted in childhood bonds with primary caregivers, which is the premise of Attachment Theory. Attachment Theory provides the foundation for understanding EFT and its impact on client response to the therapy (Schachner et al., 2003).

This chapter includes a description of the foundation of EFT, which is grounded in Attachment Theory as described by John Bowlby. Next, I will offer a description of EFT and the steps and stages of this therapy that was developed by Johnson and Greenberg. Also included in the theoretical analysis within this chapter is discussion of the Relationship Model that I developed in my own practice and used alongside the CBT therapy that allowed an emotional

component to be addressed within therapy. Within my field practicum placement, I found that this Relationship Model complimented EFT, providing an initial framework for clients to focus on and to help de-escalate their emotions when initiating counselling.

1. Attachment Theory

Emotionally Focused Therapy is based on John Bowlby's work on Attachment Theory developed in the mid-1950s (Bowlby, 1969; Johnson, 2004). Attachment Theory is based on research into the attachments to our primary caregivers that we make as children. Bowlby's observations of children separated from a primary caregiver, mainly mothers, noted both the responses of the child while separated from the parent, and the responses of the child when the parent returned (Bowlby, 1969). The parent response to the child was also seen as significant to the pattern that developed. If a parent soothed and attended to the child upon return, the child would calm and return to an emotionally stable state. If a parent ignored the child, or scolded the child upon return, the child did not return to an emotionally stable state. In the cases where the child was scolded or ignored, the emotional pattern that developed between parent and child was seen as leading to unhealthy connections (Bowlby, 1969). From Bowlby's (1988) work, three patterns of attachment were identified and described as: (1) anxiously attached to mother and avoidant – which is referred to as Pattern A; (2) securely attached to mother – which is referred to as Pattern B; and, (3) anxiously attached to mother and resistant – which is referred to as Pattern C (Ainsworth, Blehar, Waters, & Wall, 1978). These initially identified patterns eventually became known as (A) Avoidant, (B) Secure, and (C) Anxious patterns (Bowlby, 1969; Schachner, et al., 2003).

Attachment and experiential views of human functioning emphasize the adaptive nature of most needs and desires that we have. Attachment behaviour is developed from our basic

individualistic needs being either met or unmet within a primary relationship as a means to resolve fear or helplessness (Bowlby, 1988; Doyal & Gough, 1984). When an individual is threatened, one's adaptive behaviour cues are activated to seek assurance or proximity to a loved one for comfort (Johnson, 2003). It seems that if a child's basic needs are not met, that child's behaviour will adapt in order to have those needs met. For example, fear is activated if a child's security is compromised. If a primary caregiver is able to alleviate the fear response, the child will be comforted and be able to return to a secure state. If the child is not comforted in a satisfactory way, the child's behaviour may escalate, and the child may become more fearful in order to get comfort. If no comfort comes, the child may give up and if this happens repeatedly, may not cry in times of distress. The level of attachment activation is related primarily to the mother's response and how the child felt in relation to her and her presence. The mother was identified by Ainsworth as a secure base for the child (Ainsworth, et al., 1978) when response for the child was not activated and the child remained comforted and calm. Ongoing research in the area of attachment behaviour and its application to intimate relationships has led to the development of a four category classification system based on two dimensions of anxiety and avoidance. The resulting four categories are: secure, preoccupied, distant and fearful (Schachner, et al., 2003; Bartholomew, 1990).

The mother's feeling for, and behaviour towards, her child is based on her own personal experiences, especially childhood experiences, and the same seems true for fathers (Bowlby, 1988). This earlier pattern of attachments with one's own parents influences the adult's style or methods of parenting their own children. If the attachment process was not healthy, the adult will display resultant maladaptive attachment processes. There is growing consensus that the quality of a person's primary attachments in childhood is intimately linked with patterns of interpersonal

relatedness throughout their life-span (Fisher & Crandell, 2001). The attachments made in intimate relationships follows a pattern of behaviour that is often repetitive implying that early attachment styles influence adult attachments (Crowell & Treboux, 2001). The premise of EFT is that these attachments from childhood are replayed in our primary intimate relationships in our adulthood. When we disown, deny or constrict our emotional needs and desires, they are not expressed and we are left without emotional fulfillment, leading to problems in our personal relationships (Johnson, 2004). These unfulfilled emotional needs then fuel fear, frustration, or hurt that is then transferred to the spouse (partner) who is perhaps unintentionally blamed for not fulfilling the needs that were unmet by one's parents in childhood or adolescence (Beckerman & Sarracco, 2002). The ensuing dynamics become a 'dance' of emotions. A pattern of behaviour is developed that causes distress for one or both individuals in the couple and the other responds based on their own pattern of attachment. This behaviour is usually expressed as some form of conflict dynamic, which is then influenced by the patterns of attachment that exist for both individuals within the couple relationship.

The patterns of attachment that adults make based on childhood attachments are described as: secure, preoccupied, distant and fearful (Bartholomew, Henderson, & Dutton, 2001) or as secure, dismissing and preoccupied based on their descriptive items for research (Wampler, Riggs, & Kimball, 2004). For the purposes of this paper, the model developed by Bartholomew, et al., (2001) will be used as it succinctly describes adult attachments and provides a framework that assists couples in identifying their attachment style.¹ The attachment types are briefly described as:

- 1) Secure: comfortable with intimacy and autonomy in close relationships.

¹ For a more complete overview see Appendix 1.

- 2) Preoccupied: preoccupied with close relationships and overly dependent on others for self-esteem and support.
- 3) Dismissing: downplays the importance of close relationships and is compulsively self-reliant.
- 4) Fearful: avoids intimacy for a fear of rejection and is overall socially avoidant.

Identifying the attachment style of a client or individuals who are part of a couple provides clarity and enables them to understand how different attachment styles can cause a dysfunctional dynamic within the relationship. It also helps both partners to understand how the dynamic has evolved to enable them to adapt in order to have their needs met.

Relationship dynamics have long been researched and, within the literature for EFT, these dynamics began to portray the ‘dance’ of the individuals in distressed relationships. Couples initiating counselling will describe various unhealthy ‘dances’ that can include deceit, blame, withdrawal, mistrust, lack of support, or competition. These unhealthy dynamics are common in the highly manipulative or controlling relationships that are often described as emotionally or mentally abusive relationships (Bartholomew, et al., 2001). When young children learn which behaviours will get the attention they require to have their needs met it becomes a pattern, and adults behave in a similar fashion. Unfortunately, if the attachment needs are not met, these behaviours can become increasingly combative due to insecurities. The combative or abusive behaviour is an attempt to have one’s own emotional needs met but the result is that the other partner suffers for it in an unhealthy way (Mikulincer, Gillath, & Shaver, 2002).

When there is evidence of manipulation or control type behaviours, the controlled individual may take a stand and put an end to the relationship. The escalated behaviour of control is again used to meet the abusive person’s needs and the result may be that the hurt or abused

person (exhibiting fearful or preoccupied attachments) will rescue the abusive partner. Once rescued, the abusive person (usually dismissive attachment) distances from the partner (Bartholomew, et al., 2001). This pattern plays out until the abused partner decides the dynamic needs to change. Perhaps it changes because the abused partner leaves, or perhaps is successful in getting the abuser to go for counselling; either way, the pattern needs to change in order for the couple to be healthy. Attachment Theory provides a description of the style of connection in a dualistic intimate relationship. During my field practicum placement, investigating and understanding a couple's dynamics and their individual attachment style was essential to be able to offer a description of this dynamic to them as a couple. It is therapeutically beneficial to understand the root of the unhealthy conflict. The benefit to this approach is their subsequent ability to consider and suggest changes in the dynamics and then begin to improve the relationship.

People can be unaware of the impact their behaviour has on themselves and their partner. Some people know exactly what the impact is and will continue exercising the behaviour to hurt or control the partner. Either situation is often a result of early development of attachment style and its manipulative benefits in having one's needs met within the intimate couple relationship (Mikulincer, et al., 2002). A powerful change agent for the couple is the knowledge that comes from understanding the childhood attachment development and how that is unconsciously expressed within the couple (Schoore & Schoore, 2007). It is also important that they come to the realization that the only person that they can change is themselves. Initially this is a challenge given that most people choose to focus on the partner's behaviour and want them to change rather than addressing their own behaviour. Couples in therapy look at their attachment patterns from childhood, see how it is expressed within the dynamic of the couple and then make or

suggest changes with respect to their own or their partner's behaviours. This process can then assist the couple to improve and meet their own and each other's needs which will move them towards a secure attachment in the relationship (Bradley & Furrow, 2004).

Attachment Theory informs the couple and the therapist regarding what needs to change, and EFT then becomes the map for the therapist. This map provides an understanding of people's primary emotional needs and fears and then these emotions can be used as agents of change (Johnson, 2007). It is critical that individuals in therapy are able to share these emotional needs and fears from a vulnerable yet trusting perspective for change to occur. EFT allows couples or individuals to make the connection between attachment type and behaviour and then suggests the changes required in order to progress through the therapy (Greenberg, 2010).

2. Emotionally Focused Therapy

Emotionally focused therapy (EFT) was developed by Susan Johnson and Leslie Greenberg in the 1980s using a more humanistic, as opposed to behavioural, approach to marital therapy. This therapy focused on the emotional connection between couples and the difficulties that develop when emotional needs are not met within the intimate relationship (Greenberg & Johnson, 1988). Based on Attachment Theory, EFT is a therapeutic process which identifies emotions and emotional communication that hinder relationships and assists individuals to appropriately communicate those emotions to enhance the relationship and produce long term change (Johnson, 2004). The focus on emotional connections, unmet needs and communication in therapy is a shift from other therapeutic practices. EFT is an experiential and integrative process as the therapist observes the interactions between the couple and the interpersonal responses of the individuals (Greenberg & Johnson, 1988). The therapist, after building trust within the therapeutic alliance, guides the couple through these interactions and responses while

shifting negative and often rigid responses towards a more flexible and understanding response (Denton, 2008).

There are several key factors that distinguish EFT from other therapies. First, the therapist is not expert in the couple's situation but a collaborator guiding the process as the couple defines the goals and direction of the journey (Johnson, 2004). In EFT, general goals for treatment are focused upon securing emotional bonds within the couple. This results in a positive alliance between therapist and couple where communication, understanding, trust and respect are foundational and significant in the dialogue within the sessions to emulate a secure base within the therapeutic relationship. Second, although background is gathered regarding childhood attachments and how that can influence the intimate relationship, the work within the couple is focused on accessing and reformulating emotions (Johnson, 2004). This makes the therapeutic process very fluid and requires the therapist to maintain observation not only of the person talking but of the verbal and non-verbal responses of the partner. This process does not employ future-oriented interventions or homework, only practice of changes identified within the sessions. Third, therapeutic change is facilitated by restructuring the interactions of the couple from the old 'dance' to a new and positive dance (Johnson, 2004). Understanding the emotional responses we have and altering as necessary to better meet one's own needs as well as one's partner's needs is very powerful within therapy. As a couple recognizes this and makes changes for themselves, the shift or 'softening' within the couple happens naturally. These key factors set the ground work for the process of EFT (Greenberg & Johnson, 1988).

The process for EFT is outlined in the following nine steps that are separated into three distinct stages:

1) Stage 1. The De-escalation of Negative Cycles of Interaction

- **Step 1.** Creating an alliance and delineating conflict issues in the core attachment struggle.
- **Step 2.** Identifying the negative interactional cycle where these issues are expressed.
- **Step 3.** Accessing the unacknowledged emotions underlying interactional positions.
- **Step 4.** Reframing the problem in terms of the negative cycle, underlying emotions, and attachment needs. The cycle is framed as the common enemy and the source of the partner's emotional deprivation and distress.

2) Stage 2. Changing Interactional Positions

- **Step 5.** Promoting identification within disowned attachment emotions, needs, and aspects of self and integrating these into relationship interactions.
- **Step 6.** Promoting acceptance of the partner's experience and new interactional responses.
- **Step 7.** Facilitating the expression of needs and wants and creating emotional engagement and bonding events that redefine the attachment between partners.

3) Stage 3. Consolidation and Integration

- **Step 8.** Facilitating the emergence of new solutions to old relationship problems.
- **Step 9.** Consolidating new positions and new cycles of attachment behaviors.

(Johnson, 2004)

In *Stage 1*, the first goal of therapy is to develop an alliance of trust and respect with both partners (Denton, 2008). Listening and confirming each individual's experience within the relationship is important. The challenge at this stage is to allow each individual to share their experience without alienating the partner. This is managed therapeutically by close observation of non-verbal cues of the partner while the other partner recounts their perspective (Johnson,

2004). To build this therapeutic alliance, some therapists will have individual sessions with each partner to minimize distress in conflict-escalated relationships. Generally, it is the therapist's role to understand the negative emotional cycle of the couple's conflict or 'dance' (Johnson, 2004). This dance describes that pattern of responses throughout a conflict regardless of the topic or who begins the conflict. This dance is generally repetitive or cyclical; having the couple walk the therapist through this dance is both informative for the couple and the therapist. This process can also strengthen the alliance between therapist and couple and facilitate the process to see the negative cycle as the enemy to the relationship rather than the individuals within the couple (Johnson, 2004).

De-escalation and transformation can begin once the negative dance is identified (Greenberg, 2010). Both partners see how their own behaviour and their partner's responses in the dance impact their relationship. This understanding allows the individuals to voice what they need from their partner or to change their own responses to better meet their partner's needs in the relationship (Greenberg & Pascual-Leone, 2006). The negative or maladaptive dynamic generally follows two patterns: (1) blame/withdraw; or, (2) pursue/distance in order to decrease the level of conflict (Crawley & Grant, 2005). These two patterns are descriptive of the majority of the 'dance' that couples will describe. In context with the aforementioned four attachment styles (secure, preoccupied, dismissing and fearful), after couples understand or describe their attachment style, either the blame/withdraw or pursue/distance patterns typically emerges (Johnson, 2004). Generally, couples become descriptive of their dance, using terms such as a 'tug-of-war' or "boxing match". Individuals also have descriptions of their internal or personal attachment styles. One client during my field practicum described the negative dance as the "sharks circling", which indicated how threatening it was for the individual to address these

emotional needs. These descriptions and identifying the negative patterns usually provides significant insight early in therapy, which results in a diminishing of the escalated negative behaviors. Occasionally in severely escalated couples, it seems directed intervention on the part of the therapist is required to make both the counselling sessions more productive and their home situation safer for both individuals within the couple. These negative patterns develop because individuals deny or withhold sharing their deepest emotions or needs, avoiding vulnerability to protect oneself (Greenberg 2010).

Once the de-escalation has occurred, it is then possible to identify those deep hidden emotions or primary emotions (Johnson, 2004). Initially, the emotions people express are the secondary defensive emotions and not the primary emotions (Greenberg & Johnson, 1988). These secondary emotional expressions provide cues upon which to focus towards developing a deeper emotional understanding that identifies the primary emotion that is unexpressed (Greenberg & Johnson, 1988). Accessing the primary emotions requires a strong alliance within the therapeutic relationship that maintains a safe and respectful environment and is required to invite adaptive responses to those emotions and then to invite change towards a positive interaction between the couple (Johnson, 2004). The issues identified by the couple become the focus of the therapy, rather than the focus being on the individuals themselves (Greenberg & Johnson, 1988). At the end of the first session, goal setting and commitment in therapy are discussed (Denton, 2008). Goals may change as the relationship and therapy evolves; however, a starting point and direction that both partners agree to as most important is the first step to move forward in changing the negative dynamics. Once goals are set, the therapist then reviews or reframes the issues for the clients, as he or she understands them (Johnson, 2004). This reframing provides an opportunity for the therapist to review the couple's understanding of their difficulties

in the relationship, ensure that the perceptions are accurate, and confirm that both individuals are comfortable with the therapist's account of their situation. It is also important to include the behaviour of both partners connected in a circular manner using their own words as much as possible (Denton, 2008). Once there is agreement and commitment for therapy and de-escalation has stabilized the relationship, the next stage can begin.

Stage 2 builds on the trust and rapport developed within Stage 1, which requires the individuals to be challenged in disclosing deep emotions. A safe and secure environment for this disclosure and a sense of trust are paramount as the therapist delves further into the emotional needs and wounds that exist for each partner (Johnson, 2004). Individuals disclose their vulnerability when voicing these emotional wounds, which can be very frightening initially but revealing one's vulnerabilities is encouraged under the guidance of the therapist (Greenberg & Johnson, 1988). The therapist identifies the primary emotions as they are voiced and then encourages the individual to share the deep feelings experienced in response to something their partner said or did (Greenberg & Johnson, 1988; Johnson, 2004; Greenberg 2010). The therapist takes the verbal and non-verbal cues from each partner, using astute observations, and identifies them as they happen.

This process of observing and identifying feelings is the busiest aspect for the therapist in this stage of EFT (Johnson & Greenman, 2006). There is an ongoing description of emotions from one partner to the therapist as intermediary who relays it to the other partner for their response and is then delivered back to the original partner through the therapist (Johnson, 2004). This facilitates the communication process collaboratively and keeps the couple in the moment instead of bringing up old emotional wounds and conflict patterns. Validating each person's emotional responses and bringing that back to the other partner prepares the path for introduction

of new steps to the dance resulting in a new interactional pattern and replacing the old negative cycle (Johnson, 2004). This process is essential for both partners to experience in order to introduce new and healthier responses to the needs they desire from one another. Building new relational patterns allows for emotional healing and growth both within the intimate relationship and to address old attachment injuries. This assists each individual in moving towards a secure attachment within their unique relationship as they set out in achieving their goals for therapy (Makinen & Johnson, 2006). As the couple becomes familiar with the new interactional pattern and are able to share their emotions openly they become ready to move forward to the third stage of therapy, which consolidates all that they have learned and incorporated into their patterns with each other.

Stage 3 facilitates the consolidation of new interactional patterns to replace the old negative interactional cycle. Through the process of Emotionally Focused Therapy to this Stage, the couple has experienced new means through which to safely voice their deepest emotions in a respectful and understanding environment within the relationship. By voicing their primary emotions in order to have their emotional needs met, the partners begin to trust each other to meet those needs (Greenberg, Ford, Alden, & Johnson, 1993). Even when discussing incidents where one partner has disappointed or hurt the other, this communication can take place in a calm and understanding environment that enables the couple to resolve potential conflict before it escalates. EFT does not prevent hurt or emotional injury from happening in a couple's relationship; but it does provide a means by which those difficult conversations can take place, minimize defences, and enable repair and resolve of the emotional injury (Makinen & Johnson, 2006). These emotional repairs are a form of forgiveness and a primary factor for recovery within the intimate couple.

Although not a specific step for EFT, I have found that couples and individuals benefit from one to two sessions regarding forgiveness before completing therapy. Forgiveness is generally considered the act of reconciliation after interpersonal violation that involves mending emotional wounds, restoring trust, and repairing the relationship bond (Makinen & Johnson, 2006). Healing emotional injuries is a function of the EFT process in that the injured person makes improvements in emotional healing and is able to find forgiveness (defined by the individual) for their partner in the intimate relationship. This also holds true for those interpersonal injuries that are mistakes we make that can hurt ourselves and impact our self-esteem. Forgiveness towards an offending party, someone who has transgressed us, can provide relief and enable us to resolve internal conflict (Greenberg, Warwar, & Malcolm, 2010). Within the literature, forgiveness has been reviewed, or investigated, from various perspectives regarding its therapeutic benefit.

Forgiveness is often framed within moral, religious, cultural and personal constructs (McCullough, Pargament, & Thoresen, 2000). It is important to identify the distinction between the act of forgiveness and the role of forgiveness for emotional healing. Forgiveness can be an act that lacks depth or sincerity if there is not some form of repentance by the transgressor that is identified without prompting from the injured person (Exline & Baumeister, 2000). Forgiveness can also be a resolving factor that, with great sincerity, eradicates an emotional injury (Greenberg, et al., 2010). Forgiveness literature highlights work between two persons in therapy or individual therapy regarding a relationship emotional injury that works towards a more balanced perspective of the offender, decreasing negative affect towards the offender and no further retribution toward or restitution from the offender (Gordon, Baucom, Snyder & Dixon,

2008). Forgiveness towards oneself is a topic that is difficult to find within the literature, but research in this area could have tremendous benefit for individual therapy.

3. Relationship Model²

As discussed earlier within this report, I worked with individuals and couples regarding emotional issues prior to learning EFT and Attachment Theory within my practicum placement. While doing so, I developed a *Relationship Model* (Thoroughgood, 2014) that assisted me in therapeutically identifying the cycle of negative interactions and facilitating the foundation of a healthy relationship that was weakened from negative interaction. This model was developed over several years within the active process of counselling couples according to a framework for the main issues clients described as 'broken' within the relationship; communication, understanding, trust and respect. Based on practice experience over several years, the following is a description of the components of the *Relationship Model*. Communication is the basic aspect and common starting point of any relationship. Communication is both non-verbal and verbal with varying levels of interpretation based on intonation and inflection used (Motschnig-Pitrik & Barrett-Lennard, 2010). Active listening is a vital aspect of communication as this leads to understanding the person with whom we are engaged in conversation. Motschnig-Pitrik & Barrett-Lennard (2010) identify similar criteria using person-centered language that communication, respect and understanding characteristics are pivotal to person-centered education. These characteristics are essential as well in personal relationships as we decide to develop relationship (or co-actualize) in a dyad. Trust as a characteristic of healthy relationship is identified by Johnson (2008) as a predictor of success in couples' therapy for female partners and is likely highly important in male partners as well. Respect and trust form a relationship that

² See Appendix 2 for complete Relationship Model

is interdependent for healthy experience of these traits. If one is compromised, the other will be as well. The *Relationship Model* that I developed years ago, and continue to use in practice, is typically delivered in one session and I lead the couple through the following dialogue as an educational component of the session:

- All relationships start with some form of communication (verbal & non-verbal).
- From communication, we learn about and begin to understand that person.
- Eventually we decide if we want to invest in that relationship and we base this on our personal values & beliefs (form an attachment bond).
- We invest in trust and respect, which deepens the relationship when both are reciprocated.
- Communication, understanding, trust and respect become the foundation of an intimate relationship. This intimacy is expressed in various ways (verbally, emotionally, physically & spiritually). When these areas are healthy in a relationship, the result is an intimate relationship that is safe and secure. Our relationship with ourselves is also reflected in our communication with and understanding of ourselves, how we trust ourselves and how we respect ourselves with the result identified as our self-esteem.
- Every aspect is connected (arrows) and influences the other aspects of the model.
- We often do not know if damage has occurred in the foundation until intimacy is absent: which is analogous to not knowing there is damage to the exterior of a tire until it is flat.

In a therapy session, individuals are asked to identify the aspects of the model that they see as being most 'broken' in the relationship or what they would like to see improve the most. It is interesting to note that observations in couple work show most individuals will identify opposing aspects from their partners as priorities.

The original design of this model was developed to work with couples to provide a resource that would assist them at home. Further, this model was geared towards assisting couples, parent-child relationships, and those in conflicted work relationships. Since studying EFT during my field practicum, I have come to believe that this model complements EFT and it was a natural transition to incorporate the language and theory of Attachment Theory and EFT into the model. Thus, 'Intimacy' could change to Attachment, which can then be expanded to assist people to understand their base attachment style using the diagram developed by Bartholomew, et al., (2001). This also helps in identifying the dysfunctional pattern that couples develop enabling them to see where the cycle becomes problematic, their role in the dysfunction, and then how they can develop methods to make changes to their negative cycle.

Many contemporary relationships begin with a strong sexual attraction; however, without building on the external foundations these relationships are not likely to remain long-lasting. Those relationships that depend entirely on a sexual component are likely to be short lived (Ainsworth, 1989). The development of the foundational aspects of the model or relationship leads to a secure bond or attachment within the couple. The external foundational aspects of the relationship influence each other and ideally the result is a healthy and secure attachment or 'intimacy.' With our internal relationship, our communication and understanding of ourselves and how we trust and respect ourselves, influences our overall self-esteem, which can influence the style of attachment adults make with intimate partners (Hepper & Carnelley, 2012). Bowlby identifies that 'unhealthy' attachments can be strong attachments as is made evident by abusive relationships that last for many years (Bowlby, 1969; Bartholomew, et al., 2001).

EFT and Attachment theory require strong skills for therapists and a prominent ability to forge healthy therapeutic relationships with clients that are based in trust and respect. There

needs to be a secure bond within the therapeutic alliance in order to do this work. Without secure relationships with a therapist, clients can be further harmed in a therapeutic process due to the level of vulnerability that clients access in this therapeutic process (Timulak, 2014). Values and ethics are a therapist's guidelines for standards of practice to maintain a professional approach to clients' issues. In the next chapter, values and ethics are discussed as they apply within the practicum environment working with clients while learning a new practice approach.

Chapter Five: Values & Ethics

Values within a private practice environment are a reflection of the individual therapist. The person a client has most contact with is the therapist and if the therapist is not respectful or does not provide a safe environment, the therapeutic relationship will be diminished and could be damaging (Palmer & Johnson, 2002). I was challenged in my practicum because I did not always feel confident as I learned this new therapeutic process; however, I endeavored to provide the best therapeutic environment for the clientele. The therapeutic environment I want to provide for people who choose me as their clinician is one of respect and dignity for the privilege to accompany them on their therapeutic journey. There is significant emotional work involved in the process of EFT; this requires a strong and secure therapeutic alliance built on trust and respect to ensure the success of the collaborative therapeutic process (Greenberg, 2010).

Straightforward communication between therapist and client is a prerequisite for the therapeutic relationship to develop. This direct communication is necessary to build the relationship and allow the client to be heard regarding difficult issues that they may not have been able to share in the past. Empathy and sincerity towards a client's situation is found in the 'understanding' aspect of the *Relationship Model* discussed in the previous section (Thoroughgood, 2014). Understanding the clients' perspectives through reframing provides the therapist the opportunity to learn insight into the dynamics of the relationships (Greenberg & Johnson, 1988). Without this process, the therapist will come across as an 'expert' when it is really the couple themselves that understand the intricacies of their unique relationship and the therapist needs to learn from them. This requires the therapist to interject for clarification if they do not understand some aspect of the dynamics and allow the couple to correct any misunderstanding. I believe this process invaluable to develop a strong therapeutic alliance so

that both individuals are heard, understood, and respected as they progress through therapy. The therapist's values influence the overall rapport and relationship connection developed between therapist and clients. This relationship can influence the success of the interventions made and can impact the client's decision to continue in therapy. For social workers, the therapeutic relationship is guided by our Code of Ethics (CASW, 2005), as we strive to provide the best care for our clients.

As a social worker in the Province of Saskatchewan, I am a registered member and follow the governance of the Saskatchewan Association of Social Workers (SASW), which is under the umbrella of the Canadian Association of Social Workers. The Code of Ethics, as defined by the Canadian Association of Social Workers (CASW) and shared by the SASW, identifies the core social work values and the principles that underlie those values. The identified core values are:

Value 1: Respect for Inherent Dignity and Worth of Persons

Value 2: Pursuit of Social Justice

Value 3: Service to Humanity

Value 4: Integrity of Professional Practice

Value 5: Confidentiality in Professional Practice

Value 6: Competence in Professional Practice (CASW, 2005)

This Code of Ethics provides guidelines in practice that are discussed on the CASW website (CASW, 2005). For me, it is the first value, *Respect for the Inherent Dignity and Worth of Persons* that is the basis of all social work with all other values, ethics, and beliefs following from there. Because of this value, I follow the humanistic ideology of therapeutic practice. Without providing respect and dignity to all persons, the practice of social work is diminished

and in some ways desecrated. In my practicum placement, there was a high priority put on this value by all staff towards all clients.

I learned in my field practicum that, although the value outlining the *Pursuit of Social Justice* is still important, it is in some ways harder to facilitate within the private practice environment. Advocating takes the form of assisting individuals to advocate for themselves or to find community resources that can facilitate a process for social justice. Ultimately, in private practice, therapists are limited in the influence they can have for their clients within a greater context. The ability to advocate for a client is limited to the boundaries of confidentiality and maintaining appropriate boundaries within private practice. During the field practicum, I learned that with the client's consent, a letter to an employer could be provided outlining recommendations to support or assist a client. However, I was not required to provide this level of advocacy. I believe that private practice therapists do their social justice work through external agencies by volunteering or providing research or assistance to other agencies that are in a position to advocate for clientele on a more global scale and thus have greater impact as a voice for those populations.

The third value of the Code of Ethics is *Service to Humanity*. This value is expressed both in the social justice context and in part within the humanistic approach to therapy. Providing counselling services for people, regardless of their situation, is also encompassed in the previous two values. The values demonstrated by the Code of Ethics are all connected with significant cohesion and co-existence between them.

The fourth value of the Code of Ethics is *Integrity of Professional Practice*, which means that a therapist's words are only as strong as their actions. Therapists are measured by their integrity by clients and referral agents. Integrity is enforced by the adherence to these values as

outlined by the Code of Ethics. A therapist may have only one session with someone but with that one session, an impression is made that can influence that person either positively or negatively. Clients will promote services of an agency by a 'word of mouth' factor based on their experience with, and reputation of, a therapist or agency. The therapist I aim to be is one described by the words integrity, respect, and, confidential. No therapist is going to meet the specific needs of all potential clients but it is helpful to be known as a person of integrity who is respectful and elicits the trust and confidence of people, even if we were not the preferred clinician to provide services. I endeavor to always employ these characteristics in my work with all clients, employers, referral agents, and other professionals.

The fifth value of the Code of Ethics is *Confidentiality in Professional Practice*.

Confidentiality is the ultimate act of respect for our client's private and difficult journey. During my practicum, I learned to appreciate even seemingly small things like the design of the office layout that enabled one to enter and leave the Agency through different doors, thus protecting each person's privacy. With each new client, the designated therapist went over the Agency's policy on confidentiality with the client who then signed a document providing consent to share non-identifying information for supervision and team meetings if necessary. This provides the therapist the opportunity to access guidance for situations that may be challenging to them while protecting the client. This is a common practice for practitioners in any team environment and the consultations are guided by confidentiality for all clients of the agency.

The last value in the Code of Ethics is *Competence in Professional Practice*.

Competence is similar to integrity as it is the demonstration of a social worker's actions that adheres to the values outlined in the Code of Ethics as well as the requirements of the governing body. Professional development and supervision are two main features for competence in social

work practice. The desire for professional development is why I focused on EFT for my practicum as I had not been able to access training in EFT in my work environment. If I had accessed training through my workplace, I would go back to an environment where there is limited supervision and none that could support my learning about, and building skills in delivering Emotional Focused Therapy. As a clinician, I am hesitant to learn a new therapy and ‘practice’ without supervision. Fortunately, through attending university, I have networked with several clinicians and can now access their knowledge and practice. The supervision through the practicum was helpful and effective in adjusting my ideas on how to approach emotional subjects without adding further injury to a client. I have always been wary to address emotional injuries without a framework as further harm can happen in therapy if the clinician is not competent in a therapeutic process, or if there is not sufficient supervision while a clinician learns a new therapeutic process.

In one circumstance during my clinical practicum placement I made the decision to remove myself from participating in a client session. The clients had agreed to have a student participate; however, I realized that I was familiar with one of the new clients. Rather than put the client in a difficult situation of deciding whether or not to continue with a familiar person, I removed myself from the session. Knowing the ethical guidelines and following those guidelines facilitates decision-making regarding potentially difficult client situations. In any therapeutic practice, the focus must be on the client’s inherent value and must demonstrate the utmost respect for them and their situations. Clients will not return if they do not feel they are being treated with respect.

The six values adhered to by each therapist demonstrates competency and dignity towards each client. For me, an ethical practice is a priority and these values influence my work with clients while the therapeutic relationship develops and exists.

Chapter Six: Relationships

The relationships we develop in the profession of social work should be defined by trust, respect, honesty, integrity and dignity within our relationships with our clients, colleagues and other professionals. As therapists, we learn intimate details of people's personal lives, their stories, and their emotional hurts. These details are usually their most vulnerable parts of their lives that they do not access themselves, or share with others. Therefore, disclosing these details takes tremendous courage and trust on the part of the client and a client can only disclose that information once the above criteria are evident in the relationship. Trust and respect in relationships is necessary in the client relationships, supervisor relationship and relationships within the Agency with the other therapists.

1. Client Relationships

EFT has an emphasis on the therapeutic relationships we construct with our clients (Greenberg & Johnson, 1988; Johnson, 2004; Greenberg, 2010). The role of the therapist is not one of expert, but one of collaborator on a journey with the client with the client being the expert on their experiences (Greenberg, 2010). It is critically important that the therapist take time to develop rapport with each client. Generally, this is done by being genuine in discussions with the client and using humour, common interests or other aspects of conversation in order to make the connection that is necessary for a therapeutic relationship.

During my practicum at the Agency, I was able to build therapeutic relationships with those clients with whom I worked closely. Fourteen years of clinical experience enabled me to adapt from working as a Cognitive-Behavioural Therapist to practicing as an Emotionally Focused Therapist. This shift required that I see the client as expert and allow the client to determine the focus of therapy. Although there were challenges as a clinician in learning

Emotionally Focused Therapy and its fit for me, the shift to recognizing the client as the expert did not create any obstacles to my therapeutic relationships. However, I did not anticipate the challenges this therapeutic approach would create for me from a personal perspective.

2. Professional Associate Relationship

EFT focuses on the relationship that is developed between client and clinician. For the clinician, this involves more than a strong professional ethical approach to therapy. The Emotionally Focused therapist will be challenged from the perspective of our own deep emotional injuries. If there are unaddressed emotional injuries, the therapist can be limited or ineffective if a similar emotional injury surfaces from a client. Therefore, it is imperative for the Emotionally Focused therapist to resolve those personal injuries for themselves through completing their own work. This is easier stated than addressed because similarly, as therapists we do not always know our own emotional injuries or the depth of them.

As a student in this practicum, emotional injuries surfaced for me that at the time I had believed were non-issues or previously resolved. For these injuries to surface under an evaluative process after years of practice is humbling. In some respects, my confidence in the learning and practicing of EFT was diminished and I also questioned my competence as a clinician. A negative pattern or dynamic surfaced within my relationship with my professional associate. There is no definition of where or how the negative pattern developed and as with therapy with clients, this is not always necessary to define. The correction of the pattern, using EFT, required external intervention by my academic advisor and my professional associate's clinical supervisor.

Initially, it was difficult to admit that a negative pattern existed and that it was detrimental to the learning environment. I identified that my professional and personal

insecurities, plus evaluative processes, heightened my emotional sensitivity to feedback. Once this sensitivity was identified, I was able to work with my professional associate and academic advisor to suggest changes that would correct the negative patterns and enable me to focus on new patterns of interaction. It is perhaps a learning point that both mentor and protégé be aware of their attachment styles to identify ‘best fit’ for the learning environment (Germain, 2011). This proved to be a successful process and the remainder of the field practicum was successful.

Emotional vulnerability occurs in all people and those of us within a counselling profession are no less emotional, but we do need to have strong insight to our own vulnerabilities and a method to keep ourselves healthy, effective, and professional. Through this process, I gained insight and knowledge about myself, my emotional vulnerabilities and the professional challenges involved in using EFT. Without this experience under clinical and academic supervision, I may not have learned about my vulnerabilities. If I had practiced EFT without the supervision and feedback, I may have professionally burnt out or been an ineffective therapist. The experience was valuable and has enriched my appreciation of EFT. I have gained a deeper respect for clients who choose counselling and work on addressing their emotional wounds as they are not simple issues to address.

3. Agency Relationship

During my field practicum at the Agency, I worked primarily with my professional associate. However, I did also participate in counselling sessions with the senior therapist of the Agency while he was using EFT with a couple. The clinicians and staff at the Agency were supportive and helpful during my time at the placement, and during staff supervision I was welcomed and invited to participate in their training sessions. I truly enjoyed the collegial environment and appreciated the various clinical challenges the therapists had and the different

suggestions for proceeding with difficult counselling situations. The Agency has both psychologists and social workers available for clients, and there is great professional respect among the therapists towards each other and the skills they bring to counselling. Interdisciplinary collaboration seems to be a recommended case management process for the progress and well-being of clients. Collaboration consists of sharing of objectives, responsibility, power and decision-making (Petri, 2010), with a mutual goal of client wellness.

4. Professional Relationship

The profession of social work is mainly captured within community based organizations or government organizations. Private practice social workers, although growing in numbers, are still a minority within private practice therapists and social workers as a whole in Saskatchewan. There is value to have the profession of social work promote and encourage clinical therapy as a viable option within the profession. In 2013 and 2014, SASW accomplished the goal of having clinical diagnosis re-instated for appropriately trained and graduate-level prepared social workers. This will assist many private practice and public service social workers to provide added care and service to clients. Much of clinical therapy for social work is within the mental health field, which is connected to the hospitals and provincial Ministry of Health. In the future, to continue to promote and provide service to the profession of social work, I would like to participate in possible research to investigate the viability of social workers employed within medical clinics as a means to improve access for the general population. I believe this would assist in ensuring timely access for clients as well as provide primary physicians a more integrated approach to mental health care for their patients. I also believe that the stigma for accessing care would be greatly reduced if access was through the same clinic as the family physician.

Following such an integrated approach to practice, social workers could be hired and paid by the Province but placed within each medical clinic, which could diminish wait lists and provide more comprehensive care for our population. Research shows that work-life imbalance leads to increased stress and burnout for employees who can show higher rates of mental illness (Mental Health Commission of Canada, 2009). This research supports the need for mental health to improve the overall well-being of people which will improve work environments and home life. Psychologists generally seem to have a more ego-centric view of the client or patient and may put less emphasis on external factors causing difficulties for a client in the area of finances, family issues, or employment concerns. A psychiatric nurse is more mental illness focused and their skill set is more appropriate for those people who would require admittance to hospital or long term care facilities. Social work seems an appropriate fit within a community access context due to the psycho-social perspective for causal distress and a comprehensive ability to address these factors to facilitate healthy mental fitness. For example, the family where parents are conflicted by time, tensions and constraints likely experience higher levels of stress (Caligiuri & Givelekian, 2008). Available mental health counselling could improve our population's overall general well-being and the social work profession would be well suited to provide the level of care and intervention required for people to achieve good mental health. The work should begin within each community wherein social workers can have a presence and increase the understanding of the benefits that can be accomplished through counselling with a social worker.

5. Community Relationship

During my field practicum, my professional associate and I worked on a couple of projects to provide couples counselling within a community context. The two projects we focused on were a couple's weekend retreat and a date night with a bonding focus at a local

business. The date night was planned as *Date Night at Scratch Kitchen* in Regina. Scratch Kitchen provides a food preparation service for families. People can come and put together their meals with ingredients and recipes provided by Scratch Kitchen or pick-up prepared uncooked meals that are healthy and are easily completed at home. Our plan was to have a date night where six couples would come and prepare different meals while enjoying a fun evening doing so. We had prepared different challenges that would be added to each meal station with a couple-focused skill. We advertised through Scratch Kitchen, but unfortunately not enough couples signed up to make it a viable event. This would be a great avenue for future events to promote couples time together and to invest further in their relationship. Working with my professional associate to develop and plan the event was an important part of my learning experience during this placement.

The other event was a couples' day retreat. We initially prepared and advertised for a weekend retreat but changed it to a one day workshop due to lower interest and lack of commitment by potential participants during the summer months. We were able to reduce the topics and offer a one-day couples retreat that had full participation. We prepared different topics for sessions at the day retreat including: Communication, Conflict Resolution, Knowing Self – Knowing Partner, Relationships, and Dating Ideas. We had six couples attend the workshop and given the evaluation forms completed at the end of the day, it was well received with positive comments for both the workshop format and the information presented. The group participants were couples who had connections to both my professional associate and me. I really enjoyed the group participation as I was able to improve my group presentation skills with feedback from my professional associate. This experience enhanced my learning strategies as discussed in the next chapter.

Chapter Seven: Learning Strategies

Learning strategies for my clinical field practicum utilized different approaches to gain the greatest access to, and supervision of, EFT within my field practicum time. The primary focus was to learn and execute the skills of EFT through working primarily with couples. However, there were a low number of couples accessing services during the summer, making it necessary to adjust that expectation and to use the EFT framework with individual clients as well. Applying the skills, steps, and stages of EFT with both couples and individuals enhanced my application of this therapy model. Throughout the field practicum time, skill development improved, my overall knowledge increased, and my confidence grew using the various learning strategies of co-counselling, solo counselling and group work. Video recording some sessions while solo counselling provided opportunity to identify positives in using EFT and as well suggestions on how to improve, or where to focus, within the EFT therapeutic learning process.

1. Co-counselling

For my field practicum I observed or participated in co-counselling sessions with my professional associate with 11 clients for a total of 33 sessions. In these sessions, my professional associate led the sessions and I observed her techniques for EFT. With many of these clients, my professional associate had already established a therapeutic relationship so my interaction within the sessions was initially minimal. The professional associate would ask for my input and encourage my participation once clients were comfortable with me in the sessions. With two counsellors in session, it is important to maintain flow and to respect the client-counsellor relationship that exists within the counselling session (Haines, 2003). As these co-counselling sessions progressed, my professional associate suggested that I lead with particular clients with her present and participating as the observing counsellor. Once she was comfortable with my

skill level, she determined that I could work solo with clients. We would review sessions and identify EFT components used and the stage or step that the clients were working within. It was not uncommon that at the onset of a session, some de-escalation from conflict was needed if there had been a setback during the time away.

2. Solo Counselling

I saw 11 clients as a solo therapist totalling 34 sessions; including 3 couples. This combined with the sessions I sat in and co-counselled totaled 11 clients for 67 sessions including work with 6 couples for 21 sessions both with and without in-session supervision. With one specific couple, I was able to have one-to-one sessions with both individuals, which further enhanced the EFT process.

I was able to video record 10 sessions that I did with various clients that my professional associate and I reviewed and she could critique my use of Emotionally Focused therapy and provide feedback for improvement of skills. These 10 sessions included both individuals and couples. The strategy to use video recording allows the therapist to see their own counselling techniques and make critical changes very consciously (Haggerty & Hilsenroth, 2011). Video recording allowed my professional associate and I to review the sessions and stop to discuss possible improvements and aspects of EFT that were applied well. I found this extremely useful and helpful in learning the language and techniques of EFT.

Couples are a microcosm of group work. Extending this couple process to a larger format for group work provided me the opportunity to present emotionally-focused practices within a group context for couples. My professional associate and I used the weekend retreat for this aspect of my field practicum learning and professional development.

3. Group Process

This opportunity offered the techniques of EFT in a group format and provides individual couples time to work on the information together. It was an opportunity to provide several hours of counselling information within one day to multiple couples. This type of a format of service delivery can decrease the overall costs of counselling for couples and can condense the format in which they receive information to take home and use to change negative patterns (Ferguson, 2010). The group process used with couples was different in that there was not significant group discussion of personal information compared to intimate couple sessions. Allowing group discussion can assist all participants to acknowledge their issues, learn that they are not dissimilar from others, and to learn various ways of addressing issues outside of group (Stith, Rosen & McCollum, 2004). However, the format allowed the counsellors the opportunity to talk with each couple as they worked through the handouts and discuss the information provided as it pertained to their situation and relationship. Although some of the couples who attended the group workshop had attended couples counselling and had received the information before, the evaluations indicated that the information and format was useful and beneficial. Most stated they would recommend the couples workshop to other people. These strategies assisted in my learning the skills and techniques of EFT with individuals, couples, and in a group format.

Chapter Eight: Skills

Within my field practicum placement, I wanted to learn new skills and specifically EFT, which challenged my practitioner skills in the shift from Cognitive-Behavioural Therapy to Emotionally Focused Therapy. The primary context to learn EFT was within couple's work but also incorporated individual work with EFT. Along with the primary goal of learning EFT skills, I had opportunity to improve my group work skills within an EFT context. As well, I had hoped to improve clinical documentation of sessions. I don't believe that I was as successful in meeting this particular goal, due to the fact that in many practices, an individual therapist will document differently or as required by the agency based on the agency's needs. Therefore, it is more difficult to teach and practice this particular skill set in a way that is not agency-specific.

1. Emotional Focus

I was able to observe my professional associate in sessions using the EFT framework to build rapport and therapeutic relationships with clients. My professional associate provided clear boundaries as the clinician but also developed a therapeutic relationship with all of her clients. For new clients, I was able to observe how my professional associate built the therapeutic relationship with clients. This is a process that is vital but also its completion is unique for each clinician. As I began to practice using the EFT framework, my professional associate provided constructive feedback in instances where I tended to use cognitive behavioural skills instead, and explained how to shift it back to the EFT framework.

The most significant challenge for me was to transition from skill based therapy to focusing on emotional wounds and looking for the cues from clients as we get closer to revealing those wounds. In the initial stage as the negative pattern is identified, I was challenged to observe the subtle changes in both verbal and non-verbal responses to those emotional wounds. Initially,

delving into those emotional cues was challenging for me, as a therapist who had practiced cognitive-behavioural therapy for a significant length of time. I actually thought it was ‘harmful’ to ask clients to disclose their feelings. I had recognized that identifying those emotions could be helpful but without a clinical technique in which to delve into those emotions, I had interpreted accessing those emotions as potentially harmful. My comfort level in assisting clients in identifying their emotional responses to triggers, or to disclosing their emotional wounds, improved as my professional associate provided guidance and suggestions in our supervision sessions. The techniques used in identifying these wounds involve acute observational skills. The therapist must be highly aware of body language, intonation, facial expressions and their choice of words as dyadic communication within the couple generally indicates the pattern of negative interactions and the emotional responses that occur within that pattern.

2. Couple Intervention

Challenging the old negative patterns within the couple provides them the opportunity to make suggestions as to how this pattern could look different and be less negative for both of them. Couples often do not want to explain how they have been emotionally hurt by their partner since we often protect others from harm or criticism regarding how they have hurt us before, particularly before addressing one’s own emotional wounds. As the individuals share these wounds, it often provides new perspectives on how they treat or interact with one another. As shifts take place and the couple continues the process of establishing a new pattern of interaction, those emotional wounds soften and heal and the couple is able to move forward with their relationship in a healthier, more respectful manner. Both individuals are able to speak up when emotional triggers occur and this allows changes to be made, or more clarity in the interaction that prevents those triggers from becoming emotional wounds. It is within this process that

individuals in the couple relationship are able to find their voice and communicate openly and honestly with their partner; being vulnerable and safe to share when they hurt each other. This level of trust and safety within the relationship is truly powerful to observe when couples achieve this goal.

3. Individual Intervention

Similarly with individuals, the process of identifying emotional wounds begins with how the person is responding to colleagues, children, parents or others in their lives. Often this involves poor attachments from childhood that interfere with adult relationships; even non-intimate relationships. These emotional wounds for individuals from their childhood can be replayed as adults and often the client can inflict these wounds upon themselves. When clients accessed childhood wounds, this allowed the client to process their hopes for their various relationships, which influenced their overall relationship with themselves and improved their self-esteem. If the client perpetuated the wounds upon themselves via anger, self-loathing, depression or anxiety, a negative pattern existed within the client's relationship with themselves. To change this pattern for the individual required the client to see themselves with greater respect. Clients needed to access their emotional wounds from others and from themselves and process those wounds thereby allowing a new healthier pattern of interaction to emerge. This process remains consistent within couple work, individual intervention or within group work.

4. Group Work

Through the aforementioned couple's workshop that my professional associate and I designed, I prepared and presented a module which focused upon Communication and Knowing Self – Knowing Partner. The communication section included much of the information I had

researched for my practicum and I began with the *Relationship Model*.³ Next I presented the Attachment & Intimacy handout as outlined by Bartholomew, Henderson & Dutton, 2001.⁴ I used this to facilitate couples to identify their personal attachment style from childhood and their attachment style within the relationship. Information from the self-help book, *Levels of Intimacy* (Kelly, 2007), that provides general information on communication levels was also distributed.⁵

After this information was provided to the participants, couples then took the information and discussed in private their attachment style, and their style of communication related to the intimacy handout. For the Knowing Self – Knowing Partner module, I found a personality inventory in Gary Smalley's 1996 book, *Making Love Last Forever* (Smalley, 1996) that is simple to use. The inventory was developed by Dr. John Trent and Dr. Rod Cooper. The personality descriptions provide identification for each personality type using animals, specifically lion, retriever, otter, and beaver. The use of animals allows the individual a picture of their personality style based on the understanding they have of what those animals' characteristics are. From the personality inventory, I then had couples work through the *Five Love Languages* as described by Gary Chapman (Chapman, 1992). The love languages are physical touch, acts of service, gifts, quality time, and words of praise. These resources helped to reinforce the importance of connecting with one's partner on an emotional level in a positive manner, essentially meeting each other's emotional needs. These resources are helpful tools for couples who have tried to improve their relationship but have disappointed each other and now do not want to fail again in their efforts. Couples work is very challenging but often rewarding. It is a therapeutic success when couples are able to discuss their emotional needs and vulnerabilities openly and honestly. This is true regardless of the end result of the relationship.

³ The handout provided to each participant is included in Appendix 2.

⁴ See Appendix 1.

⁵ See Appendix 3.

The individuals' choices to remain in the relationship or to separate are not an indication of success; rather it is the ability to communicate and share their feelings and have that process respected that measures the success of the therapy. Sometimes couples complete this process and decide that, although the relationship is healthier, it is not as complete as either individual wants or expects, and the relationship ends. If the relationship ends, it is usually a more amicable process than if the couple did not attend counseling.

5. Clinical Documentation

Learning more about the clinical documenting of sessions was a goal that did not meet the intended result going into this graduate program. The lack of standardization for clinical documentation in academic training leaves this process much to the individual clinician to meet the requirements within the agency they work for (Kane, et al., 2002). There is incongruence with the learning goals of clinicians to focus on strength based progress of clients, while managed care (Employee Assistance Programs) authorize interventions based on client deficits (Kane, et al, 2002). Other stakeholders and factors such as family, medical-legal, insurance and diagnostic evidence can influence the clinical documentation requirements of various therapeutic agencies (Davis, Zayat, Urton, Belgum & Hill, 2008). External requirements, interdisciplinary teams and individual therapist practices seem to influence clinical documentation which complicates the instructional value in academic environments.

The opportunity gained through the clinical practicum for this graduate program has provided me with additional personal goals to go forward as a clinician, graduate and mentor others in the social work profession.

Chapter Nine: Visions

Returning to university and taking on the challenge of a Master's degree in Social Work inspired me to become more involved as a social worker in other areas. As an isolated clinician, I know the challenges of connecting with other social workers either locally or in a similar area of practice. It is important to network, not only for community resources for clients, but also for our own practice and companionship within the profession. This is a challenge with busy caseloads, limited time, and geographic distances. However, with today's technology, no social worker needs to be isolated. It would be ideal to have some method of connecting with social workers in similar situations that is coordinated through the SASW or perhaps the University of Regina as a means of outreach with alumni.

It was the connection I made with classmates while enrolled in the Program that was most enjoyable and valuable to me as a clinical social worker entering graduate school. As an experiential learner, this environment where experiences and other theories and practices were shared truly enhanced my education and ultimately my practice. With the connection and network established for those social workers who work alone, a means of supervision could also develop with those social workers with similar experience or practices. Through my field practicum experience, the training and direction provided by my professional associate was necessary for me to learn EFT strategies and skills to be effective in my practice once I was done. I also appreciated the team supervision I participated in that the Agency implements on a monthly basis for all the clinicians to attend to enhance their skills and to share challenges of some of their cases for possible solutions. Supervision is also useful to address any personal or professional issues that surface; as I experienced first-hand while in this placement.

The supervision from my academic advisor assisted me in addressing personal and professional issues that I did not foresee surfacing and that became detrimental to my learning environment. I learned from this experience and would like the opportunity in my future to be able to provide that level of interaction with other social workers as I am all too familiar with the personal costs of not attending to those difficult situations in our practice. Through the supervision received I learned that I did not have a healthy practice of self-care. I intermittently attempted self-care practices but was unsuccessful in maintaining the practice long-term. This is one aspect of social work practice that many social workers do not attend to well and, as a result, they suffer long-term. I have former colleagues who have struggled because they did not practice healthy forms of self-care. Connection with other social workers, regular supervision and consistent and healthy self-care are significant practices that social workers should make a priority in their practice.

Self-care in social work practice is conceptualized as methods to maintain health and well-being in an environment with stressful demands (Lee & Miller, 2013). Self-care has been promoted as good practice but very little has been done to ensure it is incorporated into a clinician's regular practice (Newell & Nelson-Gardell, 2014). This seems somewhat conflicted to promote but then not practice in order to assist new social workers in incorporating the process for a healthy practice and lifestyle early in their careers. Personal well-being improves our ability to care for others, from clients to family members, and to meet the demands of employers and educators (Moore, Bledsoe, Perry, & Robinson, 2011). Incorporating self-care as part of the education system of a social work program, and to have it as an integral part of the practicum, seems best suited for social workers to maintain self-care throughout their career. One means of ensuring that self-care becomes a prominent aspect of social work education is to incorporate

self-care as part of our value and ethics because it is important that social workers maintain healthy well-being similarly to being ethical and treating others with dignity. If we, as a profession, empower others to take good care of themselves while not maintaining our own well-being, we are not being true to ourselves or our clientele. There are various means for self-care such as exercise and good nutrition, all of which are helpful for overall good health practices. Other methods such as journaling, self-reflection, spirituality and enjoyment in hobbies or social engagements can also promote self-care for social workers (Lee & Miller, 2013).

Having approximately twenty years of social work practice, I was not prepared for the emotional self-reflection that would rise from the direct application of EFT within my field practicum placement. This emotional self-reflection made my experience in the Master's Program more challenging. I was fortunate to have chosen to do a field practicum placement to learn and develop my skills in EFT because otherwise I may not have allowed myself the time for this self-reflection. I also believe that, without that whole experience, I would not fully understand how difficult emotional work is for our clients. As clinical practitioners, our personal issues are never far away and this reality requires a system of checks and balances to maintain a healthy clinical environment for our clients. It is this system of checks and balances that assist therapists on the proper course of treatment or referral for all of our clients. A clinical practice must provide a healthy environment for the safety and well-being of the clientele. I wanted to experience working with a team of therapists from various backgrounds, but also to work specifically with a clinician skilled in EFT. A field practicum in a clinical placement has always been a personal goal for me in pursuit of a graduate program.

As a practitioner, and with recent connection to the university, I plan to increase my level of involvement in both the SASW and University of Regina. I think it is important to be involved

in the SASW. I previously belonged to the Moose Jaw chapter; however, it was difficult to manage with workload and a young family at the time. I now have more time to put towards involvement in the SASW through opportunities with its many committees. I am greatly interested in ethical practice concerns and complaints against social workers. I believe it is important to have a committee that hears the complaints but I also think it is important to have a 'team' available to provide support through that process. There are different ways this could be put into practice and attending SASW meetings is the best way to have these ideas brought forward.

Through my time at the University of Regina, I was able to connect with the professors and practitioners connected with the academic programs for social workers. I was fortunate through this connection to be able to supervise a Bachelor's level social worker upon my return to my workplace. I enjoyed the supervision opportunity and I would like to continue as a resource for social work students in the future and perhaps eventually supervise Master's level students. As a clinical practitioner, I also would like to be involved in other aspects of social work students training including mentoring, public education on the role of social workers, and perhaps even through participating on the committee for students applying for entrance into the social work program. I am at a point in my career that I believe I can give back to the SASW and to the University of Regina Social Work Program to continue the level of excellence for which they are known.

There are also areas that I am interested in furthering the practice of social work within existing Employee and Family Assistance programs. I believe that significant change cannot be made in the four to six sessions that are usually allotted by these programs. Understanding that this is usually a fiscal issue, there can be other means to promote emotional and mental wellness

in our population; as we currently do for physical fitness and healthy nutritional programs. I work within a federal program that could be scaled to benefit the population at a provincial level. This is something that could be promoted through the SASW or from a community based organization. My involvement in this could be as a volunteer on a community based board. I realize that I have neglected to promote both social work and community needs during a busy time in my life and now can commit the time and energy to benefit others in the community outside of the population that I serve. My belief is that mental health care should be readily available for all persons within our province, similar to the accessibility of general medical care, and that it should be part of our medical care system thereby allowing equal access for all through medical clinics. Mental health care kept within a private setting makes the service inaccessible for many while a fully public system is understaffed for the number of people who would benefit from mental health care. Further, I believe that the current practice of situating mental health care provision primarily within hospitals serves to reinforce the stigma related to mental health care.

The last area of interest that I would also like to eventually put my energies towards is to promote work-life balance at both micro and macro levels. My own experience with work-life non-balance has given me many ideas for creative solutions to this issue. I was always taught that if you have a complaint, you should at least have an idea for a solution. This mantra has benefitted my clientele and I would now like to promote creative solutions at other societal levels. Change does not happen for the sake of change, but out of the necessity of change. Work-life balance is necessary since without balance, the family and employees suffer which then ultimately, the employers experience lower productivity and greater absenteeism when employees are not able to meet the demands from family or work (Pocock, Skinner, & Ichii,

2009). Although I have had difficulties with work-life balance during my career, I did not know about the changes that were happening in this field and the amount of research available that supports work-life balance.

Since my return as a practitioner, I see the amount of work-life imbalance that many people experience and I would like to help to address changes in this area. I can start in my own work environment and assist in other areas when I have opportunity. This is one area within which I will continue to follow the research as it is an area that impacts many people where I work and there is often no room for work-life balance. The “work first and family second” adage (or lower) does not promote a healthy lifestyle for anyone. People need a format to voice their concerns and thankfully there are studies going on that can help voice those concerns for the general populace. I suspect that the work-life balance practices and policies in recent years will have worsened as the economy experienced a downturn and there continue to be fiscal restraints and employee downsizing. There are many ways to serve within our communities in which we live and work, but also specific ways to serve the communities of social workers as students within the academic process, and more significantly, with the Saskatchewan Association of Social Workers. The voice of the many social workers through the Saskatchewan Association of Social Workers can promote new and more efficient and effective methods of delivering mental health care and design a system that leads our country and others in providing comprehensive and early care for life issues that can, and often do, become mental illness.

Chapter Ten: Conclusion

The most significant aspect from my practicum experience that I can take forward into my practice and profession as a social worker is the skill learned to help people ‘find their voice’ in order to share their deepest emotions and improve their relationships. I was able to combine my learning about EFT and Attachment Theory with previous training, and as a result, I have enhanced my practice to a more holistic approach to help address client concerns. EFT provides a framework that re-directed my practice and I feel prepared and confident to address emotional wounds with clientele in a respectful and therapeutic manner.

EFT also helped me to find a voice for my own professional and personal wounds and that experience, coupled with my research in this area, has provided me an avenue for change in dealing with individuals and couples with emotional wounds. We do not coast through life without those wounds, some are deeper than others, but it is the strength to address those wounds and share the hurts that is promoted by EFT so that true healing can take place. Sharing our hurts requires a level of trust and honesty that takes time to build, especially if it is a loved one that has caused the hurt. That trust and honesty comes initially in the therapeutic relationship and then shifts for the personal or intimate relationship between the clients. Initially it seems like a giant leap of faith to make that statement, identify the emotional wound, and to recognize our need to make the hurt stop that it can overcome our fears. Once that step is taken, trust and honesty are respected; clients and couples can move forward and redefine their interactions in a healthier and more respectful way.

I am truly honoured in the level of trust clients give to practitioners and it is my ultimate goal to uphold that trust. In many circumstances, it may take only one person to hear the hurt or help to identify the emotional wound and to recognize the strength and courage to live with those

wounds so that clients can move forward in their own journey of healing and growth. Once a client learns to hear their voice, they can express their hurts before their wounds are too deep for them to shift old patterns to healthier interactions with all the people in their lives. It is not always a spouse that causes injury, sometimes it is a colleague, an employer or supervisor, a coach, a teacher, a parent or a child; anyone can cause harm. Those who do cause harm without intent only need to be informed of the hurt caused and change can and will happen.

I will always believe in the inherent good of people. I do know that some people are able to make changes easier than others but everyone has the potential to change. I will endeavour to assist those who want to make changes to do so. I also will support those people to see the potential they hold inside for something greater than they have known. Simple truths hold great value for me and the following reflects my values for those who I have worked with and those whom I have yet to meet:

“Promise me you'll always remember: You're braver than you believe, and stronger than you seem, and smarter than you think.” Christopher Robin, in Walt Disney's Pooh's Grand Adventure: The Search for Christopher Robin.

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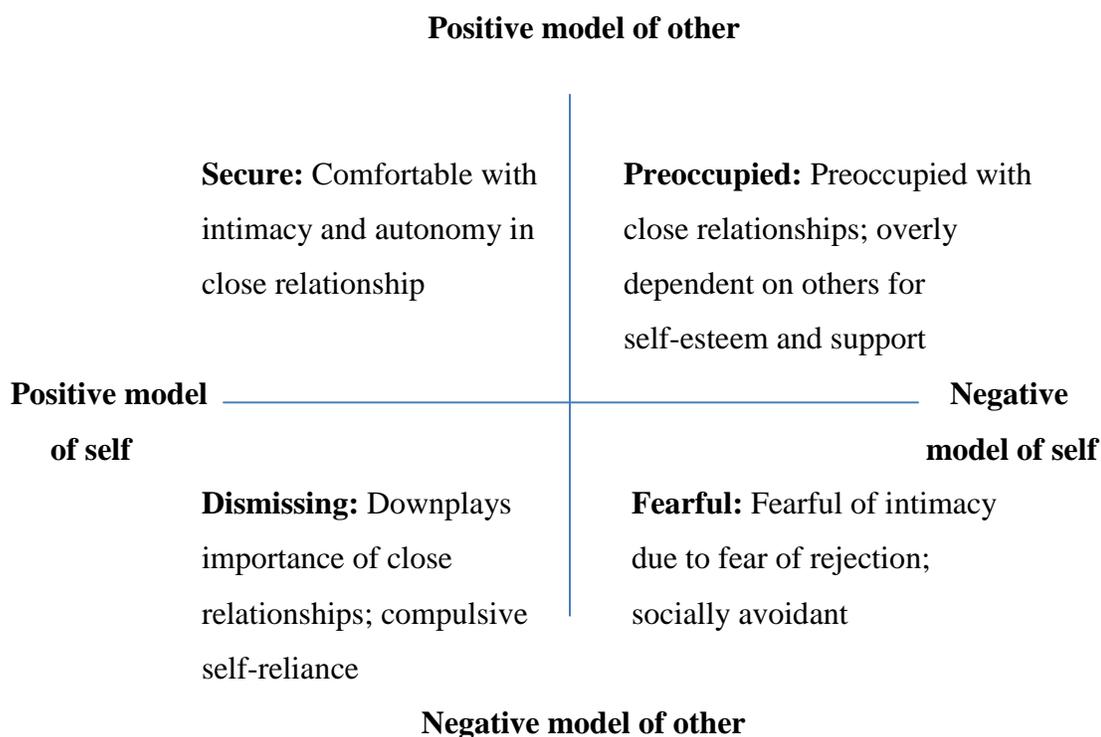
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Appendix 1: Attachment Theory

Bartholomew, Henderson & Dutton (2001) in Clulow's *Adult attachment and couples psychotherapy: The 'secure base' in practice and research* developed a two-dimensional, four-category model of adult attachment that I would describe as influencing our levels or type of intimacy we experience.



Secure attachment: experiences of consistent responsive caregiving are needed to facilitate the development of positive image of self and others. Secure individuals are comfortable with autonomy & intimacy and able to use others as a source of support. They are characterized by high self-esteem and an ability to establish and maintain close intimate bonds with others without losing sense of self. They will likely form intimate relationships in which both partners provide safe and secure bases for each other.

Preoccupied attachment: experiences of inconsistent and insensitive caregiving are thought to contribute to preoccupied attachment having a positive model of others and negative model of self. In parenting, this may lead children to believe they are to blame for the lack of love from caretaker resulting in an overly dependent style characterised by intense feelings of unworthiness and excessive need for others' approval and expressed as intrusive and demanding interpersonal style. If they feel their attachment figure is unresponsive, will experience anxiety and respond with high levels of attachment behaviours (seeking contact, clinging, and angry protest). Avoidant attachment patterns (fearful & dismissing) characterised by avoidance of close contact with others. Perhaps due to a history of rejecting or unresponsive attachment figures, they have learned not to turn to others as a source of security.

Fearful attachment: experiences of uncaring and unavailable attachment figures have resulted in conclusion of being unlovable. Desire acceptance by others & are hypersensitive to social approval, they avoid intimacy for fear or expectation of rejection. They do not expect others to be responsive which gives rise to fear & anxiety. They are inhibited in expressing their anxiety and asking for support. Cope with anxiety by maintaining a comfortable distance with the close relationship. (If not too close, can't be rejected as much).

Dismissing attachment: maintain a positive self-image by distancing themselves from attachment figures and relationships. With characteristic self-reliance and emotional control and defensive downplaying of the importance of intimate relationships, they become relatively invulnerable to potential rejections by others. They defensively deactivate the attachment system reducing their tendency to experience the anxiety that

typically follows from unmet attachment needs; this is complemented by an avoidant behavioural stance in which distance is maintained in close relationships.

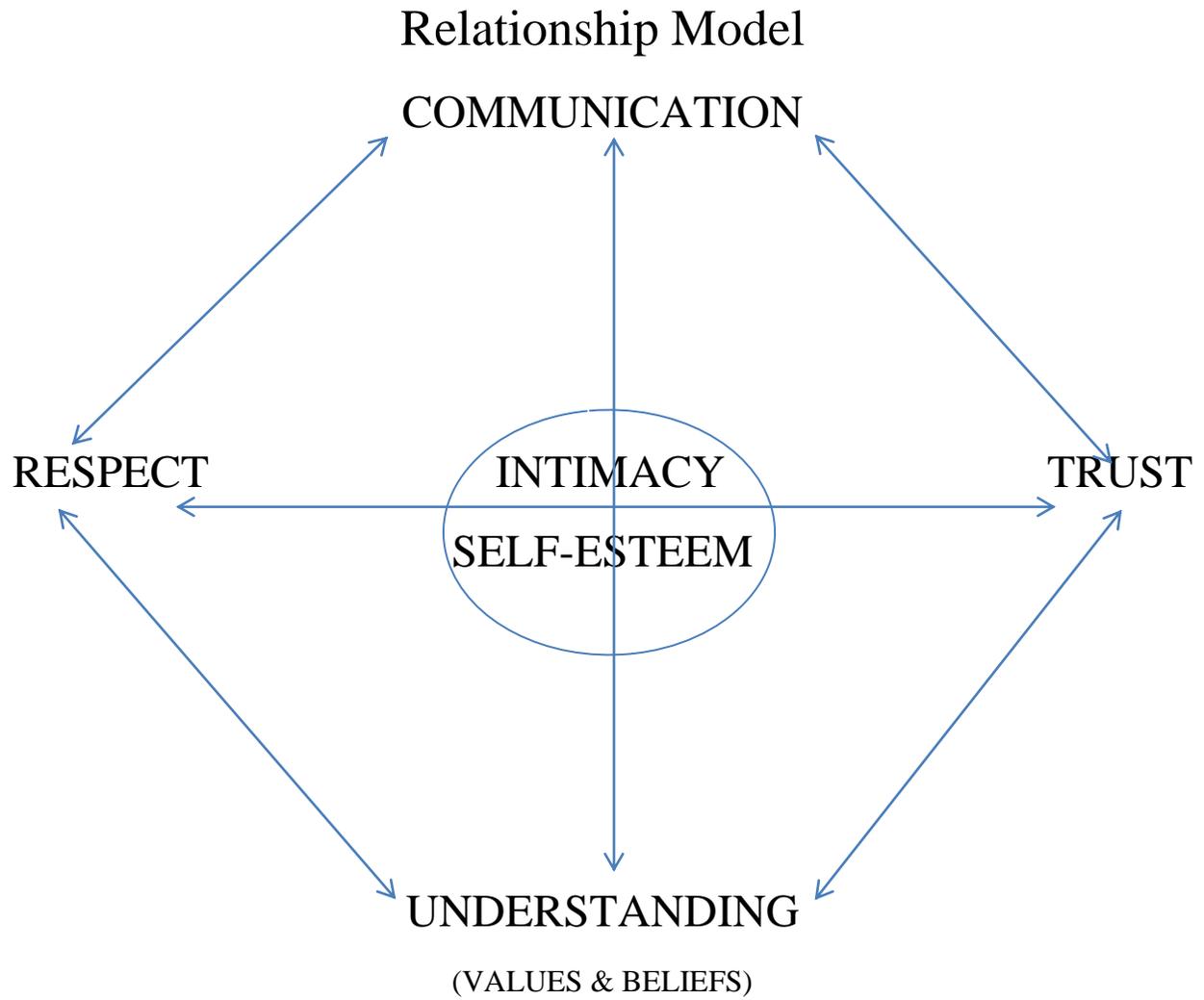
The other option is to provide some discussion on levels of intimacy. This is strongly connected to levels of communication. We communicate our level of intimacy in verbal and non-verbal methods.

Appendix 2: Relationship Model

I developed this model within my practice to have a tool to share information with clients from.

- All relationships start with some form of communication (verbal & non-verbal).
- From communication, we learn about and begin to understand that person.
- Eventually we decide if we want to invest in that relationship and we base this on our personal values & beliefs; (form an attachment bond)
- We invest in trust and respect which deepens the relation when both are reciprocated.
- Communication, understanding, trust and respect become the foundation of an intimate relationship. This intimacy is expressed in various ways (verbally, emotionally, physically & spiritually). When these areas are healthy in a relationship, the result is an intimate relationship that is safe and secure. Our relationship with ourselves is also reflected in our communication with ourselves, our understanding of ourselves, how we trust ourselves and how we respect ourselves and the result is identified as our self-esteem.
- We often don't know if damage has occurred in the foundation until intimacy is absent. (Tire analogy – we don't know that there is damage to the exterior of the tire until it is flat).
- This is my original description of this model. I have been trained as a CBT therapist and worked with this model to assist couples, parent-child relationships, working relationships and it also works for conflict management.
- Since studying Emotionally Focused Therapy (EFT), I believe this model works well with EFT and I am working on incorporating the language and theory of attachment theory and EFT into the model.
- Thus, Intimacy could change to Attachment (which can then be expanded to assist people to understand their base attachment style.)

- This also helps in identifying the dysfunctional pattern that couples develop and then they are able to see where the cycle becomes problematic, their role in the dysfunction and then they can come up with some methods to make changes to their cycle.



Appendix 3: Levels of Intimacy

Levels of Intimacy: Kelly, M. (2007). *The seven levels of intimacy: The art of loving and the joy of being loved*. New York: Simon & Schuster.

Level 1: Clichés:

Are casual interactions and encounters that reveal little about a person; fleeting and superficial exchanges. Generally used to become acquainted with someone or in day-to-day transactions. However, relationships are not transactions and speaking mainly in clichés in our intimate relationships can be detrimental.

Level 2: Facts:

Communication focuses on the facts about our lives and the world we live in. Discussions at this level of intimacy involve the weather, sports, stock market performance, and our daily activity.

Level 3: Opinions:

Introduce the first level for vulnerability. Sharing opinions is a risk factor that if not mastered, many of our relationships will stagnate at this level. Every opinion says something about who we are; reveals our core values, expectations and beliefs. Kelly uses Acceptance in place of Understanding (I have done so as well in the past). Acceptance is the key to this level of intimacy; developing the acceptance necessary to respect each other's opinions & remain dedicated to common search for truth, then the mastery opens up for deeper levels of intimacy.

Level 4: Hopes & Dreams:

Dreams often reveal our hopes, fears, fantasies and our deepest desires. Hopes & dreams are a crucial part of life and of any healthy relationship. Mastery at the third level is paramount as we generally reveal our dreams to those with whom we feel accepted by.

Level 5: Feelings:

Are “emotional reactions” which we have thousands of every day. Learning to share our feelings is an integral part of intimacy. At this level, we face the fear of rejection. Feelings often reveal our brokenness, humanity, needs, and our willingness to be vulnerable.

Level 6: Faults, Fears, & Failures:

It is often at this level of intimacy that we tend to our wounds from the past.

These wounds can be infected and need cleaning which can be a painful process but necessary for recovery and growth.

Level 7: Legitimate Needs:

At this level of intimacy, we encounter dynamic collaboration to meet our physical, emotional, intellectual and spiritual needs. Knowing each other's needs is important in our quest to know each other in relationship. Having what we need causes us to thrive, not what we want.