

The Application of Emotionally Focused Therapy in Treating Couples who have Experienced the
Death of Child: A Grounded Theory Study for the EFT Therapist

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Abstract

This qualitative study sought to understand how Emotionally Focused Therapists (EFT) apply the EFT model with couples that have experienced the death of a child. Criterion sampling and snowball sampling were used to recruit participants within the United States and internationally. Semi-structured interviews were conducted with 5 participants, all of whom were women therapists. The data were analyzed using the Grounded Theory Method and two processes emerged. To convey and organize the processes and concepts of each, two diagrams of the actions and experiences noted in the interviews during analysis were created (Figure 1 & Figure 2). Figure 1 represents an external, multi-directional process of how EFT clinicians apply the EFT model with their clients. This figure encompasses “how” clinicians adjust their approach to the model to meet the needs of their clients and work with couples that have experienced the death of a child. Figure 2 represents an internal process model of how applying the EFT model impacts the therapist on a personal level. This will be discussed through a self-of-the-therapist lens.

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General Audience Abstract

The following study sought to examine how Emotionally Focused (EFT) therapists use the EFT model with couples who have experienced the death of a child. Qualitative interviews were conducted with 5 clinicians and two models explaining this process emerged. The first process model depicts how clinicians apply the model with couples who have experienced the death of a child. The second process model explains the internal process that these clinicians experience for themselves when working with these couples. All therapists reported an intention to honor the loss that their clients had experienced. The following study can be used to aid EFT clinicians in their application of EFT with this population, as well as expand the literature of couple therapy approaches to the death of a child.

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Chapter I: Introduction

Emotionally Focused Therapy (EFT) is a well-established model in the field of marriage and family therapy for couples experiencing distress. Since its creation in the 1980's, researchers and scholars have studied its efficacy among varying populations. These include, but are not limited to, couples in which one or both partners are experiencing or have experienced depression, trauma (e.g. Post Traumatic Stress Disorder (PTSD)), sexual abuse, or chronic illness. There has been much progress in addressing these specific presenting problems that couples may face, yet there still remains a gap in the literature surrounding the efficacy of this model treating death and bereavement, specifically the death of a child. There is clear support from the fields of grief and bereavement that the death of a child is a significant attachment loss. Similarly, the bond between parents has been found to be a strong predictor of resilience. Rooted in Attachment Theory (Bowlby, 1969/82) and having an emphasis on strengthening secure bonds, EFT could be clinically appropriate for parents who have lost a child.

The EFT literature and scholars in the field support the use of EFT for most, if not all, of the issues that cause couples distress. The following study will explore how EFT clinicians are already using this model with couples that have experienced the death of a child. Through a Grounded Theory approach, the researcher sought to understand how grief specific issues are addressed in a clinical setting when practicing EFT, as well as the strengths and weaknesses of the model with this specific population. It is the hope of the researcher that the results of the study will aid clinicians practicing EFT with this population, as well as expand perceptions on how to clinically address the loss of a child within the couple relationship.

The Problem and Its Setting

Each year, more than 60,000 children younger than 20 years die in the U.S. and Canada (Gilmer, Foster, Vannatta, Barrera, Davies, Dietrich & Fairclough, 2012). The death of a child is one of the most painful events a parent may experience (Gilmer et al., 2012). Adjusting to a world without the loved one is a part of the grief process, which may take considerable time and effort (Gilmer et al., 2012; Price, Jordan, Prior & Parkes, 2011; Salakari, Kaunonen & Aho, 2012). The death of a child is counter to the expected order of life events and defies basic assumptions about the world. As a result, research has emphasized significant negative effects for parents on adjustment, health outcomes, and social relationships after the death of a child. Parental grief is prolonged and can intensify during significant periods (e.g., holidays), a concept known as “regrief” (Gilmer et al. 2012). Bereaved parents routinely score worse on most scales of adjustment, especially internalizing problems, relative to norms and controls. Studies have shown that bereaved parents, particularly mothers, are at a higher risk for psychiatric hospitalization than nonbereaved parents. Some parents experience severe anxiety, whereas others have regrets or guilt over not being able to protect their child. Still other parents undergo changes in their basic assumptions, priorities, and perspectives about life. However, emotional ties to the deceased child often continue indefinitely, and negative emotions may persist despite apparent normalcy in other dimensions of functioning (Field, 2006).

It is well established in the research literature that the death of a child is strongly associated with significant psychological disturbance and the development of depressive symptoms (Dyregrov & Gjestad, 2011; Gilmer et al., 2012; Hagemesiter & Rosenblatt, 1997; Song, Floyd, Mailick Seltzer, Greenberg & Hong, J., 2010; Tambling, 2012). After the death of a child, risks to parental health include reduced quality of life, physical illness, and even death

(Dyregrov & Gjestad, 2011). Some bereaved parents have described physical pain resulting from their grief similar to having been injured or mutilated (Tambling, 2012). The pain has been reported to linger even seven to nine years after the death of a child from cancer (Gilmer et al., 2012). Bowlby (1969/1982) found that somatic disturbances such as loss of appetite are often coupled with cognitive difficulties of confusion and obsessive thinking. Bereaved individuals who experience extreme loneliness and depressive symptoms may be at risk for suicidal ideation, and mortality rates may be higher among bereaved parents, especially in the first three years after a child's death. Some parents may even exhibit symptoms similar to PTSD after the unexpected death of a child (NIMH, 2014).

In general, research suggests that women tend to have a greater need to talk about the loss than men (Lang & Gottlieb, 1996). Bereaved mothers' satisfaction with their relationship with their partner seems closely related to the opportunity to talk, even though this can result in more intense grief reactions soon after the loss (Stroebe, M., Finkenauer, C., Wijngaards-de Meij, L., Schut, H., van den Bout, J. & Stroebe, W., 2013). More intense grief over time has been reported by mothers who have not been able to talk about their thoughts and feelings; they view the emotional closeness to their partner as having deteriorated (Stroebe et al., 2013).

The loss of a child has also been shown to have an impact on the marital relationship (Dyregrov & Dyregrov, 2015; Martin & Doka, 1999; Sanders, 1999). Grieving parents tend to look toward one another for comfort following the death of a child (Avelin, 2013; Stroebe et al., 2013; Wing et al., 2001). The majority of parents are likely to accommodate this loss together; for others, however, significant disruption can occur (Kazak & Noll, 2004). Differing grieving styles, coping mechanisms, and gender specific responses to the loss, are a few of the factors that researchers believe contribute to parents who report feeling connected or disconnected from their

partner during the grief process (Avelin, 2013; Stroebe et al. 2013; Wing et al., 2001). For many, grief serves as a bonding experience. If there is a lack of vulnerability, willingness to understand and face each other, the unity and the bond of the couple can be threatened (Wijngaards-de Meij et al., 2008). Recent studies have indicated an increase risk for relational break up following the death of a child (Dyregrov & Dyregrov, 2015; Gold, Sen, & Hayward, 2010; Lyngstad, 2007).

Grief literature categorizes the loss of a child as dyadic grief, being experienced by both individuals (Dyregrov & Gjestad, 2011; Figley, 1997; Gilmer et al., 2011; Hagemesiter & Rosenblatt, 1997; Song et al., 2011). Relationship satisfaction is lower the greater the emotional distance between two partners, that is, where one partner wants to talk, while the other does not (Dijkstra, van den Bout, Schut, Stroebe, & Stroebe, 1999; Dyregrov & Dyregrov, 2015). Marital closeness has been shown to be a significant predictor of better health in bereaved couples (Song et al., 2010). In a study of 89 bereaved parents, Greeff, Vansteenwegen, and Herbiest (2011) found that commitment to the family was an important recovery factor in families following a child loss. Based on their findings,

“The family’s ability to work together, the awareness of internal family strengths and interdependence, the family’s ability to be innovative and active and to learn and experience new things, and, to a lesser extent, having a sense of control over life events are important recovery factors that contribute to family adaptation (p. 355).”

Grief Therapy and Current Approaches. According to Worden (2008) there are four tasks of mourning. These include: 1) accepting the reality of the loss, 2) experiencing the pain of grief, 3) adjusting to an environment in which the deceased is missing, and 4) finding an enduring connection with the deceased and move on with life (Worden, 2008). The literature also denotes that there are different types of losses (Gilbert, 2006). Ambiguous loss and secondary

loss are two common manifestations of grief. An ambiguous loss is a loss that occurs without closure or understanding (Gilbert, 2006). This kind of loss leaves a person searching for answers, and thus complicates or delays the process of grieving, often resulting in unresolved grief. Clients experiencing an ambiguous loss report feeling stuck or unable to move forward in the grieving process (Gilbert, 2006). Secondary losses are all of the losses we experience as a result of a main loss or death. This could include the loss of a primary family member, such as a parent or child (Gilbert, 2006). The process of grief is unique for each individual and has been shown to be dependent on the type of loss, whether or not a griever has access to resources and social support, and the emotional state of the individual prior to the loss. Grief therapists help clients to complete these four tasks of mourning in various ways (Gilbert, 2006).

According to Winokuer and Harris, “At its core, grief counseling is good counseling practice that is also embedded with the current research, theory, and clinical wisdom of those who have spent years in research and practice with the bereaved individuals (2012).” The primary mode of intervention for grief has been individual and group psychotherapy. Cognitive Behavioral Therapy (CBT) and other related approaches have received the most rigorous empirical attention and validation. CBT grief interventions usually employ some form of cognitive restructuring and exposure (Mancini, Griffin, & Bonanno, 2012). These restructuring techniques help the griever to identify problematic aspects of the loss and revise their understanding of them, making new meaning of the events. Exposure techniques typically involve story telling or confronting avoidance of places or people associated with the loss (Mancini et al., 2012).

There are relatively few studies of family-based grief interventions. One randomized control study of family-based CBT for relatives of suicide victims found that 13 months post-

death treated individuals failed to report fewer grief symptoms. It has been suggested that grief interventions are most effective for persons with higher levels of distress. This study has shown initial promise, but has insufficient data to validate their efficacy to date (Mancini et al., 2012).

In recent years, grief researchers have begun to challenge the long-standing belief deriving from psychoanalytic tradition (Freud 1917/1957) that ties to a deceased person's need to be relinquished, in order for adaptation to bereavement to take place (Stroebe, Schut, & Boerner, 2009). Moving away from this belief, grief research placed more focus on the benefits of continuing a connection with a deceased person (Stroebe et al., 2009). Recently, however, various studies have found that it is neither generally adaptive for bereaved people to continue their bonds with deceased loved ones, nor to relinquish them (Field, 2006; Stroebe & Schut, 2005). There is now an emergence of the focus on the role of individual differences and how these differences dictate whether or not it is helpful to continue the bond with their deceased loved one or to create distance (Stroebe, 2011). Furthermore, several models within the bereavement field have linked attachment phenomena or (marital) relationship variables to ways of coping (e.g. Stroebe & Schut, 1999).

The Dual Process Model of Coping with Grief (DPM) has the advantage that specific connections with attachment styles, mental representation processes, and coping styles can be made. Originally developed by Stroebe and Schut (1999) to describe the grief associated with the death of a spouse, it has been shown to have validity for describing the processing of other kinds of losses through death (Stroebe, 2011). According to Stroebe, the DPM is broad enough to account for different aspects of inter and intrapersonal experience associated with grief. The model posits that the two arenas of stress attendant to grief are those associated with the coping with the loss itself and those stressors that are related to secondary losses are implicated in

moving forward with a new life adapted to the absence of the person (Stroebe, 2011). This model, while linked with attachment theory, is not a treatment or intervention model. Instead, the DPM can be used to support the emphasis on attachment theory and the importance of attachment bonds through the grieving process.

Although there is a lack of empirical studies exploring the efficacy of family-based interventions for the bereaved, studies suggest that for many adults experiencing the death of a child, one's partner can play a key supportive and healing role (Dyregrov & Gjestad, 2011; Hagemesiter & Rosenblatt, 1997; Johnson, 2004; Song et al., 2011). Researchers and clinicians have come to appreciate the value and benefits of partner-involvement when treating distress (e.g. trauma, PTSD) (Johnson, 2004; Johnson, 2002). While not all parents exhibit symptoms of PTSD following the death of a child, such a loss is likely to produce trauma-like symptoms. It is common that grief therapy approaches or techniques are integrated into current models and therapeutic modalities. Recently, the grief literature has begun to place an emphasis on the couple's emotional bond as a predictor of resilience facing the death of a child (Avelin, 2013; Dyregrov & Dyregrov, 2015; Stroebe et al. 2013).

Emotionally Focused Therapy. Emotionally Focused Therapy is a structured approach to couples' therapy formulated in the 1980's and has developed alongside the science on adult attachment and bonding to expand our understanding about what is happening in couple relationships (Johnson, 2004). The goal of EFT is to foster the creation of a secure bond. This is achieved by expanding and re-organizing key emotional responses and shifting a partners' interactional positions to create new patterns of interaction (International Center for Excellence in Emotionally Focused Therapy (ICEEFT), 2015).

Attachment theory holds that distressing events can be perceived as disruptions in

attachment (Greenman & Johnson, 2012; Johnson, 2002; Johnson, 2004; MacIntosh & Johnson, 2008). When viewed from this perspective, the process of healing should thus help the grieving couple to “establish safe emotional connections to significant others (Greenman & Johnson, 2012, p. 2).” The EFT therapist’s work focuses on the “creation of loving, supportive bonds between romantic partners as essential components of the healing process in the wake of trauma (Greenman & Johnson, 2012, p. 3).” This same goal of strengthening secure bonds between partners remains salient in the face of most, if not all, of the distressing presenting problems a couple may face (Johnson, 2002).

EFT has been found effective in treating many of the symptoms within the couple dyad that the literature suggests as commonly experienced following the death of a child, such as sadness, despair, depression, trauma, and general marital distress (Denton, Nakonezny, Wittenborn, & Jarret, 2010; Greenman & Johnson, 2012; Johnson, 2002, MacIntosh & Johnson, 2008). EFT has been found to be effective in both reducing PTSD symptoms and improving the quality of interpersonal relationships among trauma survivors (Greenman & Johnson, 2012; MacIntosh & Johnson, 2008). Similarly, EFT has been found to be effective in reducing depressive symptoms (Denton et al., 2010).

Significance

This study is important for several reasons. Recent studies have indicated an increased risk of relational break up among couples that have experienced the death of a child (Gold, Sen, & Hayward, 2010; Lyngstad, 2007). Bereaved parents may be at higher risk of more emotional distress, more hostility, more frequent psychiatric hospitalizations, decreased sexual desire, a higher rate of certain types of cancers, and higher mortality rates than non-bereaved parents (Dyregrov & Gjestad, 2011; Gilmer et al., 2011; Hagemesiter & Rosenblatt, 1997; Song et al.,

2010). In addition, the literature suggests that the death of a child disrupts parental health and well being both during the acute phase of bereavement and for extended periods over the course of their lives (Gilmer et al., 2011).

EFT is an evidence-based, empirically validated approach that has been shown to be effective in helping individuals, couples, and families recover from trauma (Greenman & Johnson, 2012; Johnson, 2002; Johnson, 2004; MacIntosh & Johnson, 2008). More recently, it has become evident that to be resilient in the face of trauma, people need not just friends and a sense of community, but close attachment bonds (Johnson, 2004). Given that this model has been shown to be effective with populations experiencing trauma and other forms of distress (i.e. depression, marital discord) it can be argued that EFT would be appropriate to treat the symptoms of grief and bereavement. Even though this notion may be widely supported within the EFT community, this gap in the research still remains.

This study could potentially influence how grief is addressed within the couple context on a much larger scale. There are many parallels between what the grief literature defines as causes for distress and the solutions and theoretical framework that EFT provides. Both fields conceptualize the death of a child as a significant attachment loss and place an emphasis on the couple relationship as a place for healing. The bereavement literature also reports the distress faced by these parents leads to them feeling disconnected (Kazak & Noll, 2004; Wittouck, Van Autreve, De Jaegre, Portzky & van Heeringen, 2011). This can manifest in one partner withdrawing (typically fathers) and the other partner needing more support, room for discourse over the loss, and more connection (typically mothers) (Dyregrov & Matthiesen, 1987; Lang & Gottlieb, 1993; Salakari, 2012; Wijngaards-de Meij et al., 2008).

For EFT clinicians, this study has the potential to assist them in understanding the application of this model with bereaved couples. Understanding how seasoned EFT therapists have worked through the various steps of the model, addressed each partners' grief, explored the attachment implications for the couple, etc., will be invaluable for those who practice EFT regularly with clients. The pursue-withdraw pattern is a major tenet of EFT. While this has not been tested or examined with the withdraw or pursuit patterns associated specifically to grief, EFT employs a specific protocol to address the patterns of pursue-withdraw, distilling the underlying emotions of each partner, and changing the steps in a couples' potentially negative cycle. A study of this kind will gain the perspectives of seasoned clinicians in EFT to understand how to address the needs of couples grieving the loss of a child. Gaining support and consensus among those in the field of EFT could lend itself to future studies that could actually explore the efficacy of EFT with couples that have lost a child.

Rationale for Methodology

This qualitative study will implement in-depth, semi-structured interviews to understand the clinical experiences of certified EFT therapist's experiences regarding the application of the EFT model with couples that have experienced the death of a child. Using a qualitative framework will allow for the participants to share as much or as little detail about their experiences as they find satisfying. Collecting in-depth accounts from therapists who are experts in the field of EFT and grief therapy may shed light on the unique challenges and issues that they face, as well as provide greater understanding of the theoretical perspectives of grief within the context of EFT.

Theoretical Framework

The guiding theory informing this study was Grounded Theory. Grounded Theory seeks to understand a process or to develop a theory based on data analysis (Strauss & Corbin, 1990).

Based on the interviews conducted with participants, the researcher developed a theory or consensus regarding “how” to apply EFT with this specific population. To maintain a grounded approach, the researcher went back and forth while comparing data, continually modifying, and sharpening the growing theory (Strauss & Corbin, 1990). While Grounded Theory serves as the theoretical framework for the design of the study, Attachment Theory and the Life-Stress Model also served as theoretical frameworks in understanding loss and the impacts of grief on the family from a systemic perspective.

Purpose of the Study

This study will be used to understand how certified EFT clinicians apply the EFT model with couples that have experienced the death of a child. To explore this, this study will use the following research question: How do EFT therapists apply the EFT model with couples that have experienced the death of a child? This study will inform researchers and clinicians how certified EFT therapists have used this model in the field. These findings can be used to better assist couples grieving the loss of the child, as well as expand the approaches used with this specific population. It may also permit academic support and future funding and grant opportunities for other researchers. The literature in EFT is constantly growing. This study will be the first of many that begin to explore grief and the efficacy of the EFT model.

Research Question

- 1) How is the EFT model applied by EFT therapists to couples who have experienced the death of a child?

Chapter II: Literature Review

A review of the literature will assist in understanding the scope of what is known from previous research and review gaps in research concerning this topic. The literature reviewed includes an exploration of loss and its impact on parents, clinical implications for treating couples that have experienced the loss of a child, and a review of studies and literature detailing EFT and its application. These reviewed topics will help illuminate how EFT could be an appropriate model for this population, as well as what is useful to understand in applying the model to couples experiencing this specific type of loss.

Traumatic Loss and Its Significance

The death and loss of a child is one of the most painful events that an adult can experience (Prigerson et al., 1999; Price, 2011). It is associated with complicated grief reactions, including symptoms related to trauma (Prigerson et al., 1999). Traumatic loss is defined as a sudden, accidental, or unexpected death. This loss may involve violence, homicide, or an accident that causes loss of life (Price, 2011). The death of a child defies the order of expected life events and can, therefore, cause parents to experience the loss as a child as a challenge to basic existential assumptions (Price, 2011).

Recently, there has been an emphasis on the impact of bereavement as a trauma and the negative psychological and health outcomes. One study found that bereaved parents, particularly those with extreme emotional loneliness and severe depressive symptoms, are at risk for suicidal ideation (Stroebe, Stroebe, & Abakoumkin, 2005). Another study of bereaved parents found that both partners, particularly mothers, were at increased risk for a first psychiatric hospitalization compared to non-grieving parents (Li, Laursen, Precht, Olsen & Mortensen, 2005). Maternal risk of hospitalization remained significantly elevated for 5 years or more after the death (Li et al.,

2005). Using Danish national registries, these investigators also found that mortality rates were higher among bereaved than non-bereaved parents, particularly for deaths due to unnatural causes (e.g., accidents and suicide) within the first 3 years after the child's death (Li, Precht, Mortensen, & Olson, 2003). Bereavement was associated with long-term mortality due to illness (e.g., cancer) for the mothers, presumably because of stress, a weakened immune system, or poor health behaviors (e.g., smoking, alcohol consumption) (Li et al., 2003). Even though the death of a child holds such significance, possibly leading to severe emotional, physical, and psychological reactions, research on parental bereavement is more limited than might be expected.

Johnson (2002) proposes that secure connections to others built through EFT can provide a powerful antidote to the experience of trauma and loss. In *Strengthening Bonds* (2002) Johnson writes,

“Trauma is defined in the dictionary as a wound. More specifically, trauma occurs when a person is confronted with a threat of physical integrity of self or another, a threat that overwhelms coping resources and evokes subjective responses of intense terror, helplessness, or horror. Trauma nearly always involves a sense of loss. It is a moment when we can see the world shift and turn, understanding that neither the world nor we will ever be the same. Once we have been so wounded, we are faced with our own vulnerability in an irrevocable and palpable way (p. 14).”

According to EFT, the therapist's goal must be not to just lessen the distress in a survivor's relationship, but to “create a secure attachment that promotes active and optimal adaptation to a world that contains danger and terror, but is not necessarily defined by it (Johnson, 2002, p. 10).”

EFT maintains that our closest relationships can provide the ideal context in which we can heal and grow (Johnson, 1996, Walsh, 1996). The attachment significance associated with the loss of child is understood as inherently traumatic, defying the perceived order of natural events. This experience irrevocably shapes the way a survivor defines the world and his or her self (Johnson, 2002). According to EFT and Attachment Theory, a sense of felt security with a loved one increases a person's ability to tolerate and cope with traumatic experience (Bowlby, 1969/82). It is believed that secure attachment creates resilience in the face of terror and helplessness and a natural arena for healing. Isolation and a lack of secure attachment, on the other hand, is understood to add to our vulnerability, exacerbate traumatic events, and are actually wounding in themselves (Bowlby, 1969/82). Conversely, secure attachments with significant others offer a powerful antidote to traumatic experience. Simply stated, close bonds are physiological regulators (Johnson, Moser, Beckes, Smith, Dalgleish, Halchuk, Hasselmo, Greenman, Merali, & Coan, 2013).

Outcome Studies of EFT Treating Trauma and Depression. Over the last 20 years, several studies have been conducted testing the efficacy of the EFT model with populations experiencing symptoms of depression and trauma (e.g. PTSD). Several studies have recently been conducted focusing on couples dealing with distress or trauma. In 2012, Greenman and Johnson explored the use of EFT with couples in which one partner had been diagnosed with PTSD. The researchers found that PTSD has a negative impact on quality and stability of interpersonal relationships. As hypothesized, close connections to others served as a protective factor from PTSD and were facilitative in the healing process.

In a randomized controlled trial, Dalton, Johnson, and Classen (2009) examined the efficacy of EFT for women with a history of childhood abuse. The study recruited twenty-four

distressed couples in which the female partner had a severe history of childhood abuse, who were then assigned to either 20 sessions of EFT or a waitlist control group. Dalton et al. (2009) reported significant reduction in relationship distress and trauma symptoms, such as dissociation, interpersonal sensitivity, and phobic avoidance. Additionally, 70% of couples that received EFT scored as nondistressed or “recovered” at the end of treatment.

Similar results were reported by MacIntosh and Johnson (2008). This efficacy trial of EFT was conducted with survivors of chronic childhood sexual abuse and their partners (MacIntosh & Johnson, 2008). Half of couples reported improvements on the Dyadic Adjustment Scale (DAS) and significant improvement in trauma symptoms, measured by the Trauma Symptom Inventory and structured interviews. The researchers argue that EFT is particularly suited to couples facing trauma as it deals directly with affect regulation and assists couples in obtaining social support. Most couples showed decreased relationship distress and improvements in trauma symptoms following an average of 19 therapy sessions.

Naaman, Johnson, and Radwan (in press) also executed a study examining the use of EFT with maritally distressed breast cancer survivors. Twelve couples were randomly assigned 20 sessions of either psychoeducation or to EFT. Researchers tested participants at pretreatment, midtreatment, termination, and at follow-up. At the time of data analysis, 50% of couples that received EFT showed significant improvement on the DAS measure of marital adjustment, quality of life, mood disturbance, and trauma symptoms. There was no evidence of relapse at follow-up; in fact, marital adjustment and quality of life continued to improve.

In the area of depression, two studies have been conducted. Denton, Nakonezny, Wittenborn, and Jarret (2010) studied the impact of EFT on major depression that co-occurs in relationship distress. For the study, couples were divided into two groups – one group receiving

anti-depressant medication combined with EFT, the other group just receiving medication.

Depressive symptoms for women in both groups decreased significantly. Women in the groups receiving EFT reported significant improvement in relationship quality. An earlier study conducted in 2003 by Dessaulles, Johnson, and Denton examined partners in which the female partner had been diagnosed with Major Depressive Disorder (MDD). Results indicated that EFT reduced depressive symptoms as much as pharmacology alone.

Loss and the Marital Relationship

Researchers have argued that whether a relationship will remain strong or be negatively impacted following the death of a child depends on the climate of the relationship prior to the loss (Martin and Doka, 1999; Sanders, 1999). According to Kazak and Noll (2004), the majority of parents likely accommodate to the loss of a child without significant long-term disruption in major life domains; for others, however, “moving on” does not occur smoothly. The extent of disruption and the need for professional help during recovery are influenced by the level of pre-existing problems and the psychological resources that parents bring to the grieving process (Kazak & Noll, 2004).

Studies report that grieving parents tend to look towards one another for comfort immediately following the death of a child (Avelin, 2013; Kamm and Vanderberg, 2001; Wing et al., 2001). EFT views partners as having an innate need for emotional contact and security, which is viewed as healthy and adaptive (Johnson, 2004). Relationship satisfaction is then based on the degrees of closeness and security between partners and the level of accessibility and responsiveness to one another. The assumptions underlying the theory and practice of this type of therapy are identified: 1) emotion is key in organizing attachment behaviors and in organizing the way the self and the other experience intimate relationships; 2) attachment needs and desires

of partners are essentially healthy and adaptive; 3) change in EFT is associated when the accessing and reprocessing of the emotional experience underlying each partner's position in the relationship. EFT assumes that the most appropriate paradigm for adult intimacy is that of an emotional bond (Johnson, 2004). These bonds address our innate need for security, protection and contact. Additionally, these bonds provide an environment of healing during times of distress (Johnson, 2002). According to grief and bereavement literature, there are multiple factors that may make this more difficult for parents that have a lost a child. These include different coping patterns, where in the grieving process each partner may be, and gender specific responses.

Several studies support the notion that there are clear differences in grieving styles between parents. Bereaved mothers and fathers tend to have different roles in the grieving process and express the loss differently (Cacciatore et al., 2008; Corbet-Owen, 2003; Dyregrov and Matthiesen, 1987). Increased use of substances has also been described in earlier studies on the grief of fathers (Aho et al., 2006; Davies, 2006; Li et al., 2003). According to a study conducted by Salkari (2012), a man's increased substance use brought negative changes to the marital relationship. This study also revealed an emergence of physical violence in men, which women described as manifesting after the death of their child. Other studies on relationship violence show that psychological suffering (Vest, Catlin, Chen, & Brownson, 2002), excessive alcohol use, depression symptoms, and a withdrawing, anti-social personality are in connection with male violence and the emergence of violence in a relationship (Peek-Asa, Zwerling, Young, Stromquist, Burmeister, & Merchant, 2005). In sum, the psychological suffering caused by a child's death can lead to violence emerging in a relationship.

For women, more intense grief over time has been seen in mothers who have not been able to talk about their thoughts and feelings; they view the emotional closeness to their partner as having deteriorated (Gold et al., 2010). Women tend to have a greater need to talk about the loss than men (Lang & Gottlieb, 1993). Bereaved mothers' satisfaction with their relationship with their partner seems closely related to the opportunity to talk, even though this can result in more intense grief reactions soon after the loss (Kamm & Vanderberg, 2001). These differences between mothers and fathers have been found to increase the risk of conflict over coping styles and other matters at an already stressful time (Dyregrov and Matthiesen, 1987; Gold et al., 2010).

While parental grief is a personal experience, unique to each individual, the loss of the child can potentially serve as a bonding experience (Toller & Braithwaite, 2009). If there is a lack of vulnerability, willingness to understand and face each other, the unity and bond of the couple can be threatened. Studies report that this can lead to feelings of withdrawal (Gold et al., 2010; Toller & Braithwaite, 2009; Wijngaards-de Meij et al., 2008). Studies report that relationship satisfaction is lower the greater the emotional distance between two partners, that is, where one partner wants to talk, while the other does not (Dijkstra, van den Bout, Schut, Stroebe, & Stroebe, 1999).

According to EFT theory, relationship distress is understood as an increase in negative affect, emotional disconnection, and unmet attachment needs between partners (Johnson, 2004). The EFT model assumes that the negative emotions and negative interaction cycle of distressed couples represents a struggle for attachment security (Johnson, 2004). Therefore, distress between partners results from ongoing negative interaction patterns where individuals feel their attachment needs are not being met (Johnson & Denton, 2002). These patterns are understood to

be circular in nature, reinforcing each other's ways of interaction and responding (Johnson & Denton, 2002). For example, one partner blames and pursues for contact while the other dismisses or stonewalls which cues blame from the first partner. As a result of these negative cycles, partners' attachment needs continue to be missed, which creates insecurity and feelings of rejection. For parents experiencing the loss of a child, one partner may be more inclined to share feelings, needing more time and space to grieve the loss openly and the other partner may internalize the grief, being less emotive during the grieving process.

Many couples encounter situations or life events that may lead to emotional distress. However, attachment-related incidents can have harmful effects on the relationship bond. These incidents have been called attachment injuries (Makinen, 2006) and have been characterized as a perceived abandonment, betrayal, or breach of trust in a critical moment of need for support expected of attachment figures. This event is often used as a standard for the dependability of the other partner and can create a block or impasse in the repair process. This injury can be conceptualized as a relationship trauma within itself (Makinen, 2006). Situations in which an attachment figure is the source of and the solution to emotional pain are inherently difficult to tolerate and serve as a new source of pain (Makinen, 2006). Trauma and severe distress increase the likelihood for attachment injuries to occur (Johnson, 2002). For parents experiencing the loss of a child, miscommunication over the grief of their child, feeling the need to hide the extent and potency of their grief, and the lack of safety in the relationship following the loss of a child could possibly create an attachment injury.

To address attachment injuries within the model of EFT, Sue Johnson and Judy Makinen developed the Attachment Injury Resolution Model (AIRM). The AIRM consists of three stages (de-escalation of the injury cycle, new emotional engagement regarding the injury, and

consolidation) in eight steps (Zuccarini, 2013). It is implemented in the second stage of traditional EFT for couples. At the end of these stages, reconciliation, restoration of trust, and softer emotional connection is predicted to occur. As mentioned previously, attachment injuries are more likely to occur between partners when one or both partners is experiencing trauma or distress. The prevalence of attachment injuries between parents going through the grieving process is unknown, however, the EFT process research shows it is essential to address all attachment needs. Without processing the emotions around these attachment injuries, change events in therapy are unlikely to occur (Zuccarini, 2013).

The impact of bereavement has been shown to extend to social functioning and family life. Regardless of the effects, couples are likely stretched in negotiating not only their own grief, but also the suffering of their partners and their surviving children (Lehman, Wortman, & Williams, 1987). Difficulties have been noted for parental marital functioning, in particular (Najman et al., 1993). One study indicated that the divorce rates among bereaved parents are as much as eight times the norm (Lehman et al., 1987). Although a review of the bereavement literature by Oliver (1999) challenged this conclusion, recent studies have indicated an increased risk of relational break up (Gold et al., 2010; Lyngstad, 2007).

EFT is an empirically supported treatment for couples in distress, whose effects seem to be stable over time (Cloutier, Manion, Gordon-Walker & Johnson, 2002; Halchuk, et al., 2010). It has demonstrated 70-73% recovery rated for relationship distress, with 90% significant improvement over controls (Johnson, Hunsley, Greenberg, & Schindler, 1999). EFT has not only been shown to be effective, but it has also been demonstrated to have stable results at follow-up. Across a three-month follow-up period, Johnson and Talitman (1997) found that not only were the effects of EFT stable, couples also improved following termination of EFT. At three months,

70% of couples recovered, compared to 50% at the end of therapy. Stable results were also found at 2-year follow-up for couples dealing with chronically ill children (Cloutier et al., 2002) and at 3-year follow-up for couples that were able to resolve an attachment injury (Halchuk et al., 2010). Compared to the recovery rates for couples treated with EFT, wait-list control couples have not been found to improve (Cloutier et al., 2002). At the five month and two year marks following termination of EFT, the couples treated in Cloutier and colleagues (2002) study were found to have higher marital satisfaction and lower separation rates compared to wait-list control couples. This study was also conducted with chronically ill children, indicating that these couples are part of a high-risk population for relapse.

Implications for Couples' Therapy

Marital closeness is a significant predictor of better health in bereaved couples (Essakow & Miller, 2013; Song et al., 2010). Essakow and Miller (2013) conducted a qualitative study following the experiences of 8 heterosexual couples following the sudden, violent death of a child. To participate these couples had to report their marriage as being a “protective factor” after their loss. Couples who experienced bereavement, yet remained resilient in their marriages reported feeling: (1) safe, secure, and protected; (2) mutually understanding; and (3) possessing the ability to reintegrate and reorganize relationships. Feeling safe, secure, and protected allowed for participants to trust, remain open, and feel connected to his or her partner. When these aspects of relationship were present, participants felt their marriage was a safe haven to endure the trauma and grief associated with the traumatic loss. The more securely attached the couples appeared to one another, the more they described their relationship as helping to “lessen” and contain the overwhelming feelings related to traumatic grief (Essakow & Miller, 2013). Johnson (2002) stated that when an individual is threatened by traumatic events, there is an innate and

compelling attachment need for comfort and connection. All of the participants described the need for support, comfort, and connection from their spouses (Essakow & Miller, 2013). Clinicians' ability to assist partners to meet these needs helped create a safe, secure, and protective relationship.

Politansky and Esprey (2000) found that participants who perceived benefit from therapy and their attempts to cope, reported a change in self-perception, changes in interpersonal relationships, and changes in philosophy of life. Wijngaards de Meij et al. (2008) explored parents' adjustment to the death of a child in relation to patterns of attachment, finding that the more insecurely attached the parents were to each other, the higher the grief and depression-related symptoms.

Due to the fact that these studies are finding that marital closeness is a significant predictor of better health in bereaved couples, an emphasis on this in therapy appears to be needed. EFT uses nine steps and three stages to help guide changes in the negative interaction cycle that couples experience and help couples express their underlying attachment needs (Johnson, 2004). Therapists focus on developing a strong alliance with both partners, while helping partners create new emotional responses where partners can ask for their needs to be met from a vulnerable position.

There are three change events that take place in EFT: cycle de-escalation, withdrawer reengagement, and blamer softening (Johnson, 2004). Cycle de-escalation occurs in the first stage of EFT. This is a first-order change, where partners begin to recognize their cycle, resulting in small changes in how their interactions are organized. Partners begin to engage with each other and share the emotions that underlie their positions in the negative cycle. Withdrawn partners may become more engaged and critical partners may become less hostile. This results in

each partner recognizing their cycle, containing it and starting to take small risks to engage with the other in a more open manner (Johnson, 2004).

The second and third change events in EFT are considered second-order change, in which a basic change in the structure of the relationship occurs (Johnson 2004). Withdrawer reengagement occurs when the more withdrawn partner becomes more active and engaged in the relationship. The individual asserts his or her attachment needs and they become more emotionally engaged with their partner in therapy. This is compared to their withdrawn stance of stonewalling and avoiding the spouse.

The final key change moment in EFT occurs in Stage 2, where the blaming partner softens and engages in what is called a blamer-softening event. This pivotal moment is when “a previously hostile/critical partner asks, from a position of vulnerability and within a high level of emotional experience, for reassurance, comfort, or for an attachment need to be met” (Bradley & Furrow, 2004, p. 234; Johnson, 2004). Although these two second-order change events are described as occurring separately, they are intertwined in that each partner is affecting the other’s way of responding and connecting. As a blaming partner becomes less angry and the withdrawn partner becomes more engaged, the blaming spouse is then able to congruently share his or her needs and desires (Johnson, 2004).

According to Avelin (2013), instead of focusing on a singular view of loss and grieving style, parents need help to recognize the similarities in their grieving. Differences in their grieving styles can be reframed as strengths (Avelin, 2013). To achieve this, clinicians must attend to the meanings that each partner has made to the loss, as well as the underlying meaning behind responses in therapy. It is expected that each partner may be experiencing different aspects of grief and be sharing different grieving patterns. It is important that the therapist

anticipate these differences and has the knowledge to be able to assist couples in grieving both individually and together. Avelin (2013) writes, “An effective interaction with bereaved parents should include a dialogue of potential differences in grieving patterns, which would enable the parents to better understand each other in their grief (p. 671).” In another study, conducted by Greeff, Vansteenwegen, and Herbiest (2011), commitment to family and family support should be emphasized as an important recovery factor. In this study of 89 bereaved parents, the ability to work together, create new emotional experience, and gain awareness of internal family strengths and interdependence all contributed to a more positive family adaptation.

EFT is an integrative approach, taking both an intrapsychic and interpersonal focus (Johnson, 2004). The EFT clinician focuses on how individuals process their experiences, particularly key attachment-oriented responses, while simultaneously maintaining a focus on how partners organize their interaction into patterns and cycles. Experiential and systemic approaches to therapy are combined in EFT (Johnson, 2004). In a humanistic experiential approach, the therapist acts as a process consultant who focuses on the articulation, expansion, and reprocessing of couples experience, as well as their unexpressed affect and attachment needs. This perspective allows a focus on the present and ongoing emotional experience of the individual (Johnson, 2004). As an experiential approach, EFT creates a safe, collaborative therapeutic alliance as a necessary secure base from which to foster change. The therapist provides acceptance and empathy, allowing individuals to feel validated and heard, while they explore their inner worlds (Johnson, 2004).

Using an experiential lens, EFT focuses on emotion to help individuals recognize their healthy needs and desires (Johnson, 2004). According to EFT, emotions tell individuals and others what they want and need, as well as help guide responses in relationships. Experiential

theorists suggest that emotional frames are built in relation to situations that frustrate or satisfy needs and goals. These emotional frames help guide people in understanding their experience and organizing their expectations and reactions (Johnson, 2004). Emotions are not viewed as being stored; rather they are reconstructed by the appraisal of a situation that activates these emotional frames. Emotional frames then allow partners to respond in an organized way. In EFT, these emotional frames and key ways of responding are activated, explored, and then modified by new emotional experiences in session (Johnson, 2004). Emotion is accessed, developed, and restructured in EFT, and it is used to help partners send new signals to each other and create new ways of responding to each other. According to Johnson (2004),

“The process of experiencing and the process of interaction are touchstones of the therapist as he or she attempts to guide the distressed couple away from negative and rigidly structures internal and external responses, toward the flexibility and sensitive responsiveness that are the bases of a secure bond between intimates (p. 11).”

Systemically, the focus of EFT is maintained on the interaction that occurs between the couple and how each partner impacts the interaction cycle (Caughlin, 2002; Johnson, 2004). This cycle is circular in that one partner says “I blame because you withdraw” and the other partner responds, “I withdraw because you blame.” This common negative cycle has been called the demand/withdraw pattern of communication in relationships and has been found to be linked to marital dissatisfaction (Caughlin, 2002). It is believed that change in EFT occurs by therapists helping partners change elements in this destructive relationship dance. When the negative cycle is interrupted and responses begin to change, a more positive cycle that helps couples move towards a secure bond is developed (Johnson, 2004). The goal of EFT is to have partners access, express, and reprocess emotional responses that underlie their negative interactional pattern.

Partners can then send new emotional signals that allow interaction patterns to shift towards greater accessibility and responsiveness, ultimately creating a more secure and satisfying bond (Johnson, 2004).

Self-of-the-Therapist. Self-of-the-therapist is defined as “a willingness of the therapist to participate in a process that requires introspective work on issues in his or her own life that impact the process of therapy in both positive or negative ways (Timm & Blow, 1999, p. 333).” In recent years, the field has come to understand that a therapist’s personal experiences and history can impact his or her application of therapeutic interventions. (Timm & Blow, 1999). There have, however, been limited studies that have reported the internal process of EFT clinicians. One study conducted by Palmer-Olsen and colleagues (2011) focused on the EFT supervision process (Palmer-Olsen, Gold, & Woolley). From this study, six themes emerged, one being “processing self-of-the-therapist issues.” Within this theme, Palmer-Olsen and colleagues report that one hundred percent of therapists concurred that self-of-the-therapist issues must be addressed during EFT supervision (Palmer-Olsen et al., 2011).

Wittenborn (2012) also conducted a study on the attachment organizations of novice therapists on their delivery of EFT with couples. This study emphasized various self-of-the-therapist issues that arise when students learn and begin to practice the model, specifically related to each individual therapist’s attachment style. Wittenborn (2012) reports that there are clear cross-patterns in EFT treatment fidelity, especially in relation to attending to attachment needs and emotions. For example, the more secure a therapist scored on adult attachment measures, the more skilled and competent they were in delivering EFT.

These studies are important in bringing attention to self-of-the-therapist issues in EFT and also support the need for a larger emphasis on self-of-the-therapist issues in future research.

Even though it remains unclear as to how applying the EFT model impacts the clinician as he or she applies the model, it is important to consider the possible implications that come with working with clients that have experienced this kind of traumatic loss.

Conclusion

The death of a child has a profound impact on parents, both individually and as a couple. For many, the marital bond serves as a protective factor, for others marital distress is likely to occur after such a loss, compounding existing distress from the loss of a child. Grief reactions can vary between partners and this dissonance can create disconnection between partners. Due to the finding that marital closeness is a significant predictor of better health in bereaved couples (Song et al., 2010), strengthening this bond seems to be an appropriate step in the healing process.

EFT has been shown to help couples do this under distressing times, as well emphasize attachment needs and longings. It is well supported that the EFT model is an appropriate therapy for couples experiencing trauma and depression. There has also been extensive process research detailing and outlining the specific change events in EFT. It can be assumed that EFT clinicians are already currently using the EFT model with couples experiencing loss. However, there has been no study to explore the process of using the model with this specific population. This study hopes to fill in this gap in the literature, expanding the EFT research and deepening the understanding of a model that could be effective for parental bereavement.

Chapter III: Methods

Design

According to Charmaz (2014), “Grounded theory methods consist of systemic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories from the data themselves (pg.1).” In order to explore the research question, this study employed a qualitative, grounded design. Grounded methods were used to understand how certified EFT therapists have applied the EFT model to cases where a couple has experienced the death of a child. It was the researchers hope that a theory would emerge from the data to better equip EFT therapists in the field and to better serve those couples experiencing such a loss.

Creswell (2013) states that qualitative research “empowers individuals to share their stories and hear their voices” when more understanding on a complex issue is needed (p. 48). Intensive interviewing through semi-structured interviews served as the method for generating this qualitative data. The Grounded Theory Approach involves constant comparative analysis; also known as the Constant Comparative Method (Strauss & Corbin, 1994). This involved the researcher moving in and out of the data collection and analysis process. This back and forth movement between data collection and analysis is sometimes called an 'iteration.'

Grounded theory employs the technique of theoretical sampling. This is described as the process of data collection for generating theory whereby the analyst jointly collects codes and analyses data and decides what data to collect next and where to find them, in order to develop a theory as it emerges. This is conducted until the researcher reaches saturation (Strauss & Corbin, 1994). According to Charmaz (2014), intensive interviewing is the encouraged method for generating this qualitative data. There are six key characteristics of intensive interviewing. Charmaz writes,

“These include: 1) selection of research participants who have first-hand experience that fits the research topic, 2) in-depth exploration of participants’ experience and situations, 3) reliance on open-ended questions, 4) objective of obtaining detailed responses, 5) emphasis on understanding the research participant’s perspective, meaning and experience, and 6) practice of following up on anticipated areas of inquiry, hints, and implicit views and accounts of actions” (Charmaz, 2014, p. 56).

Participants

Participant selection is a critical element in Grounded theory. As mentioned, intensive interviews should be conducted with individuals who have first-hand experience that fits the research topic (Charmaz, 2014). For this study, participants’ knowledge of the subject matter at hand was significant in assuring a high-quality outcome. Therefore, participants were chosen for their expertise rather than through a randomized process. This criterion sampling procedure intended to find experts in the field of EFT, in the hopes that therapists’ application of the model would be pure and consistent.

To be in the study, participants had to have met the three following inclusionary criteria: 1) possess a qualifying degree and license in a mental health discipline (e.g. Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), etc.), (2) hold certification in EFT from the International Center for Excellence in Emotionally Focused Therapy (ICEEFT) for at least 5 years, and (3) have worked with this population within the last 5 years.

Participants were recruited by reaching out to the ICEEFT. Once granted access to the ICEEFT listserv, advertisements for the study were circulated with inclusionary criteria and contact information. The researcher used a telephone screening, which will later be explained in

greater detail, to ensure eligibility. Snowball sampling was also as an additional method of recruiting participants. The researcher asked participants to contact other individuals that they knew who would meet the criteria to participate in the study.

Procedures

Prior to the recruitment process, the researcher obtained approval to begin the study from the Institutional Review Board (IRB). Once IRB approval was obtained, the study was advertised through emails (e.g. listservs) and personal phone calls. Recruitment materials stated that participation in the study included a short telephone screening, a short demographic questionnaire, and an estimated one-hour interview over the phone.

All clinicians who expressed interest in participating in the study were called for a short telephone screening call to determine eligibility. During the call, potential participants were given a brief overview of the study and asked screening questions. Participants were asked if they were a licensed mental health professional, if they had been certified in EFT for at least five years, and if, in the last five years, they had worked with a couple who has experienced the death of a child. If the individual did not meet the mentioned criteria, they were thanked for their support and encouraged to refer any other EFT clinicians they knew who were possibly appropriate for this study.

Once the recruitment and screening process had been completed, the researcher contacted all the participants in order to schedule a phone interview. All interviews lasted roughly forty-five minutes to one-hour and were audio recorded. Clinicians who were eligible for the study were issued an Informed Consent that they read prior to data collection. In the consent, participants were informed of the aim of the study and any risks associated with their participation. It was made clear to all participants entering the study that they would be

guaranteed complete confidentiality and that they could chose to leave the study at any time. Interviews did not proceed without ensuring that participants had a clear understanding of the content of the Informed Consent form and what the study entailed.

Prior to the interview, participants gave verbal consent to the Informed Consent over the phone. In the interview, therapists were asked both demographic questions and interview questions. The demographic questionnaire included questions regarding the participant's age, race/ethnicity, education, clinical background, experience working with bereavement, EFT training and certification, and the time frame of the cases that they would be referencing in the interview. The interview questions pertained to the research question: how do EFT therapists apply the EFT model with couples that have experienced the loss of a child?

Once the interviews were completed, the researcher listened to the recorded interviews and transcribed them. All identifying information of each participant was removed from the transcripts and substituted with pseudonyms. Once the transcripts had been reviewed for accuracy, the recordings of the interviews were locked and stored in a safe location where only the researcher had access.

The researcher ensured participants' confidentiality throughout the interview and transcription processes. As stated above, all personal details involving participants were given pseudonyms. Any documents with participants' names, addresses, and telephone numbers were kept in a secure location in a laptop folder where only the researcher was able to access this information.

Instruments

According to Creswell, the researcher is the key instrument for data collection in qualitative research. Grounded theorists construct data through observations, interactions, and materials that

are gathered. This data can be gathered by what one hears, sees, as well as senses (Charmaz, 2014). For this study, the researcher collected data through a one-time, semi-structured, qualitative interview. The questions included in the interview were used to: 1) explore the clinical experiences of how participants use or have used EFT with grieving couples, 2) assess the theoretical underpinnings of EFT and its relationship to the loss of attachment and grief, and 3) collect reactions, opinions, and suggestions to using the model with this specific population.

A predesigned form was created by the researcher and was used to record information during the interview. This was used to document the time, date, and location, as well as allow room for notes, memos, and observations made during the interviews. The interviewer also bracketed biases, experiences, and opinions that could have influenced data collection, and reflected on notes once the interview had concluded to address reflexivity in the final report. A basic outline of the interview guide is below. Interviews deviated somewhat from the interview structure as necessary and were not strictly required to follow exactly as written here:

- 1) How did you apply the EFT model to couples that have experienced the loss of a child?
- 2) What did you notice in your application of EFT during Stage 1 of the model?
 - a. Compared to other clients, who have not experienced the death of a child, did you notice any differences? If so, what would I have seen you do?
 - b. Were any modifications made during this time (i.e. incorporate other strategies from different approaches)? If so, what would I have seen you do?
 - c. Were there specific steps in Stage 1 that you approached differently than you have with clients who have not experienced the death of a child? If so, what would I have seen you do?
- 3) What did you notice in your application of EFT during Stage 2 of the model?

- a. Compared to other clients, who have not experienced the death of a child, did you notice any differences? If so, what would I have seen you do?
 - b. Were any modifications made during this time (i.e. incorporate other strategies from different approaches)? If so, what would I have seen you do?
 - c. Were there specific steps in Stage 2 that you approached differently than you have with clients who have not experienced the death of a child? If so, what would I have seen you do?
- 4) What did you notice in your application of EFT during Stage 3 of the model?
- a. Compared to other clients, who have not experienced the death of a child, did you notice any differences? If so, what would I have seen you do?
 - b. Were any modifications made during this time (i.e. incorporate other strategies from different approaches)? If so, what would I have seen you do?
 - c. Were there specific steps in Stage 3 that you approached differently than you have with clients who have not experienced the death of a child? If so, what would I have seen you do?
- 5) Were there any EFT specific techniques that you found particularly helpful when applying EFT to couples that have experienced the loss of a child? If so, which ones and when were they used (i.e. stage or step)?
- 6) Were there any EFT specific techniques that you found less useful when applying EFT to couples that have experience the loss of a child? If so, which ones and when in the treatment process did you notice this?

Analysis

To analyze the collected data, Grounded Theory coding was used. All interviews, field notes, and observations were organized into electronic files for analysis. Interviews were transcribed verbatim and read multiple times by the researcher. To ensure reliability of codes, the researcher and committee chairperson coded transcripts independently. Once completed, they met to discuss themes and emerging concepts.

Grounded coding occurred in three distinct coding phases: (1) open coding, (2) axial coding, (3) and selective coding (Strauss & Corbin, 1994). Through open coding, or substantive coding, codes were conceptualized on the first level of abstraction. Transcripts were conceptualized line by line in this stage. To maintain a Grounded approach, the researcher and chairperson went back and forth while comparing data, constantly modifying, and sharpening the emerging data (Strauss & Corbin, 1994). Memoing occurred simultaneously with open coding to refine and track ideas that developed when comparing codes in the evolving themes. Once complete, axial coding occurred. Axial coding allowed for relating categories or main themes to their subcategories (Strauss & Corbin, 1994). During axial coding the connection between open codes and their causes, contexts, contingencies, etc., were made. Through this coding procedure, a hypothesis developed about the relationship among variables from initial coding and a core variable was identified.

Selective coding began once the researcher had identified two core values (Strauss & Corbin, 1994). The researcher and committee chairperson selectively coded data with the core variables in mind, omitting concepts with little importance to the core and its subcores (Strauss & Corbin, 1994). These core concepts were then used to write a narrative of the findings and the two theories or processes emerged.

Chapter IV: Findings

Two processes of applying EFT with couples that have experienced the death of a child were identified through the analysis of participant interviews. To convey and organize the processes and concepts of each, two diagrams of the actions and experiences noted in the interviews during analysis were created (Figure 1 & Figure 2). Figure 1 represents an external, multi-directional process of how EFT clinicians apply the EFT model with their clients. This figure encompasses “how” clinicians adjust their approach to the model to meet the needs of their clients and work with couples that have experienced the death of a child. Figure 2 represents an internal process model of how applying the EFT model impacts the therapist on a personal level. This will be discussed through a self-of-the-therapist lens. In the following section of this chapter the findings of the study will be outlined according to the categories in Figure 1 and Figure 2.

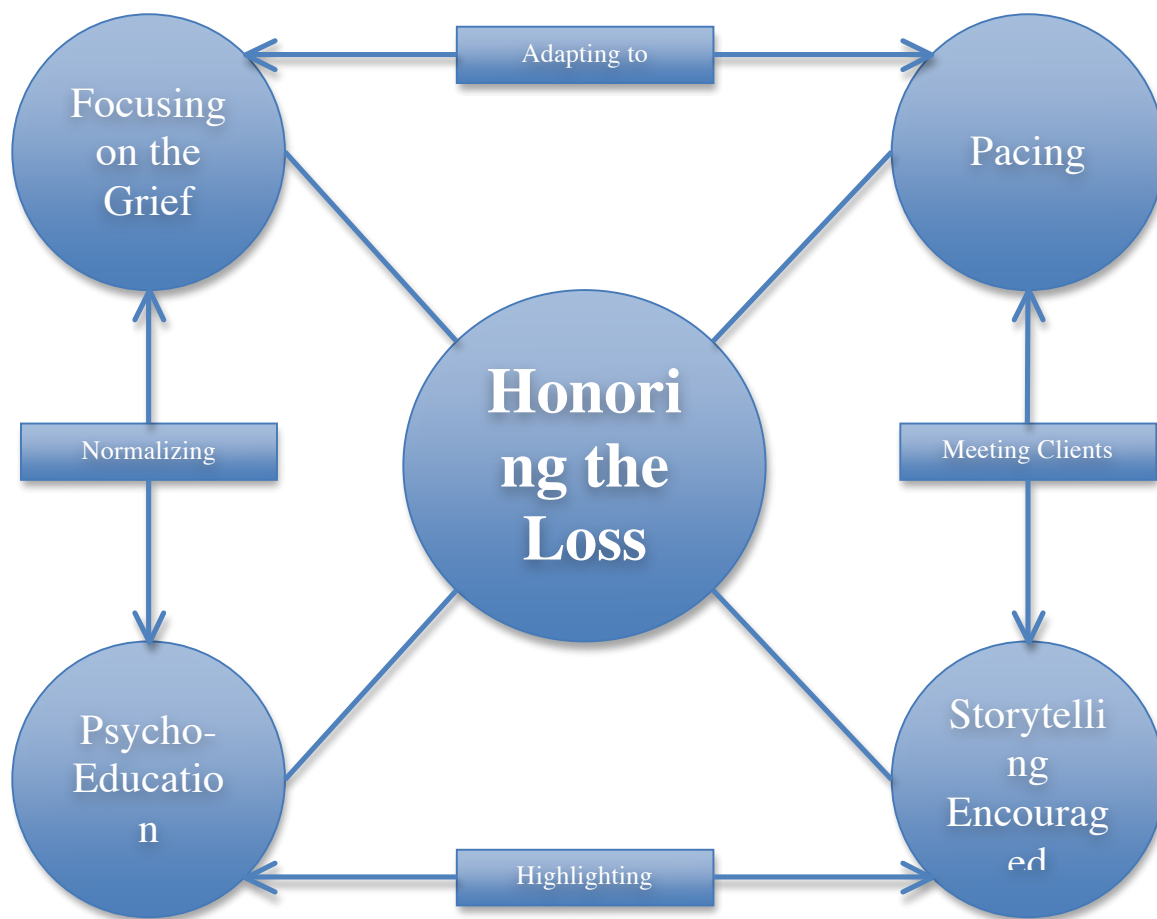
A total of 5 EFT therapists were interviewed for this study. The therapists were all female and ranged in age from 41-60 years. All therapists had been certified in EFT for more than 5 years, ranging from 5-11 years. The mean certification in EFT was 8.2 years. Two of the five participants practice in other countries outside of the United States of America.

Table 1. Demographics

Participant Number	Age	Race	Nationality	Highest Level of Edu.	Certified in EFT	Other EFT Certifications
1	59	Caucasian	Australia	PhD	9 years	Supervisor
2	60	Caucasian	USA	Master's	5 years	N/A
3	41	Caucasian	USA	Master's	6 years	N/A
4	48	Caucasian	USA	PhD	10 years	Supervisor; Trainer
5	49	Caucasian	Netherlands	Master's	11 years	Supervisor; Trainer

It is important to note that the death of a child was not the primary issue or presenting problem for all of the cases discussed by participants. Two therapists specialize in grief therapy and, therefore, worked primarily with the grieving process of each couple. Three therapists maintain a more general EFT couples' therapy practice. With these clinicians' cases, the death of a child may have been one of several problems reported by the clients. Nonetheless, the two main processes became evidential for all participants as they applied the EFT model with couples that have experienced the loss of a child.

Figure 1. Honoring the Loss



Process Model 1: Honoring the Loss

The core concept that emerged from the accounts of participants who applied the EFT model with couples that have experienced the death of a child was an emphasis on honoring the loss of the child. Honoring the loss is defined as the therapist giving special attention to the loss of the child. One participant stated:

“Well I suppose there was a basic respectful, acknowledgement of their loss and empathic reflection and attunement to the times in session when there was sadness associated with that was present, which is sort of the core of EFT...I mean we weren't talking about skills or coaching you know pragmatic or practical or behavioral approach...for me, there is a place for that, but I think that with this couple it seemed crucial that we didn't hide the baby. You know, the baby had to be with us in the room in a way. We wanted that loss to be honored and acknowledged and validated.”

Participants spoke frequently about the sacredness and the significance of the loss that these clients' endured, as well as a desire to communicate this to their clients while in session. As one participant stated, “I hope they felt a deeply respectful acknowledgment on my part of the enormity of that experience.”

Honoring the loss appears to be at the center of the process of how EFT clinicians apply the EFT model with couples that have experienced the loss of a child. Through further analysis, four distinct themes emerged that allow or assist therapists in honoring their client's loss. They include: focusing on the grief, adjusting the pace of therapy, encouraging storytelling, and incorporating psycho-education. Among these four distinct themes, four other subthemes emerged that worked bi-directionally, showing what resulted from clinicians focusing on the grief, adjusting the pace of therapy, encouraging storytelling, and incorporating psycho-

education. These include: adapting to emotional intensity, meeting clients where they are, highlighting the attachment significance of the loss, and normalizing.

Focusing on the grief

Within this theme, therapists shared the need to process emotions specific to loss and bereavement. Unlike traditional EFT, therapists reported attempts to balance emotions surrounding disconnection and marital stress with the pain and emotional despair of losing a child. Therapists shared the complexity that comes with these cases and the significant role that grief reactions have on the marital relationship. Therapists agreed that ignoring grief reactions would have minimized the importance of the loss. One therapist expressed:

“I definitely tried, successfully or otherwise, to make space for them to kind of talk about the experience of their loss and how they had kind of tried to be there for each other – like that sense of how they had tried to connect as a support for each other, but couldn’t – and I think that had been very difficult so I kept sort of bringing that back to that’s maybe part of how things have gotten harder and harder since [baby’s name] died.”

Another therapist stated:

“I stay in the emotion a lot longer, in terms of the raw grief. I keep saying “the raw,” because it’s just being with them as they’re sobbing. I’m not going to do EFT in that moment. So if that’s what we do the whole session then that is that session. Then the next session I’ll do EFT...it’s just really the use of silence and letting them feel what they feel.”

Adapting to Emotional Intensity. Focusing on the grief was depicted as necessary to adapt to the heightened emotional intensity caused by the loss. Similar to traditional EFT, therapists spoke about the importance of following the affect in the room. With this population,

however, therapists felt the need to respect, explore, and simplify this process, as a means to honor the loss. One therapist shared:

“I cannot let myself go too far into their cycle without addressing their grief, without addressing their child. At the same time, I could not only focus on the death of their child – I would not be able to do what we need to get them connected, to help them stay connected. It would negatively impact the EFT work. So that’s different. In a way it all fits so beautifully together. I think I have a more open mind, “Okay here we have pain, fear, and emotion from the relationship and here we have the death.”

Another therapist stated:

“I mean maybe I’m really out of balance in that way [focusing on the internal experience of each individual for a longer period of time], but that’s what grief does to the model. There is so much holding that I’ve had to do for each of them intrapsychically.”

Normalizing. The second function of focusing on the grief was that it allowed therapists to normalize the experience. By making room for the clients’ emotions surrounding their loss, therapists could reflect, validate, and normalize their grief reactions. Participants recall normalizing their client’s experience by heightening the impact that this loss has had on each partner, giving their client’s permission to express the array of emotions that come with the death of a child. From one therapist’s perspective:

“I do think after you have gone through something so utterly painful, that you know, puts you in a totally different club than the rest of the world. You know you’re in a different group after you’ve lost a child. Than you know everyone in the world who lives in the bubble that children don’t die. You know I think that once that happens, it’s “Can I show you this real, this pain and have it be okay?”

Normalizing the pain and magnitude of the loss for their clients enabled therapists to focus on the grief in a way that further honored the loss that each partner had endured.

Pacing

To honor the loss, clinicians reported applying the model at a slower pace than traditional EFT. Similar to working with trauma or infidelity, therapists reported that honoring the loss required a slower, gentler approach. According to study participants, slowing down the pace served two main functions when working with couples that experienced the death of a child.

Meeting Clients Where They Are. The first was that it enabled therapists to “meet clients where they are.” Therapists reported stepping outside of the normal agenda that comes with classical EFT to make space for what their clients’ may need in that moment. The complexities that come with losing a child may distract from the normal flow of EFT. Therapists reported making these changes as needed, in order to honor the loss. One participant stated:

“Pacing is so critical. I think sometimes with my EFT I’m pretty directive and I’m not that way with grief. I’m very much about being a witness to their grief. So I think, for me, when I think of my [grief] couples, they’re longer term. Longer treatment than maybe some of my other couples.”

It appears that slowing down the pace of therapy allowed for therapists to respect each client’s experience, and in turn, honor the loss of the child. This may include using more silence or following the client’s direction (i.e. attunement).

Adapting to Emotional Intensity. The second function of pacing was to adapt to the heightened emotional intensity, which clients who have lost a child tend to experience in therapy. Participants reported observing higher levels of emotional intensity in their clients throughout the collected interviews. According to participants, working slowly was necessary to accommodate

for the expression and containment of the emotional intensity that comes with loss and grief that is often layered under the couples negative cycle or emotional disconnect. As one therapist stated:

“I was going slower to create more overt safety, providing more rationale for doing what I’m doing – it’s like I so want to be respectful and create safety, yet we have to continue taking steps towards this pool [emotional] that I have to get you guys in.”

Another therapist stated:

“With one couple I am in session three and we must be very delicate. It almost feels like working with someone who has trauma in their relationship...very soft.”

With the emotional reactivity of clients being at an increased level, many clinicians emphasized the importance of attunement with their clients. Many times this meant working more slowly than they would have with couples that have not experienced the death of a child.

Storytelling Encouraged

In honoring the loss, therapists reported creating more space for the content of their clients’ experience. This may include client’s sharing stories of their child, his or her favorite things, and inviting his or her presence into the room. Traditional EFT tends to keep a focus on the couples’ process surrounding interactional patterns and emotional responses. Therapists reported an inclination to give client’s more room to share content information about their deceased child. This inclination seemed to come from a direct intent to honor the loss that each partner had experienced. As one participant stated:

“I guess I tried to do the same thing that I do with all other couples, in terms of encouraging them to tell their story, a lot of empathy and validation for the depth of their distress, trying to help them see something of the pattern.”

Another therapist stated:

“A simple sitting with her, letting her talk a bit about the baby’s life and the neo-intensive care unit and then the eventual death and all of that stuff...So I guess you would say there was a degree of modification there in that I did have those individual sessions with her that certainly included time and space for her to tell the loss story.”

As therapists encouraged storytelling and created space for couples to share the content of their loss story, two other important aspects of treatment were made possible.

Highlighting Attachment Significance. First, storytelling allowed therapists to have examples from the clients, in their own words, to heighten and reflect the attachment significance of the loss of the child, as well as the distress from their marital bond. This allowed for the therapists to continue honoring the loss, while still focusing on the couple relationship. One therapist shared a moment from a session:

“Reflecting, uhhh, lets see...probably like evocative responding. You know like “This has gotta feel so bad, this has gotta feel so hard compared to how it was when you were close.” So I think this is all kind of under the umbrella of heightening...”

Meeting Clients Where They Are. Second, therapists also reported that allowing for more content and storytelling was another way to “meet clients where they are.” Having access to the clients’ words and memories about the child allowed therapists to use real examples from their lives to emphasize the significance of the loss. This seemed to allow participants to focus on the couple, while still processing and honoring the loss.

“It’s all about meaning making...it’s about the stories. Basically my walking into the lives of their loved ones, like I want to know their child even though their child’s not here. And it’s helping them make meaning, usually there is a healing journey, some

meaning making that happens around it and some way that helps them also connect with their loved one in a different way.”

Making space for meaning making and other traditional grief therapy techniques, such as storytelling, tended to be integrated throughout the participants’ application of EFT with couples that have experienced the death of a child.

Psycho-education

Psycho-education was also used in early stages of therapy for those clients’ who experienced the loss of their child many years prior to coming into therapy. Therapists reported an emphasis on educating clients about grief and loss as a way to predict grief reactions, patterns of interaction, and marital distress. Reminding clients of the intense, often unprocessed, emotion that comes with grief seemed to allow for therapists to access aspects of clients’ experiences that were relevant to the current marital distress. Highlighting these truths about the grief process allowed therapists to honor the loss in a more concrete way, as well as provide couples knowledge and tools to help them in their grieving process.

Normalizing. Psycho-education was seen most regularly in the data as a means to normalize the clients’ experience and to highlight the significance of the loss. As one therapist stated:

“I definitely do a lot more normalizing and psycho-education than I do in regular EFT as well. I just want them to know that the trauma that has occurred. I want them to understand – my goal is for them not to feel alone in the process. I want them to feel connected to each other and connected to me when life goes on around them and they can’t go on.”

Another therapist stated:

“We did a lot of prediction you know really normalizing that grief isn’t like something you get over and it’s something that is with you forever. So I did do a lot of sort of grief processing about continuing to be there as they go through it because it just changes, it doesn’t, it just changes. Acknowledging that it will change for both of them and that they may be at different stages.”

Participants explained psycho-education as a valuable tool in normalizing the process of grieving, as well as the marital response or lack of connection that clients report feeling.

Highlighting Attachment Significance. The attachment significance of the loss is also emphasized through psycho-education to help heighten and/or contain client’s reactions to the loss, as well as marital distress. A participant shared:

“A lot of acknowledgement of the profound loss for them and just a lot of normalizing, how hard it is for couples to get over that experience, because there are different ways of grieving, different ways of coping and I think this couple certainly did. The woman was looking for softness, care, support, talking, you know a shoulder to cry on. He was an engineer, very much determined to keep supporting the family.”

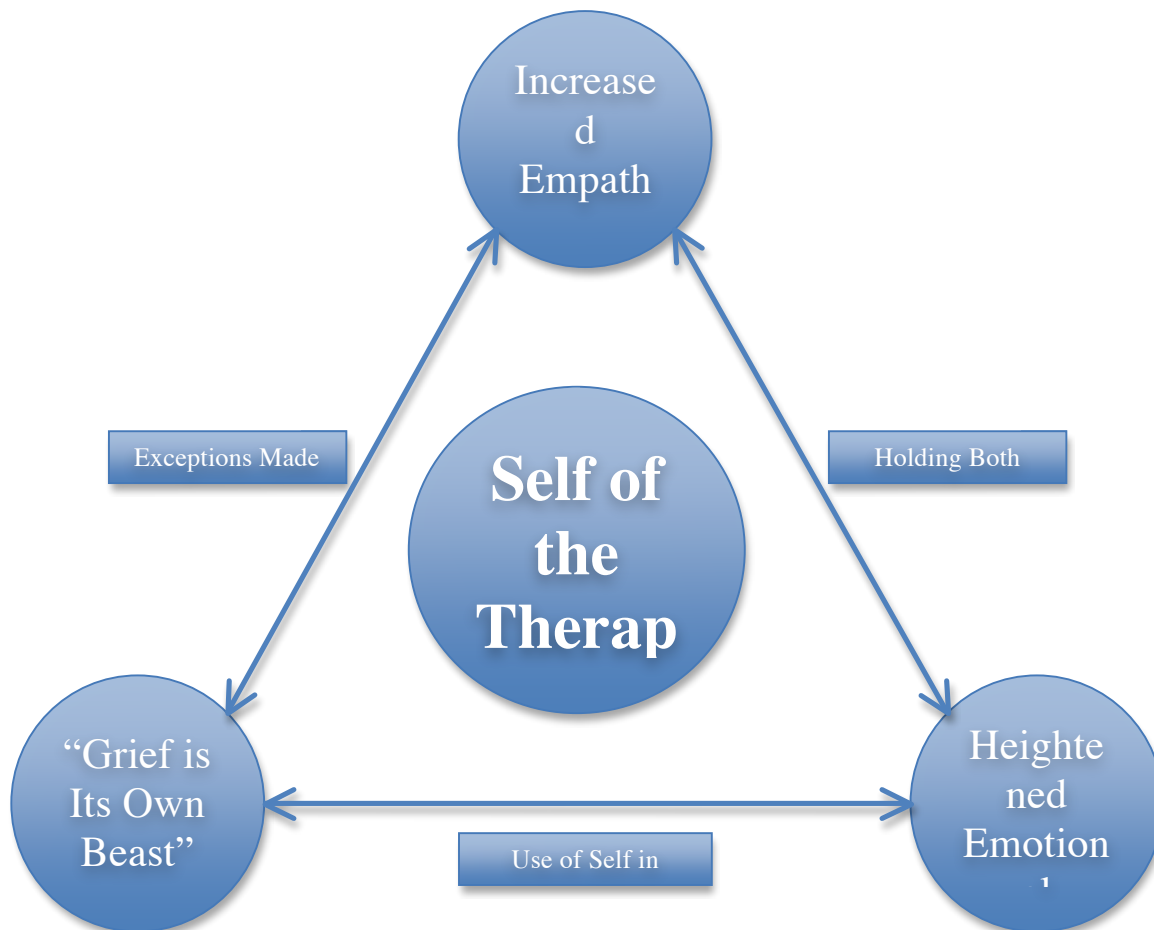
Another therapist stated:

“I guess what I noticed is that I needed a bigger space because here we have a level of hurt – they may or may not have other problems up front, it’s hard to know. So I give them more space and I try to caution them a bit. I tell them how this is the most difficult thing that a man or a woman could face.”

For example, one participant who worked with a couple that did not come to therapy to address the loss of their child, mentioned that when having difficulty heightening grief emotions, she would emphasize the severity of the loss in terms of attachment theory. In one particular session,

referencing how hard this loss is for other couples due to the closeness that they shared with their child led to a male partner experiencing emotion for the first time in therapy. This was extremely powerful and led to an experiential and therapeutic moment. The participant references this client as being particularly guarded or hardened by his grief. Heightening the attachment significance and educating the client about the loss appeared to generate a new experience in the room, bringing the work to a new level of emotional depth.

In summary, honoring the loss was a major process reported by participants when applying the EFT model with couples that have experienced the death of a child. Within this process, four major themes emerged: focusing on the grief, adjusting the pace of therapy, encouraging storytelling, and incorporating psycho-education. According to participants, these themes were ways in which honoring the loss was achieved. Adapting to the emotional intensity, meeting clients where they are, highlighting the attachment significance of the loss, and normalizing the client's experience were subthemes that participants reported while honoring the loss.

Figure 2. Self-of-the-therapist**Process Model 2: Self-of-the-Therapist**

The second core concept that emerged from the accounts of participants who applied the EFT model with couples that have experienced the death of a child was an emphasis on self-of-the-therapist. Self-of-the-therapist is defined as “a willingness of the therapist to participate in a process that requires introspective work on issues in his or her own life that impact the process of therapy in both positive or negative ways (Timm & Blow, 1999, p. 333).” Grief is understood by many as a universal experience, one that all has or will encounter in their lifetime (Gilmer et al., 2012; Price, Jordan, Prior & Parkes, 2011; Salakari, Kaunonen & Aho, 2012). One therapist stated:

“I think self-of-the-therapist is what is standing out to me as we have this conversation. It’s like maybe, maybe why I stand up and took notice, like when they referenced their daughter’s death, it’s because of my own grieving process and the potency around my own grief – so that’s what’s like – “Oh wow, you guys.” And of course I know it’s a clinically important piece to slow down clinically and be aware of, but I also think some of that had to be based on my own experience with death and loss and grief.”

Therapists reported a frequency of looking inward to see their personal experiences with grief in relation to the therapy they provided. It was during this process of looking inward that participants were able to explain their reasons for choices in client treatment. The processes included in the self-of-the-therapist concept include: an increased level of empathy from the therapist, heightened emotional responsiveness of the therapist, and the personal understanding that “grief is it’s own beast.” The following process model depicts what was happening *within* the therapists as they applied the EFT model with couples that have experienced the death of a child.

Increased Empathy

These data suggest that therapists seemed to have an innate, almost unwavering, level of empathy for couples that have lost a child. Participants reported being able to easily understand the emotions of grief and loss their clients experienced in the room. According to participants, this was related to the loss and bereavement they had experienced in their own lives or the grief they had watched other loved ones endure. Participants shared that working with these clients easily related back to their own personal experiences and other self-of the-therapist issues. As one therapist stated:

“That’s my story of how their story had so sat on my heart. That it really took me to a softer deeper place. You know maybe if they had never told me that or if they’d never had that experience, I can imagine maybe not getting such a big, strong, sad feeling. And if it hadn’t been so big and strong and clear I wouldn’t have probably disclosed it. But because the baby, the dead baby was very much a part of that experience for me, I think it really took me to that more vulnerable place within myself, in terms of just straight up compassion for how ghastly it was that they had been through so much and here they were with him screaming and her tense and afraid. For me that was highly distressing for me to watch.”

Another therapist stated:

“Grief is such an acute piece of the human experience that the clinician has to be willing – and not to say that I did this beautifully – but I can feel how vital it is that the clinician be willing to let their own heart be touched. It’s not a cognitive conversation to hold somebody’s grief with them.”

Therapists emphasized the importance of “holding” the experience of both partners. It seems that the emotional depth that therapists feel in the room when working with clients gives them a deeper desire to protect each client’s experience. Similarly, this increased level of empathy within therapists also manifested as therapists making exceptions and “being what they need” in terms of client care. These exceptions tended to be less about the model itself and more of the emotional impact their clients have on them on a more personal level. One therapist shared:

“Well I did want to share that my boundaries are a little different in my grief work. I don’t know if that’s EFT or my boundaries are just different. I make myself more available I’m a little more transparent. I feel like I am a lifer with them. I will be with

them in this grief process as long as they want me to be. So it's just different. So I think that's important to know. But I work with people who have lost a spouse – it isn't the same. When I have someone who's lost a parent – it doesn't feel the same. When I have someone who has lost a child, I'm like with them forever, that's how it feels.”

Due to the increased level of empathy that therapists experienced, therapists repeated that they may grant more individual appointments or make themselves more available to clients than they would with those who have not experienced the death of a child.

Heightened Emotional Responsiveness of Therapist

As reported, therapists reported the emotional intensity of their clients' experience awakened similar emotions within them. The increased level of empathy experienced by therapists allowed for a heightened emotional responsiveness in the room. Not only were these emotions felt internally by the therapist, but also expressed and experienced *with* clients. This is evidenced in two distinct ways. The first is the therapists' use of self in the room. When working with clients, therapist reported using their own emotional reactions to what was occurring in the room and, in turn, creating meaningful therapeutic moments. As one therapist stated:

“As I sat there glancing at that clock, I suddenly became aware within myself the terrible sense of sadness for the couple and mercifully I took us...sort of went with this decision to declare that to them. I said to them, I remember saying something the effect of, “As I sit here I see how distressed you both are, I am feeling so sad. You both have been through so much.” And I didn't name the dead baby, but I just had to say “so much” and he [the husband] started to sob. And for me it was one of the most powerful experiences I've had of using my own emotional experience to facilitate a shift in the client and certainly not what I picture would be recommended in every other session.”

Therapists reported being more open with clients, in terms of sharing how their grief touches them. Therapists also emphasized the importance of “holding” the experience of both partners. It seems that the emotional depth that therapists feel in the room when working with clients gives them a deeper desire to validate each client’s experience.

“And so self – I think self-of-the-therapist whether the clinician has actually endured the loss of a significant family member or not...I mean when we have talked about the death of the daughter I have wept with her in particular. And empathizing with her and this is what I said to her, “My own tears are my empathy for you and it’s touching the place of my heart that has lost a loved one.” And the client, after one of the sessions around the anniversary of her daughter’s passing she brought, the next session after of you know she and I having these moments of shared tears, she brought in a picture of her daughter. She said I wanted you to have a picture of her.”

The increased level of empathy that therapists reported seemed to be related to their heightened emotional responsiveness. This responsiveness appeared to create a shift into a new paradigm of experiencing and processing the grief, one that included the therapist.

“Grief is It’s Own Beast”

In different ways, therapists reported that these are some of the most difficult cases for them to work with personally. When speaking, the therapists’ tone often became exasperated as they shared their struggle when working with grief as a whole. Therapists reported needing to “take a deep breath” before each appointment, bracing themselves for the session that lay ahead. One therapist stated, “It was tricky.” Another therapist shared, “So it’s, it’s just slower and harder maybe...” Therapists reported that experiencing with the clients created a new experience for themselves as well. One therapist stated:

“I just, they left with me feeling...a very deep sense...[pause]...um having experienced very deep emotions.”

Therapists shared their emotional experiencing in terms of exhaustion, as well as highlighting the positive aspects of working with the population. For example, one therapist stated:

“I just felt very deeply for them, very compassionately, very sad for them. But also this very admiring sense of respect for their capacity to try and climb out of the quagmire.”

Another therapist stated:

“The path that I found just totally beautiful and memorable from that session was just their extraordinary sort of a dignity and quietness about both of them that spoke to tremendous suffering, but I felt they had really fought through to a place that was going somewhere good.”

It seems that an admiration and appreciation for their clients emerged, enabling therapists to continue to access their own empathy and using themselves in the therapeutic process. This empathy connected back to the participants’ tendency to want to be there for their clients and “be what they [the clients] need.” This intention was reported most frequently when participants shared about making exceptions to the normal EFT process. One therapist stated:

“With these couples, I still stay with them...I just stay in the model. You look for what they need...I ask myself what does this couple need from me? And how can I best give that to them. But that is so in the model and that is so all over EFT so it’s just my normal EFT.”

Exceptions and “being what they [the clients] need” seems relevant for clinicians when they are making decisions about treatment and serving the client in the best way they can with couples that have experienced the death of a child. One therapist shared:

“So I suppose, where the situation got a little bit, you might say modified from how the norm would go. I don’t normally see one partner for sort of a bunch on individual sessions without the partner, but in her situation I think again the history of the dead baby did influence me to sort of break that rule a little bit and I knew she felt safe with me, at least I hope she did, but it seemed like she was sort of clinging to me as a life-line and I went with that. I’ll say those individual sessions certainly were sort of a mix of some grief counseling.”

In summary, a self-of-the-therapist process emerged when participants applied the EFT model with couples that have experienced the death of a child. Three themes were identified during this process. These include: an increased level of empathy, heightened emotional responsiveness in the therapist, and recognizing that “grief is its own beast.” The subthemes that emerged – use of self in therapy, exceptions made in treatment, and holding both partners – were also present as the three core themes were experienced. Participants reported that this self-of-the-therapist process was particularly significant when conceptualizing cases and having experiential moments with their clients.

Chapter V: Discussion

This study sought to understand how EFT clinicians apply the EFT model with couples that have experienced the death of a child. The five individuals interviewed provided important insight and observations, allowing for two main processes to emerge. The two process models propose a contextualized understanding of how EFT therapists apply the EFT model with couples that have experienced the death of a child. The first process model depicts how therapists honor the loss that their clients' have experienced. This process describes what happens clinically for these therapists and their clients when applying the EFT model. The second process model describes the internal experience of therapists as they apply the model. This model reveals the self-of-the-therapist process of each therapist. The findings are both consistent with, and contribute to, the literature on EFT and grief therapy.

When working with their clients, therapists observed symptoms associated with depression and trauma, such as increased levels of emotional reactivity, irritability, loneliness, withdrawn behavior, and an overall reduced quality of life. These observations align with multiple studies surrounding parental reactions after the loss of a child (e.g. Dyregrov & Gjestaad, 2011; Hagemesiter & Rosenblatt, 1997; Gilmer et al., 2012; Song, Floyd, Mailick Seltzer, Greenberg & Hong, 2010; Tambling, 2012). Therapists also reported observing negative interactional patterns that seemed to be influenced by both the couples' grief and attachment needs. Consistent with the literature, therapists also noticed the tendency for couples to turn toward one another in their sadness (Avelin, 2013; Stroebe et al., 2013; Wing et al., 2001). When this wasn't possible, either due to a lack of vulnerability, an insecure bond, or even an attachment injury, therapists report noticing an increased level of distress in their clients. These findings support the theoretical underpinnings of EFT and the major tenets of Attachment

Theory (Bowlby, 1969/1982; Johnson, 2002). According to the therapists interviewed, this lack of security or openness seemed to hinder the emotional processing necessary for couples to reconnect in their grief.

Honoring the Loss

Most therapists reported a need to emphasize certain aspects of the model over others. This was described not as straying from the model itself, but as making adjustments in “how” the model was applied to best honor the loss and the grieving process of each client. Honoring the loss that clients had experienced appeared to be one of the biggest concerns for therapists. With clients experiencing bereavement from the loss of a child, all therapists reported wanting to give special attention to the grief. Many therapists reported a belief that minimizing the loss by focusing solely on the marital relationship would hinder the therapeutic process. For therapists, focusing on the grief appeared to be necessary to allow clients to feel heard and validated. It also seemed to enable clients to fully process the distress they were currently facing. The Rogerian approach, which can be explained as keeping an unconditional positive regard with clients, of the EFT model seems to give therapists the freedom to focus in on what is most relevant to the client in each moment of the therapeutic process. Therapists echoed this sentiment when explaining the need to give special attention to each client’s grief reactions when they, the therapists, became triggered or highly escalated with their own internal grief reactions.

The EFT literature supports the need for adjusting the traditional EFT model when working with niche populations (Johnson, 2002). For example, in 2002 Sue Johnson published an expanded version of the EFT model to be used specifically with clients that had experienced trauma. Similar to the data collected in this study, particular aspects of the model were emphasized or stressed in accordance to the needs of the client. Dan Wile’s (1993) idea of

primary and secondary therapeutic pictures in couples treatment helps to expand on the processes that emerged (Stith, McCollum & Rosen, 2011). According to Wile, the therapist's primary picture is the set of working assumptions about people and therapy with which he or she prefers to work. This set of ideas is the framework that guides the therapist's thinking even before he or she has met the client. The therapist's secondary picture is the set of ideas, techniques and approaches that he or she adopts when constraints arise that present the use of the primary pictures. According to Wile, secondary pictures apply when the therapist is unable to see, in the present moment, how to apply his or her primary picture when the immediate data suggest another approach (Stith et al., 2011). In this study, the therapist's primary picture was EFT. As they applied the model, a secondary picture emerged. Within this secondary picture, we see the two processes that were identified from the data, particularly "Honoring the Loss."

Adjusting the pace of therapy and incorporating psycho-education are two main ways that therapists in this study attempted to honor the loss of their clients. These two aspects of the process model are consistent with the EFT model for trauma survivors. Johnson (2002) writes, "The multidimensional nature of the after effects of trauma implies that to effectively treat trauma, we need to use different interventions to hit different targets. The therapist's goal must be not to just lessen the distress in a survivor's relationship, but to create a secure attachment that promotes active and optimal adaptation to a world that contains danger and terror, but is not necessarily defined by it (p. 10)." When adapting the EFT model with trauma survivors, Johnson mentions using a slower pace with clients, as well as outlining what it means to have experienced a traumatic event. This is consistent with the findings of the current study. Therapists reported using a slower pace to ensure safety in the room, build trust, and create an open environment for sharing distressing emotion. Psycho-education was also used to outline and predict what clients

should expect as they enter into the grieving process. Therapists were able to normalize the marital distress that many clients were feeling and refer back to the general experience of those impacted by the loss of a child when conceptualizing these cases.

The literature on grief and bereavement places an emphasis on meaning making, understanding it as an integral part of the healing process (Mancini et al., 2012). EFT therapists addressed this need, knowingly or unknowingly, by allowing their clients to spend more time sharing the content or information about their child. Through partial storytelling, therapists encouraged parents to help them, the therapists, to get to know their client's child. Many believed this would better help them to build rapport with their clients, as well as better understand their needs and validate their experience.

Focusing on the grief was an integral part of each therapist's process as they applied the EFT model with couples that have experienced the death of a child. This was achieved in various ways. In step 2 of the EFT model, the therapist identifies the negative pattern of interaction (Johnson, 2004). All therapists mentioned incorporating the grief of their clients into their client's current relational cycle, as a means to give focus to the grieving process. Therapists used the couples' relational cycle to anchor emotional conversations about the loss of their child. Avelin (2013) writes, "An effective interaction with bereaved parents should include a dialogue of potential differences in grieving patterns, which would enable the parents to better understand each other in their grief (p. 671)." In this sense, therapists were able to aid their clients through difficult conversations. It seems that therapists were able to achieve this goal through externalizing the couples' patterns of interaction, including their grief reactions. Simultaneously, focusing on the grief also allowed for deep intrapsychic, or internal, processing of each individual's grief reactions. Like most studies on grief reactions (e.g. Li et al., 2005; Li et al.,

2003; Stroebe et al., 2005), therapists observed a deep sense of loneliness, sadness, and despair in their clients over the loss of their child. As therapists focused on the grief of their clients, it appears that they were able to help clients communicate their pain to one another, while also addressing the individual needs of each client.

Honoring the loss of the child seems to be a major process for therapists as they applied the EFT model with couples that have experienced the death of the child. On a macro-level, this aligns with the major tenets of EFT and grief therapy models. Both approaches focus on the expression of difficult emotion and creating a supportive atmosphere to then share and process these difficult emotions.

Self-of-the-Therapist

The findings of this study identified an internal process that therapists reported experiencing when applying the EFT model with couples that have experienced the death of a child. Therapists reported having a deep emotional connection with their clients that came from increased levels of empathy, higher emotional reactivity, and the heaviness associated with grief and bereavement (i.e. “grief is its own beast”). Therapists reported having higher levels of empathy and understanding for these clients because of their own personal experiences with death and loss. As mentioned previously, the universality of grief seems to create a special bond between people (Toller & Braithwaite, 2009). It can be assumed that this is not limited to clinicians and their clients. Therapists reported a connection that seemed unique to this population. The data reveal that this empathy or innate understanding informs the clinicians’ decisions when in session.

The self-of-the-therapist process that emerged from the data is a new addition to the literature. In this study, the self-of-the-therapist process was specific to grief and loss while

applying EFT. The internal process that each therapist experienced appeared to inform the choices that therapist in the room, as well as how they conceptualized their cases. For example, it seems that the universality of grief allowed for less judgment of their clients and a deeper level of compassion for their current predicament. Therapists shared that certain client's behaviors, such as infidelity, were easier to understand when put in the context of child loss. Therapists were able to view their clients as being mutually injured by the loss. In turn, it seems that their clients' actions or behaviors following such an event were met with increased levels of empathy by their therapists. Even though one partner may have "caused" more injury in the marital relationship, therapists viewed all clients through a lens of grief and loss. While therapists reported that they strive to hold empathy and compassion for all clients, therapists reported that this conceptualization and level of care is unique to clients that have experienced the death of a child.

The self-of-the-therapist process for each therapist greatly impacted how she applied the EFT model with couples that have experienced the death of a child. Both personally and professionally, therapists shared being "deeply touched" or "moved" by their work with this population. It seems that this self-of-the-therapist process helped clinicians to make important clinical decisions, as well as maintain a vulnerable, validating presence that is needed for the experiential work of EFT (Johnson, 2004).

Limitations

The findings from this study were collected from a small number of individuals who were solely recruited through professional EFT listserv emails. The process of becoming certified in EFT is a somewhat rigorous process. The criteria that all therapists be certified for 5 years greatly decreased the amount of possible participants. While this allowed for an expert sample, it

limited the amount of participants that were recruited. All therapists were also female and identified themselves as Caucasian. It is possible that different processes in applying the model could emerge for men and individuals of other ethnicities. The presenting problem of the case, as well as the length of time that had passed since the death of the child, could also serve as a limitation. For example, some couples came in for treatment very soon after the loss of their child to address their grief. Other couples began couples' therapy years after the death of their child wanting to address their marital distress. EFT is inclusive of all emotion. Therapists shared that even if the grief wasn't the presenting issue, the emotions associated with the loss emerged and became part of their work with their clients. Therapists reported that working with grief after years had passed made the grief work less clear and succinct. This can be seen as a limitation.

Clinical Implications

Findings from the present study have important implications for marriage and family therapists and other mental health clinicians working with couples that have experienced the death of a child. These implications are especially important for therapists who have not worked with this population before or who are interested in applying the EFT model as a way to process both grief and marital distress. In general, marriage and family therapists and other mental health clinicians should be made aware that couples therapy may be a helpful option for those who have experienced the death of a child. Individual therapy and group therapy have served as the traditional structure for addressing grief and loss (Winokuer & Harris, 2012). Current empirical research and the data collected from this study support the notion that couples therapy can be appropriate when healing from this unique type of loss (Gold et al., 2010). The increased risk of relational break up following the death of a child also supports giving special attention to the marital bond while simultaneously processing each individual's grief (Gold et al., 2010;

Lyngstad, 2007). The accounts given by therapists not only support this notion, but also give insight into how the EFT model can be used to address these needs. As mental health providers, it is important to be aware of the benefits that couples' therapy can have in the grieving process.

Clinicians should understand the complexities that come with integrating the grief process into traditional couple therapy models, such as encouraging more emotional expression of grief and loss. Therapists reported the need to accommodate their approach to encompass the grieving process into the EFT model. This was achieved primarily by emphasizing existing interventions of the EFT model, such as attunement and validation. Marriage and family therapists should pay special attention to the self-of-the-therapist issues that can be awakened by working with this type of loss. As mentioned by several therapists, it is likely that a client's emotional expression of their own grief and loss can trigger or touch the emotion of the therapist. This can be a positive aspect of the EFT model, which is meant to be experiential by client and therapist; however, it is helpful for therapists to remain aware of it when working with this difficult topic. Having access to peer supervision, other training materials, and current literature on the topic would assist clinicians as they begin to work with this population in the future.

Future Research

More research is needed to fill the gap in the literature on this topic. Hopefully, this study will be the first of many to address the clinical needs of couples experiencing the death of a child. In terms of application, more research should be conducted to understand how this model is being used with couples that have experienced the death of a child. To validate the findings of this study, future research should include men in its samples since the current study was only able to recruit female therapists. There should also be more multicultural diversity among

therapists' races and ethnicities since different cultural backgrounds may contribute to different processes of application.

Future research should also explore the efficacy of the EFT model with couples that have experienced the death of child. Multiple outcomes studies have been conducted with various populations using the EFT model (i.e. PTSD, depression, abuse). There has yet to be a study focusing on using EFT with couples experiencing this specific kind of loss. Future research would not only contribute to those specializing in EFT, but also inform the field of marriage and family therapy as a whole.

Conclusion

In conclusion, the death of a child has a profound impact on parents, both individually and as a couple. Grief reactions tend to vary between partners. For some, this dissonance can create disconnection between partners. Due to the findings that marital closeness is a significant predictor of better health in bereaved couples (Song et al., 2010), strengthening this bond seems to be an appropriate step in the healing process. EFT has been shown to help couples do this in the midst of distressing times.

Even though EFT has been studied with several populations, this is the first study to explore how clinicians apply the EFT model when treating couples that have experienced the death of a child. The following study identified two distinct processes that occur: 1) honoring the loss of the child and 2) engaging in self-of-the-therapist. These two processes appear to be the main ways in which therapists make the needed adjustments to their application of EFT when addressing the grief of their clients. Therapists explained this as not making changes to the model, but emphasizing particular aspects of already existing elements.

The information from these data can be used to promote future studies of this topic. Similarly, the observations and reports from therapists presented could be used to support the EFT model as a potentially valuable tool to for addressing grief reactions and bereavement within the couple dyad.

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Appendix A

Participant Recruitment Email

Hello,

I am pleased to announce that I am now recruiting for a thesis study entitled The Application of Emotionally Focused Therapy in Treating Couples Who Have Experienced the Death of a Child: A Grounded Study. The study will explore how certified Emotionally Focused Therapy (EFT) therapists have applied the EFT model in treating couples who have experienced the death of a child.

Participant eligibility includes:

- Licensed mental health professional
- Certified in EFT
- Worked with a couple who has experienced the death of a child
- Worked with this couple within the last 5 years
- Must have held EFT certification and mental health license during the time of bereaved couples' treatment

Participants will be interviewed about their experiences over the phone, as well as complete a short demographic questionnaire. The interview will last about one hour and will be audio recorded for transcription.

Please contact me if you would like more information or would to participant in this study.

Warmly,

Emily Margaret Brown
Virginia Tech MFT Masters Candidate
Brownem@vt.edu
(804) 678-9372

Appendix B
Screening Questions

Name:

Date:

1. Where did you receive your education?
 - a. Graduate degree (i.e. Masters, Doctorate)?
 - i. When?
2. What mental health license(s) do you currently hold?
 - a. When did you become licensed?
3. In which state(s) do you hold licensure?
4. Are you certified in Emotionally Focused Therapy (EFT)?
 - a. What is the date of your certification in EFT?
5. In the last 5 years, have you worked with a couple that has experienced the death of a child?
 - a. When specifically did you work with them?
 - b. For how long?

Appendix C

Research Informed Consent

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: The Application of Emotionally Focused Therapy (EFT) in Treating Couples Who Have Experienced the Death of a Child: A Grounded Study

Researchers: Emily Margaret Brown, M.S. Candidate, Eric McCollum, Ph.D., and Angela Huebner, Ph. D.

I. Purpose of Research: The aim of the current study to understand how certified EFT clinicians apply the EFT model with couples that have experienced the death of a child.

II. Procedures: You will first be asked to complete a demographic questionnaire providing general information about you. It is expected that this form will take about 5 minutes to complete. After completing the demographic questionnaire, the interview process will begin. The interview will take about an hour to complete, and will be conducted over the phone. You will be asked to reflect and describe how you applied the EFT model when treating couples who have experienced the death of a child. These interviews will be audio recorded and then transcribed for further analysis by the researchers.

III. Risks: The researchers anticipate minimal risks for participating in this research study. As a result of the interview questions, you may experience some emotional discomfort. You may decline to participate or answer a question at any point in time if you wish to do so.

IV. Benefits: As a result of participating in this study you may feel a sense of satisfaction for contributing to an important area of research that will help future clinicians as well as the field of couple therapy.

V. Extent of Anonymity and Confidentiality: Every effort will be made to keep the information you provide strictly confidential. Your responses will be locked in a secure location for the duration of the study. Your names will be replaced with a code number and any identifying information will be destroyed. Furthermore, your names and other identifying information will not be disclosed on any future reports or publications.

VI. Compensation: There is no compensation, however, participating in this study benefits research.

VII. Freedom to Withdraw: You do not have to participate in this research study. You have the freedom to withdraw from the study at any point in time without penalty.

VIII. Participant's Responsibilities: I voluntarily agree to participate in this study. I have the following responsibilities: I will complete a demographic questionnaire. I will complete a one-hour interview over the phone.

IX. Participant's Permission:

I have read the Consent form and the conditions of this project. I have had all of my questions answered, and I hereby give my voluntary consent to participate in this study.

Participant's Name (please print): _____

Date of Verbal Consent: _____

Witness Signature: _____

If you have any questions about this research project, please feel free to contact:
Emily Margaret Brown, B.S., Principal Researcher
(804) 678-9372
brownem@vt.edu

Eric McCollum, Ph.D., Faculty Advisor
emccollu@vt.edu

If you have any questions about your rights as a human research participant, please contact:
David M. Moore
Chair, Virginia Tech Institutional Review
Board for the Protection of Human Subjects
Office of Research Compliance
(540) 231-4991
moored@vt.edu

Appendix D

Demographic Questionnaire

Age: _____

Race/Ethnicity: _____

Occupation and Certifications:

How long had you been certified in EFT before working with this couple?

Were you under supervision when you were working with this couple? EFT or other?

What was the presenting problem at the beginning of treatment according to the couple?

In your opinion, was treatment successful?

Appendix E

Interview Questions

- 1) How did you apply the EFT model to couples that have experienced the loss of a child?
- 2) What did you notice in your application of EFT during Stage 1 of the model?
 - a. Compared to other clients, who have not experienced the death of a child, did you notice any differences? If so, what would I have seen you do?
 - b. Were any modifications made during this time (i.e. incorporate other strategies from different approaches)? If so, what would I have seen you do?
 - c. Were there specific steps in Stage 1 that you approached differently than you have with clients who have not experienced the death of a child? If so, what would I have seen you do?
- 3) What did you notice in your application of EFT during Stage 2 of the model?
 - a. Compared to other clients, who have not experienced the death of a child, did you notice any differences? If so, what would I have seen you do?
 - b. Were any modifications made during this time (i.e. incorporate other strategies from different approaches)? If so, what would I have seen you do?
 - c. Were there specific steps in Stage 2 that you approached differently than you have with clients who have not experienced the death of a child? If so, what would I have seen you do?
- 4) What did you notice in your application of EFT during Stage 3 of the model?
 - a. Compared to other clients, who have not experienced the death of a child, did you notice any differences? If so, what would I have seen you do?

- b. Were any modifications made during this time (i.e. incorporate other strategies from different approaches)? If so, what would I have seen you do?
 - c. Were there specific steps in Stage 3 that you approached differently than you have with clients who have not experienced the death of a child? If so, what would I have seen you do?
- 5) Were there any EFT specific techniques that you found particularly helpful when applying EFT to couples that have experienced the loss of a child? If so, which ones and when were they used (i.e. stage or step)?
- 6) Were there any EFT specific techniques that you found less useful when applying EFT to couples that have experience the loss of a child? If so, which ones and when in the treatment process did you notice this?