Presentation Abstract:

It is important, if not essential, to establish a coherent, safe, and trusting therapeutic relationship. Regardless of your Energy Psychology (EP) approaches and orientations, research clearly indicates that the relationship is key for effective outcomes. This presentation incorporates clinical skills, methods, research findings, and tools that will help you enhance your therapeutic presence.

While there are many ways to provide mental/health care and coaching, experience suggests that some helping methods can be more effective and quicker than others. Part of the draw to EP methods relates to the novel, non-invasive, and alternative ways that treatment is engaged and the relatively quick and robust treatment outcomes by skillful practitioners. This serves to be attractive to both practitioner and client/patient. However, in most circumstances, EP methods are not stand-alone approaches, and to think of these as such can lead to challenging situations and reduced effectiveness. The newer the person is to using and/or receiving EP treatments the more likely the need for caution before jumping into treatment prematurely.

This session focuses on clinical values, ethics, and tools regarding the value of being therapeutically present. Evidenced-based therapist qualities, patience, establishing rapport, acquiring background information, treatment planning, and if/when to refer are presented to complement skills when using EP approaches.

The role of the clinician in psychotherapy: Some examples of what psychological literature advocates?

"Current psychotherapy researchers have come to the conclusion that it is the relationship that is the most salient component for successful psychotherapy."

(Vivino & Thompson, 2013; p.20)

Vivino and Thompson (2013) remind us that in this era of contemporary psychotherapy methods with “cool” names (e.g., post-modern, constructivist, mindfulness, positive psychology, DBT, CBT, Energy Psychology), it is the therapeutic relationship that sets the stage regardless of theoretical orientation and methodology. Hans Strupp (1963) reported on the importance of the therapeutic relationship over 50 years ago where he underscored the importance of therapist’s level of commitment to the individual, warmth,
and the benefit of therapist-individual collaboration. The client-centered therapeutic model involving empathy, understanding, and a non-judgmental and non-pathological stance with the individual prevailed in the 1960s as espoused by psychologist Carl Rogers (1961). This Humanistic component of psychotherapy also incorporates the notion of connectedness where a person can be free to flourish, and to “live fully in each moment” (Rogers, 1961; p. 188), which relates to “mindfulness” in present-day practices and pertains to therapeutic presence.

“Therapeutic presence” (TP) can be operationally defined as an essential ability of the therapist or coach to connect with an individual in ways that promotes effective outcomes. Psychologists Shari Geller and Leslie Greenberg (2012, 2002) write that therapeutic presence is the fundamental underlying quality of the therapeutic relationship that fosters effective therapy outcomes. They describe four core aspects that cultivate therapeutic presence: Grounding, Immersion in the moment, Expansion, and Being with and for another. Specifically they write:

“Therapeutic presence is the state of having one's whole self in the encounter with a client by being completely in the moment on a multiplicity of levels — physically, emotionally, cognitively, and spiritually. Present therapists become aware of both their own experience and that of their client through bodily sensations and emotions, and this awareness helps them to connect deeply with the client. Therapeutic presence is not a replacement for technique, but rather a foundational therapeutic stance that supports deep listening and understanding of the client in the moment.”

Importantly, TP involves a being with the individual rather than a doing to the individual. TP is a state of being open and receiving the individual’s experience in a gentle, non-judgmental and compassionate way (instead of observing and looking at or even into the person). TP involves a willingness to be impacted and moved by the person’s experience, while still remaining grounded and responsive to the individual’s needs and experience. TP strives to obtain a balance and dual level of awareness of being in contact with the other’s experience and with one’s own experience, while being able to reflect (and act) on what is occurring with and between the therapist and individual.

See Figure B in Appendix

From the viewpoint involving the role of attachment related issues (Wallin, 2007), it is important (especially when there is a history of trauma) to provide a safe and secure environment, which can be accomplished by the therapist being emotionally present, resonating to the client in kind, and non-judgmental as reflected in the Rogerian constructs of empathy, unconditional positive regard, congruence, and genuineness.

Neurobiological evidence now documents the value of mindful “presence”, awareness, attunement, and resonance in fostering a safe and healing environment by the therapist and for the client (Siegel, 2010; Vivino & Thompson, 2013).
Psychologist, Bruce Wampold (2007), recipient of APA’s 2007 Award for Distinguished Professional Contributions to Applied Research, opines that the healing change process in psychotherapy also involves an adaptive and/or functional explanation of the problem, and treatment consistent with the explanation that leads to improved adaptive functioning. The humanistic, client-centered connection is essential in effective psychotherapy and is supported by research.

“Research has shown that these variables related to interpersonal process are robust predictors of outcome and are likely causally involved in producing the benefits of psychotherapy…It appears that the focus on the therapeutic interaction as the critical aspect of psychotherapy is justified by the research evidence.”
(Wampold, 2007; p. 869)

Dr. Wampold writes further that, “Effective therapists are skilled at monitoring acceptance of the explanation and the treatment and will modify the delivery of an explanation as necessary.”
(p. 864)

Overview of important therapist traits to promote effective psychotherapy:
(as reported by the sample of authors listed above and in the Reference section)

In no particular order…

- Empathy
- Understanding
- Non-judgmental
- Non-pathologizing
- Caring
- Genuineness
- Emotionally Present
- Attentive
- Perceptive
- Compassionate
- Safe
- Secure/Grounded
- Unconditional Positive Regard
- Attunement
- Alliance
- Congruence
- Resonance
- Realism
- Client-centered [Client-directed]

It is my belief that both the above therapist qualities and therapeutic outcomes can be enhanced by some of the EP methods and approaches. Regardless of your approach, when you and your client/patient are comfortable with one another and the method, then a state of coherent resonance and healing change becomes possible.

The Therapeutic Relationship

The psychotherapeutic relationship between the therapist and the individual is of upmost importance. While the reader is free to examine the current literature, my aim is to address some of the pragmatic factors I have identified with regard to psychotherapy in general and HAT and other EP approaches in particular.

When initiating a therapeutic relationship, the most fundamental requirement is to first be a person, and a therapist second. Our personhood is the common connective denominator that sets the stage for all that follows in psychotherapy. If the individual is
unable to connect with you as a person it becomes a greater challenge to become part of
his or her experience for the purpose of healing and change.

Being genuine in our interactions, caring, and intentions to assist a person encompasses a
large degree of what to be a person entails. In most instances, the individual already
knows that the therapist possesses appropriate credentials to provide the assistance they
seek. Accordingly, how we act, speak, and go about gathering initial background
information reveals our “professionalism”, which can be done with interest, care,
concern, hope, and realistic optimism. There is a much better chance that the individual
will want to work with you when he or she feels understood, heard, and comfortable
when sharing the darkest of concerns. Just as we have learned to notice the verbal and
the non-verbal communications, remember that the individual also does the same.

However, there is a double-edge to the nature of therapist client/patient relationships.
Research (Lingiardi, Tanzilli, and Colli; 2015) shows that the type, severity, and
personality of the individual can have an undesirable impact on the therapist
(countertransference). Specifically these researchers found, in general, “the impact of
symptom severity is less sizable than one aroused by patient’s personality style.” Also,
“Higher levels of patient’s symptom severity are most associated with an intense feeling
of being overwhelmed, disorganization, helplessness, and frustration in clinicians…
These countertransference reactions are not accounted for by therapist’s different
therapeutic approaches and other variables.”

Integrating the Therapeutic Relationship and the HAT Model (or EP Models)

After establishing a workable relationship with the individual, and background
information is sufficiently obtained (e.g., reasons for seeking assistance, relevant
precursor and trigger components of concerns/symptoms, social history, etc.), now the
treatment strategies and psychotherapeutic methods come into play. In many instances
the individual has been in psychotherapy before. When this is the case I find it helpful to
learn what his or her experiences had been, what approaches were used, and how they
may have benefited.

The HAT model and many EP approaches go beyond what most individuals believe “talk
therapy” is all about. While the therapist uses all of his or her “talk therapy” skills, when
the target issue becomes clear that is the time to specify a treatment focus and “go to
work”. Figure A conceptualizes a psychotherapy session in which HAT or EP methods
are used. As can be seen, Phases 1 and 3 are more classic “talk therapy” components and
Phase 2 is the HAT or EP intervention. The therapist is free to adjust the time needed to
converse and/or prepare the individual in Phase 1 before starting the intervention.
Sometimes this is time for the usual “updates” since last session and/or clarification of
the targeted issue (Treatment Focus) on which HAT or EP methods will be used. This
can be 10 to 20 minutes at the therapist’s discretion. During this time the therapist can
use any warranted psychotherapeutic approaches given the content of the information
shared and the affect and stability of the individual. Sometimes the session never
progresses beyond this phase due to the individual’s needs or circumstances at that time
as assessed by the therapist. Therefore, a Phase 1 only session would mirror a more
typical talk therapy session in which support, information gathering, reframing, and other
psychotherapy modalities are used. As always, the what, when, and how to intervene and
assist the individual remains a clinical judgment by the therapist.

Upon completion of Phase 1, I literally say, “Ready to go to work?” This is my segue
into Phase 2, which is the HAT or EP intervention. The HAT or EP phase typically runs
from 10 to 25 minutes. Sometimes issues unfold and shift in a relatively brief amount of
time while other issues take longer (i.e., extending over several sessions). I have given
up guessing how long treatment on a particular Treatment Focus will take. When I
thought an issue would be completed quickly it took longer, and when I thought an issue
would take longer it processed through quickly! I have found no way to predict. My
stance has become “It will take the amount of time needed…it is what it is.” I also use an
individual’s query about how long will the treatment take as an opportunity to explain
more about HAT or EP approaches using images, metaphors, and/or magnets. For
example, I might explain that the shock of their experience was like a large rock being
thrust into a still pond. At first there is the noise of the splash and the ripples in the
water. However, the rock also displaces air, causing lots of tiny bubbles to more slowly
float upward to the surface. We keep working with HAT or EP approaches until there are
no more bubbles…

Phase 3 is a check-in and wind down time after the intervention is completed for the
session. Upon completion of the intervention I always thank the individual for his or her
cooperation and courage in doing the work. Yes, courage is recognized and appreciated.

**Practicing Psychotherapy in an Evidenced-Based Environment**

Just as the client/patient must become courageous to confront his or her issues and
experiences, we therapists must also become courageous with appropriate clinical
judgment. When Behavioral Kinesiology (Diamond, 1979) and Thought Field Therapy
(Callahan, 1981;1985) first hit the psychotherapy scene integrating techniques from
Applied Kinesiology and Traditional Chinese Medicine, learning and using these
methods required courage and conviction. The reality is that we only learn the efficacy
of an approach by learning, doing, and studying it. However, when one attempts to throw
out a hundred years of evolving psychotherapy methods, use only a new method, and
even state that research was not necessary, the early movement only positioned itself into
the headwinds of a professional Category 5 hurricane! Combining this with insurance
care-management initiatives and an unrelenting “old guard” in psychotherapy, we end up
with the onset of evidenced-based practice in the mental health communities.

Psychologist, Tracy Eells (2011) reminds us that the American Psychological
Association’s 2005 task force on Evidence-Based Practice in Psychology (EBPP)
reported that, “EBPP is defined as ‘the integration of the best available research with
clinical expertise in the context of patient characteristics, culture, and preferences’” and
that “EBPP ‘promotes effective psychological practice and enhances public health by

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applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention”.

Eells contends “case formulation” is at the center of EBPP, and again references the APA report: “Although clinical practice is often eclectic or integrative…and many effects of psychological treatment reflect nonspecific aspects of therapeutic engagement..., psychologists rely on well-articulated case formulations, knowledge of relevant research, and the organization provided by theoretical conceptualizations and clinical experience to craft interventions designed to attain desired outcomes”. (Eells, 2011; p17)

Accordingly, case formulation may also be at the center of integrating use of EP methods when providing mental health and coaching services.

Bottom line: Do your due diligence and gather information about your patient/client, establish a comfortable rapport, use your information about the individual, learn what he or she wants in treatment and what is getting in the way, use your clinical experience, knowledge of research, and best judgment to discuss and craft an intervention that best suits the needs and desired outcome of the individual. This form of documented case formulation will assist you in thriving in an evidenced-based environment.

Sample of an Intake Forms for Gathering Background Information

Feel free to copy, change, and use the Intake form in any meaningful way!

Consider beginning with page 5 of the Intake below. Discover why they are coming into treatment. Why now? What are his or her expectations, goals, etc.

I do the complete intake in person during the first session or over the following sessions depending on the individual, their background, and how extensive the circumstances. This information gathering process can also reveal much about the person that is unsaid, and fosters the connecting process in building a desirable rapport.
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Licensed Psychologist (#1523)  
856-778-9300  

Victoria Medical Arts Building  
703 East Main Street  
Mooresstown, NJ 08057  

INTAKE INFORMATION  

Date: ___________

Referred by: ____________________________

Thank You Sent: ________________________  
(Date)

Adult  Adolescent  Child

A. Patient Name: ____________________________  
Age: ___________

D.O.B ___________

Address: ____________________________  
How long at this address: _____

__________________________

__________________________

Home Phone: ( ) ___________________  
Work: ( ) ___________  Cell: ___________

(If child/adolescent) Parent’s Name: ____________________________

Address if different: ____________________________

B. Marital Status: _______________  
No. of Marriages: 1 2 3 4

How Long Married: _______________  
Date of Divorce: _______________

How Long Separated: _______________  
Previous marriage for: _______________

C. Spouse/Partner’s Name: ____________________________

Employment: ____________________________  
Position: ____________________________

Educational Background: ____________________________

Spouse/Partner’s Involvement: ____________________________
D. Patient Employment: ________________ Position: ________________
__________________________ Salary: ________________
Duration: ________________ Date Last Worked: ________________

E. Educational Background:
Highest Year Completed in Sch. or Degree: ________________ G.E.D. ________________
School: ________________

Extra Curricular Activities: ________________

Grades: ________________ Years Repeated: ________________
Difficulties: ________________

F. Branch of Military Service: ________________ Highest Rank: ________________
Dates of Service: ________________ Type of Disch. ________________

G. Religious Affiliation(s): ________________ How Active? ________________

H. Family Constellation:
1. Family Physician: ___________________________ Phone: ______
   Address: __________________________________________
   __________________________________________
   Primary Specialist: ___________________________ Phone: ______
   Address: __________________________________________
   Medication: Yes No Not Now Last Taken____
   RX By:

Hospitalization/Surgery: Dates Reasons
   __________________ __________________
   __________________ __________________
   __________________ __________________

Other Relevant Medical History:

Health, in general?:

Ht: _________ Wt: ___________ Headaches?

Appetite: TMJ?

Sleeping: Other?

Seizures?
Blackouts?
Dizziness?
Diabetes?
Hypoglycemia?
Allergies?
J. History of Previous Psychological Help: Yes    No
   Name: ____________________  Name: ____________________
   Reasons: ____________________  Reasons: ____________________
   When?: ____________________  When?: ____________________
   Duration: ____________________  Duration: ____________________
   Why Term?: ____________________  Why Term?: ____________________
   History of Psychiatric Hospitalization: Yes    No

K. Smoke Cigarettes? ______  How Much? ____________________
   Alcohol Use? ____________________
   Drug Use? ____________________
   Trouble with the Police? ____________________

L. Hobbies/Interests: ____________________

M. Medical Insurance? Yes    No  IN. CO. name ____________________
   Name of insured ____________________  DOB of insured ____________________

N. Other Relevant Information/Comments
N. Specific Concerns/Symptoms:

O/S (a)/(t)

Blocked Resource:

P. Physical Description, Behavioral Observations, Clinical Impressions:

Q. Tentative Recommendations:

R. Diagnostic Impressions:
Psychotherapy, counseling, and coaching almost always entail more than just the administration of a technique or model of treatment. We have learned much during our training and experience as clinicians and helpers, and we ought to continue to make space before and after a specific intervention for these clinical skills in relating to the individual who seeks our assistance.
**Figure B**  
*A Model of Therapist Presence in the Therapeutic Relationship*

<table>
<thead>
<tr>
<th>Preparing the Ground for Presence</th>
<th>Process of Presence</th>
<th>Experiencing Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-session</strong></td>
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<tr>
<td>• Intention for presence</td>
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<tr>
<td>• Clearing a space</td>
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<tr>
<td>• Putting aside self- concerns</td>
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<tr>
<td>• Bracketing (theories, preconceptions, therapy plans)</td>
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<tr>
<td>• Attitude of openness, acceptance, interest and non-judgment</td>
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<td><strong>In Life</strong></td>
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<td>o · Philosophical commitment to presence</td>
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<td>o · Personal Growth</td>
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<tr>
<td>o · Practicing presence in own life</td>
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<tr>
<td>o · Meditation</td>
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<tr>
<td>o · Ongoing care for self and own needs</td>
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<tr>
<td><strong>Receptivity</strong></td>
<td></td>
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<tr>
<td>• Open, accepting, allowing</td>
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</tr>
<tr>
<td>• Sensory/bodily receptivity</td>
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<tr>
<td>• Listening with the third ear</td>
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<tr>
<td>• Extrasensory perception/ communication</td>
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<tr>
<td><strong>Inwardly Attending</strong></td>
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<td>• Self as instrument</td>
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<td>• Increased spontaneity/ creativity</td>
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<td>• Trust</td>
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<tr>
<td>• Authenticity/ congruence</td>
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<tr>
<td>• Returning to the present moment</td>
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<tr>
<td><strong>Extending and Contact</strong></td>
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<tr>
<td>• Accessible</td>
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<td>• Meeting</td>
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<td>• Transparency/congruence</td>
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<tr>
<td>• Intuitive responding</td>
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<tr>
<td><strong>Immersion</strong></td>
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<tr>
<td>• Absorption</td>
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<tr>
<td>• Experiencing deeply with nor attachment</td>
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<tr>
<td>• Present-centered (intimacy w moment)</td>
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<tr>
<td>• Aware, alert, focused</td>
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<td><strong>Expansion</strong></td>
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<td>• Timelessness</td>
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<td>• Energy and flow</td>
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<td>• Inner spaciousness</td>
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<tr>
<td>• Enhanced awareness, sensatic and perception</td>
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<tr>
<td>• Enhanced quality of thought ; emotional experiencing</td>
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<tr>
<td><strong>Grounding</strong></td>
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<tr>
<td>• Centered, steady, grounded</td>
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<td>• Inclusion</td>
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<tr>
<td>• Trust and ease</td>
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<tr>
<td><strong>Being With and For the Client</strong></td>
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<tr>
<td>o · Intention for client’s healing</td>
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<td>o · Awe, respect, love</td>
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<tr>
<td>o · Lack of self-conscious awareness</td>
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</table>
Clinical Considerations

Remember to be mindful of your personal and professional clinical values and ethics when agreeing to take an individual into treatment. Do you have the needed training and/or experience for the needs of the individual? Do you want/need supervision? Do you want/need to refer the individual to someone else?

Be patient. Allow your treatment planning to unfold and build around the acquired information and your relationship with the individual relative to your areas of expertise.

Be mindful in your case conceptualization regarding a past-present-future orientation. In other words, be simultaneously mindful of his or her past in the present as you influence their future.

References


