

**WHAT IS IT ABOUT THE THERAPEUTIC ALLIANCE THAT
ENABLES TRUST WITH ADULT SURVIVORS OF CHILDHOOD ABUSE?**

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ABSTRACT

The current study involved an investigation of qualities of the therapeutic alliance that contribute to trust and engagement when working with survivors of childhood abuse, a clinical population renowned for high dropout rates. These clients frequently have insecure attachment patterns, cognitive schemas portraying the world as unsafe, others as unreliable, unpredictable or dangerous, avoidance behaviours, and difficulties in relationship with self and other. Alliance has been shown empirically to be one of the strongest predictors of success in psychotherapy (Wampold & Imel, 2015) with weak alliance correlating with client dropout. A qualitative approach was adopted using semi-structured interviewing to explore the complexities of both the clients' and their therapists' experiences in their therapeutic relationship. This enabled an in-depth understanding of what was helpful or hindering in the therapeutic relationship when counselling survivors of childhood trauma.

Participants included 13 psychologists with at least five years of counselling experience and 30 clients, who had worked through issues of childhood trauma. Clients who were deemed sufficiently stable by their psychologist to be interviewed were offered the research information. Clients contacted the researcher directly to avoid coercion. The research questions were provided in advance and were related to the therapeutic alliance. Both the clients and psychologists were separately interviewed by the researcher for one hour in a venue convenient and mutually agreed upon by the participants. A Person Centred approach was taken by the researcher who supported the participants throughout the interview process. Semi-structured interviews allowed for open-ended questions, with flexibility to probe further, yielding breadth and detail in the responses. Questionnaires on demographics and informed consent were completed and approval to audio record the interviews was sought to assist with and to deepen the researcher's analyses. Giving the clients control and minimising the effects of power imbalance was particularly important to avoid retraumatisation.

Sixty hours of transcripts were summarised with themes and patterns that emerged from the data identified and grouped. Data were paired comparing outcomes across psychologists and clients. Two research supervisors experienced in qualitative enquiry oversaw the whole process. Analyses highlighted factors related to: advanced empathy (cognitive understanding, deep emotional empathy, secure attachment,

empathy tailored to the individual, non-verbal behaviours and instilling responsibility); deep client acceptance (validation, use of humour and metaphor, therapeutic presence); therapeutic boundaries (firm and flexible, boundaries between self and therapist, therapist self-disclosure); issues of power and control (slow pace, goals and direction of therapy); and effective repair work (qualities of the repair process, the powerful effects of apology). In-depth, clinically meaningful data was revealed that enriches current alliance theory, as is applicable across psychotherapeutic orientations. Future research recommendations were made, limitations of the current research identified and clinical implications presented.

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DECLARATION

I declare that this thesis does not incorporate any material that has previously been submitted elsewhere for a degree or for educational purposes or publication without acknowledgement through referencing.

I also declare that the ethical principles that were advised by Swinburne University of Technology Human Research Ethics Committee were abided by during the implementation of the present research project.

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PREAMBLE

My first experience of the therapeutic alliance was as a client. Mary related to me in a way that no one ever had before. John was similar to Mary in his unstructured, free flowing, yet informed and knowledgeable psychological approach. Not a mention of a goal beyond “being myself”. Mary gave me space. John came closer. Their wisdom was broad and I thrived with both. Leah was more similar in age, and I disclosed far and wide with an assurance of full acceptance. Other experiences along the way were useful, yet less profound. One therapist was too distant and I felt alone in my vulnerability. Another interrupted my emotional experiencing. Experiential professional development groups with colleagues brought more differences amongst therapists, some were warmer, while others had broader understanding. I observed and wondered with curiosity what it is that enabled trust in myself and within others. Some asserted interventions while others had depth of therapeutic presence. Each had their place.

Progressing into my counselling practice I found myself emerged in confusion. Within the profession itself, conflicting messages were evident. Some psychologists asserted certain methods as superior or inferior. Professional criticism was everywhere, debating method while overlooking the individual, both clients and counsellors. I noticed righteousness and rigidity, and a lot of emphasis on labels and boxes. Defensiveness and imposing guidelines felt restrictive and interfering of the therapeutic process. Nowhere in my training did I learn how to connect deeply, lovingly with another human being, and yet that is what stood out in my own experiences as being the most powerful.

Clients also gave me a variety of messages. Once after attending a workshop on evidence based practice my therapeutic practise worsened. Clients did not always like tasks and directiveness. An ‘expert’ was not what they wanted. On other occasions clients would say to me, you are different to previous counsellors. They liked the warmth and genuine caring. They found some therapists were too cold, clinical, distant or ‘right’. This intrigued me. Clients’ secrets emerged that had never been spoken of before, sometimes after years of therapy with another practitioner. I sensed that clients were nourished by the therapeutic relationship. We laughed, we cried. We tried different things. I was honest. The clients kept coming back.

The depth of relationship reached with some clients was profound and intense. The stories were painful for both of us. Suicidation, at times, was like walking along the edge of a knife. Fear, anxiety, shame, deep sadness, wonder, awe, and strength. Strong emotion. Relief, once they had passed through the worst and had begun to recover.

Survivors of childhood trauma clients are a therapeutic challenge. These clients often notice their therapist's actions and intentions vigilantly. They frequently challenge me as their therapist, often early during the process, sometimes before we have even met each other. Sometimes they leave for a while, and then came back. Others have not returned and I do not always know why. They usually appreciate being 'held' and heard, during disclosure of their painful stories. The work has been rich, challenging, and fun, as well as sad, disturbing and heart breaking at times. Intense emotions. Strong relationships. Meaningful and deeply satisfying work.

The clients' stories have opened my mind, grown my compassion and I have learned a lot about the therapeutic process and myself. The connection with each client continues to be unique, getting to know them more intimately a privilege, and refining the relationship an area of ongoing interest and growth, and hence the emergence of the current study.

CHAPTER 1

Introducing the thesis

The alliance, or the relationship between therapist and client, has been strongly supported empirically to be one of the best predictors of success in psychotherapy (Norcross & Lambert, 2011; Wampold, 2001; Wampold & Imel, 2015). Although thousands of studies have been found related to the alliance showing that it has been researched extensively (Norcross & Lambert, 2011), in relation to adult survivors of childhood trauma, alliance research was scarce. Survivors of childhood trauma were a more complicated group to research due to their high level of vulnerability to be retraumatised and to their tendencies to misinterpret others' motivations, as well as having at times extreme symptomatology and emotional reactions (Allison & Rossouw, 2013; Paivio & Pascual-Leone, 2010; Siegel, 2009; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). These participants were often excluded from involvement in research studies and as a result remained an under researched cohort. It was well known that survivors of complex trauma were complex individuals to engage with and that dropout rates from therapy remained high (Paivio & Pascual-Leone, 2010; van der Kolk et al., 2005).

The experience of disrupted trust during childhood experiences with key adult attachment figures, resulted in these individuals frequently possessing insecure attachment styles and schemas of others as dangerous, untrustworthy and unpredictable (van der Kolk et al., 2005). Hence, within the therapeutic alliance these trust issues interfered with the establishment and maintenance of a strong, secure therapeutic relationship as clients anticipated their therapists behaving in disappointing or abusive ways, that were similar to early attachment relationships (Holmes, 2014). These individuals arguably required therapists with specialised skills, knowledge and interpersonal abilities. This was required in order to manage this complex alliance arrangement while also engaging in evocative and often emotionally painful trauma therapy, intended to assist the clients to improve in life satisfaction, reduce symptomatology and gain functional outcomes (Courtois & Ford, 2013; Kezelman & Stravropoulos, 2012; Kinsler, Courtois & Frankel, 2009).

Guidelines for working with complex trauma have been compiled by specialists in the field based on clinical experience, theory and evidence based research. Different

theories and evidence based psychotherapeutic approaches emphasised different aspects of the alliance, however interventions for trauma had limited attention focused on the alliance. The qualities of the alliance required for survivors of childhood trauma seemingly also extended beyond current alliance theories and needed more elaborate investigation as to *what* was required and *how* it was implemented in the therapeutic encounter to improve the service delivery of psychological services to this cohort.

Outline of the thesis

In Chapter One of the thesis the reader is guided through definitions, theories and research related to the therapeutic alliance generally, with the history and progression of the alliance explained. Following this, the complexities and definitions related to complex trauma are outlined, as well as alliance theories and psychotherapeutic approaches frequently applied when working with complex trauma clients. Empathy is introduced as an important element that is often supported in alliance research, as well as the process of alliance rupture and repair work with the alliance, which is found to be a common occurrence when working with this client population. Finally, research related to alliance and trauma specifically is reviewed before introducing the importance of the current research and then methodology in Chapter Two.

Chapter Two represents the methodology of the present study. It gives a rationale for the qualitative methods used and details related to special ethical considerations that were taken into account when designing the research. Survivors of complex trauma need to be protected during the research process, as this vulnerable group could be easily retraumatised. A Rogerian approach was used during all interactions with clients and therapists to facilitate safety and non-coercive disclosure. Maximising client control over pace, seating, time and venue was important as well the interviewer having the skills required to support the client emotionally during the interviewing without intentionally deepening client experiencing. As such, the researcher maintained committed to focusing on the role as a researcher. At the same time, it was important that interactions with the interviewees were respectful, flexible and responsive. Though some of the interventions may have had a therapeutic impact, this was not the primary aim.

Chapter Three reports on findings related to the experience of empathy, the most prominent theme that emerged from the whole analysis. It was separated out into the areas of; cognitive empathy, advanced emotional empathy, empathy through secure attachment, and body language. Furthermore empathy balanced with the instilling of responsibility is outlined in the management of avoidance of painful material, in which differences across therapists and clients emerged. Literature and research are compared to the findings of the present study.

Chapter Four reports on findings of the experience of deep and genuine acceptance from a broad array of clients, physically, emotionally and spiritually. Rather than limiting clients to diagnostic labels and difficult behaviours which risks reinforcing dysfunctional perceptions of self, therapists accessed, related to and accepted vulnerable and undesirable aspects of self in their clients. Sometimes this involved managing angry exteriors and understanding complex childhood experiences while being able to remain therapeutically present to their clients' cognitive and emotional experiences, non-judgmentally, and without the therapists avoiding their own uncomfortable emotions. Therapists made sense of client presentations within the context of their past. When clinical labels were found useful for their client, they were shared empathically and non-judgmentally. Clients appreciated profound acceptance immensely as they made their own well-constructed decisions around safety and disclosure based on their perceptions of their therapists' ability to handle their emotions, their stories and different shameful aspects of self.

In Chapter Five issues related to therapeutic boundaries are explored from the perspective of therapist and client. Firm, clear and at times flexible boundaries were found to be useful for clients. Reports of negative client experiences from previous therapy included the imposition of rigid boundaries, which had the potential to undermine perceived therapist empathy. In contrast unexpected 'above and beyond' behaviours that stretched outside usual parameters appeared to sometimes deepen clients' perceived empathy and trust.

Therapists' self-disclosure was also found to be important, having the potential to reduce client shame and increase trust when delivered in a manner that was client focused and brief. Problems were highlighted with therapists self-disclosing too much detail about themselves and when the issues were inadequately resolved for the therapists. Conflicting findings in the literature and research were presented in this

controversial area. Therapists also provided explanations of the separation between themselves and their clients while simultaneously maintaining emotional closeness.

Chapter Six describes key findings in the areas of power and control including goals and directions of therapy. Having a sense of control in relation to therapeutic interventions, content of therapy, pace of therapy, and goals was found to be important. Therapists differed in their level of directiveness with accessing of trauma material, however all therapists instilled a sense of choice and minimised power differential. Particularly avoidant clients were found to require and appreciate increased directiveness. Goals were often found to be broad, while sometimes they were not even made explicit. An absence of pressure to attain goals was described as important by both clients and therapists. Comparisons were made with previous literature and research in this area.

Chapter Seven reports on alliance difficulties that were found to occur even within a trusted, secure therapeutic relationship. The chapter demonstrates how easily survivors of childhood trauma can be negatively affected by an alliance rupture and highlights the importance of repair work. Therapists' empathic presence and ability to handle the discussion about the alliance difficulty without becoming reactive, while also owning a good part of the responsibility was found to be useful. It was found that there was also a place for offering a genuine apology. Instances were found with even strong alliances in which the clients were unable to bring forward the alliance issue with their trusted therapists, underscoring the necessity of therapists attuning themselves to non-verbal behaviours, and actively asking their long-term clients about the alliance.

Finally in Chapter Eight, a summary of the main findings is outlined with psychotherapeutic implications explained. Limitations of the present study are defined in areas of the parameters of qualitative research, the potential for therapists and clients to withhold information, and for clients to protect their therapists. Furthermore, possible researcher biases are made overt.

Suggestions are made for future research studies including replicating the current research project, exploring the effects of diagnostic labeling, making decisions related to therapist self-disclosure, and the effects of forgiveness and increasing clarity around when and how to apologise effectively. Finally, the concept of adapting the

areas of empathy, acceptance, boundaries, power and control and repair work when working with different ethnic groups has been highlighted.

Implications for the findings of the current research are rich and broad with the potential to improve therapeutic relationships and outcomes with survivors of childhood trauma across psychotherapeutic approaches. Strategies to improve therapists' practice of empathy, acceptance and therapeutic presence was described as well as recognising signs of and managing alliance issues. Suggestions are made in the areas of goals, boundaries, supervision, and being trained across a number of different psychotherapeutic modalities to enhance skill development and knowledge in the above areas.

ALLIANCE AND COMPLEX TRAUMA

1.0 Alliance Defined, Measurement and Progression

1.0.1 Definitions of alliance

Terms such as therapeutic alliance, therapeutic bond, helping alliance, and working alliance have been used interchangeably over the years (Bedi, Davis, & Arvay, 2005a; Horvath & Bedi, 2002; Hyman, 2011; Martin, Garske, & Davis, 2000). More recently, working alliance has been defined as the “quality and strength of the reciprocal relationship between a client and a counsellor and includes both the affective elements and the collaborative working elements of this reciprocal relationship” (Bedi et al., 2005a, p71). This included the bond between clients and therapists (liking, care, respect and trust), and the collaboration and consensus on goals and *how* these will be addressed. It was a mutual process in which both clients and therapists were involved and committed in the therapy. Working alliance was seen as conscious and purposeful (Horvath & Bedi, 2002). Bordin’s (1979) concept of the working alliance was the most commonly applied term in alliance research (Crits-Cristoph, Connolly Gibbons, & Hearon, 2006; Hyman, 2011).

Zetzel (1956) introduced the term *therapeutic alliance*, which in addition to working alliance, considered past relationships that influenced the current therapeutic encounter. Attachment Theory (Hersoug, Hoglend, Monsen, Havik, 2001; Kivlinghan, Patton & Foote, 1998; Tyrrel, Dozier, Teague & Fallot, 1999), and dysfunctional relationship schemas in Schema Therapy (Kellog & Young, 2006; Young, Klosko & Weishaar, 2003) examined how the individuals’ childhood experiences and past relationships’ experiences affected current relationships, including the one between therapist and client. A combination of both working alliance and past relationships were considered important elements when examining overall relationship factors (Horvath & Bedi, 2002).

Most authors used the terms working alliance and therapeutic alliance synonymously. However, some authors (e.g., Greenson, 1965; Hausner, 1998) asserted these should be separate definitions. Hausner (1998) specified that a therapeutic alliance needed to be established first before a working alliance was made possible. For the

purpose of this paper, the term alliance and therapeutic alliance will be used to include both working alliance and therapeutic alliance definitions.

1.0.2 Why is the alliance important in psychotherapy?

We currently live in a climate of progressive emphasis on evidence based practice to achieve symptom reduction within a limited time frame, with increasing pressure to perform to a medical model within the psychology profession (Moloney & Andrew, 2016; Norcross & Lambert, 2011). The competitiveness in striving for political gain, included proving particular therapeutic approaches as superior to others for specific diagnoses (Norcross & Lambert, 2011). Recently, clients who met prerequisite criteria for specific interventions received Medicare and insurance company rebates making psychological services more affordable, however this medical model approach fuelled competition among therapeutic orientations. It also encouraged highlighting of the *most* effective evidence based practice to guide treatment for specific conditions and manualised treatment programs. This risked simplification of the psychotherapeutic process, and overlooked the considerations for relating with each person as individuals with unique concerns (Moloney & Andrew, 2016; Norcross & Lambert, 2011).

Manualised treatment in therapy was designed to increase therapy effectiveness. Structured step by step treatment approaches were outlined for specific diagnostic criteria. However, it was the unique relationship with the individual clients that has been found to be arguably an important contributing factor to good outcome (Erskine, 2015; Hubble, Duncan, & Miller, 1999; Moloney & Andrew, 2016). As an example, survivors of childhood trauma most often present meeting multiple, rather than single, diagnoses and with numerous problems (Weathers, Keane & Foa, 2009), and hence these clients frequently have a more complicated path to recovery and do not fit neatly into simple diagnostic boxes.

Wampold (2001) questioned whether the medical model had suitability crossing over into the psychotherapy field at all. Through meta-analyses and a review of 1100 research articles on the alliance, he concluded that 60% of the outcome of treatment was attributable to common factors, (including alliance and therapist effects), 30% to allegiance and 8% to model or technique used, giving support to the significant contribution of the alliance. Ahn & Wampold (2001) provided evidence to support the common factors approach purporting that characteristics of clients, therapists and

psychotherapy which were the same across different psychotherapeutic approaches (e.g. Insight, corrective experiences, expressing emotions, sense of mastery achieved, therapeutic alliance, client expectancies, and change processes) were significantly more important therapeutically than specific ingredients of manualised treatments, symbolising and questioning the medical model. The results supported a contextual model emphasising a focus on clients' worldview and clients' sense of meaning in the world, rather than relying on scientifically proven manualised evidence based treatment methods aimed at reducing symptomatology (Wampold, 2001; Wampold & Imel, 2015).

Meta-analyses research has affirmed an absence of support for the benefits of specific ingredients (Ahn & Wampold, 2001; Norcross & Wampold, 2011; Wampold & Imel, 2015), and unspecific variables have been shown to contribute to therapeutic change (Bohart, 2000; Messer & Wampold, 2002; Norcross & Wampold). In quantitative reviews of research and in meta-analyses, specific techniques only accounted for 5-15% of outcome variance (Beutler, 1989; Shapiro & Shapiro, 1982; Wampold, 2001). Most research has been for single diagnoses of DSM (Norcross, 2001), whereas many clients presented with a complex array of symptoms, particularly those with childhood trauma histories (Najavits, Ryngala, Back, Bolten, Mueser & Brady, 2009; Paivio & Pasual-Leone, 2010; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Norcross and Wampold asked whether it was more productive to determine who the client was rather than which diagnostic boxes they fit into.

The notion of therapeutic equivalence was first put forward by Rozenzweig (1936) through the labelling of the Dodo bird effect that states "everyone has won and all must have prizes" (Hunsley & Di Giulio, 2002, p12). Numerous meta-analyses have supported the Dodo bird effect with findings supporting that different approaches have resulted in similar outcomes (Luborsky, Rosenthal, Diguier, 2002; Wampold, Mondin, Moody, 1997). Specific techniques were seen as less important. Vandenberg and Aquino (2005) outlined three types of reactions to this outcome. Firstly, that there was a need for further controlled studies exploring variables that contributed to change (Chambless, 2002; Eysenck, 1994; Elliot, 2010); secondly, finding unspecific variables that were contributing to therapeutic change (Bohart, 2000; Messer & Wampold, 2002) such as core relationship variables (Norcross, 2002), self-disclosure (Hill & Knox, 2002), alliance ruptures (Safran, Muran, Samstag & Stevens, 2002) and relationship

interpretations (Crits-Christoph & Gibbons, 2002); thirdly, the process by which therapies affect clients, for example through acceptance (Heffner, Sperry, Eifert, & Detweiler, 2002).

Supporting alliance research findings, the American Psychological Association's (APA) Division of Psychotherapy and Division of Clinical Psychology performed meta-analyses on correlates between the therapeutic relationship and good outcomes, finding that the alliance was as significant as any particular treatment method in contributing to positive outcomes (Norcross, 2011). Outcomes guided recommendations and emphasised attending to the therapeutic relationship regularly throughout treatment, and to actively address alliance ruptures to improve the alliance and to prevent client dropout (Muran, Safran, Samstag, & Winston, 2005). Furthermore, regardless of the treatment approach being used, the therapeutic alliance needed to be addressed collaboratively with the therapists and clients to foster optimum treatment (Moloney, 2016; Norcross). Overall, there was convincing empirical evidence urging practitioners to attend to the alliance during therapy.

1.0.3 Measurement of alliance

Measurement of the alliance began in 1976 with the Penn Alliance Scales, developed from psychoanalytic knowledge (Elvins & Green, 2008). Around six further measures were developed from Greenson and Bordin's theories (Wyman, 2011). The most frequently used measure, the Working Alliance Inventory (WAI) was developed from Bordin's theory (Hatcher & Barends, 2006), by Horvath and Greenberg (1989). It contained questions in three subscales related to Bordin's three aspects of alliance; the goals, the tasks and the bond (Wyman).

Although popular and used extensively in alliance research over the past 25 years, the Working Alliance Inventory (WAI) has some limitations (Wyman, 2011). It consisted of simple questions based on rational, conscious and objective factors that gave a measure of alliance. However it did not capture the depth of alliance detail, particularly negative alliance, nor did it bridge the gap between alliance and intervention (Hatcher & Barends, 2006). To elaborate, it did not differentiate the potentiating bond, such as therapist's expectations of therapy outcome, from the appreciating bond, of therapists' feelings towards or understanding of their clients. In

other words there were complexities around the alliance that could not be addressed by this simple questionnaire (Hatcher & Barrends).

The importance of measuring clients' reported alliance has been shown through results found among clients and therapists that differed to each other when reporting on alliance (Hersoug et al., 2001; Meier, Donmall, Barrowclough, McElduff, & Heller, 2005). Research with meta-analyses has shown that the clients' judgment of alliance strength as a predictor of improved outcome was stronger than the therapists' judgment (Horvath & Symonds, 1991). Client ratings of alliance have been found to be more predictive of outcome than therapists' ratings (Castonguay, Constantino, & Holtforth, 2006; Horvath, 2001; Horvath & Bedi, 2002). In the mid-late phases of therapy, therapists' and clients' self-reported alliance became increasingly aligned and related to outcome (Gunderson, Najavitis, Leonhard, Sullivan & Sabo, 1997).

1.0.4 Progression of the alliance

The therapeutic alliance has had a reasonably complex development since first mentioned in psychoanalytic literature in the early 1900's. Differing definitions and conflicting ideas about alliance conceptualisation and the significance of the alliance within therapy, has been evident since this time and across therapeutic orientations. Discussion of the development of alliance and expansion of its meaning over time will now follow, before presenting more recent theories and models that address the therapeutic impact of the alliance.

The concept of alliance was derived from psychoanalytic theory beginning with Freud (Horvath, 2005; Hyman, 2011). Within the psychoanalytic model the alliance was noted, though not formally defined. There was emphasis on the importance of neutrality in the therapists, and an absence of therapist selves in the therapeutic encounter (Bioy, Benony, Chahraoui, & Bachelart, 2012; Kudler, Kruprick, Blank, Herman, & Horowitz, 2009). The neutrality was thought to assist the "blank screen upon which transference can be projected" and then analysed (Kudler et al., 2009, p348). Freud emphasised the need for the clients to have an attachment to the therapists as a precondition of treatment (Freud, 1963; Hatcher, 2011; Shaughnessy, 1995). Freud commented that positive feelings of the clients towards their therapists enabled treatment to progress (Freud; Shaughnessy, 1995). Furthermore, Freud's writing elaborated on the normal progression of clients' experiencing negative feelings towards the analyst.

Transference, or the unconscious process of the clients' experiencing the analyst as either his mother or father, was different to the alliance. Freud (1963) acknowledged that it was common for the patient to go through a period in which the analysts were viewed negatively by the clients. This was considered a fragile time in the relationship with risk of dropout. Freud also noted a power differential through the parental figure transference by the clients and emphasised the importance of not abusing power in the relationship.

In response to a perception that psychoanalytic therapies and behaviourism were lacking in humanness, and in particular the neutrality aspired to in psychoanalysis, humanistic psychology was developed in the 1950's, including Carl Rogers' Person Centred Therapy. Rogers' (1967, 2007) concepts partly overlapped in time and content with Freud's notion of alliance, but with a stronger emphasis on bringing yourself as therapist, into the therapeutic encounter. This contrasted with the neutral psychoanalytic stance of patient positioned on the couch with an expert analyst giving interpretations, as feelings and memories related to childhood and parent child interactions emerged (Hausner, 1998). Rogers was the first theorist to describe empathy, warmth and genuineness as essential in the therapeutic encounter (Norcross, 2002; Rogers; Weiner & Bornstein, 2009). He emphasised a strong, close, mutual relationship with the clients, with a therapist's attitude of openness and acceptance of all of the clients' values and experiences. He summarised six conditions that he believed were necessary and sufficient to allow for the process of effective therapy and positive change to occur. These were; first, the clients and therapists needed to make contact psychologically; second, the clients were vulnerable or anxious; third, the therapists were congruent; fourth, the therapists provided unconditional positive regard towards the clients; fifth, empathy and conveyance of understanding were delivered; and finally, the clients needed to have an ability to perceive and recognise the conditions of unconditional positive regard and empathy. Unconditional positive regard involved an openness with a loving attitude to all of the clients including undesirable aspects of clients' presentation. Rogers' therapeutic goals were broad and designed to increase clients' consciousness and become increasingly present in the world through congruence in self.

Rogers' (1967; 2007) notion of congruent therapists referred to the need for the therapists to be authentic and honest in themselves, not pretending or masking, rather being genuine and "integrated". The therapists needed to be aware of their own feelings

towards clients' content and of their own wandering attention, although they might not necessarily share this with the clients. Rogers reinforced the importance of the therapists using a method that was congruent with their values, or else the therapy was "doomed to be unsuccessful" (Rogers, 1951; 2012, p48).

The subtle difference between therapists maintaining their own attitudes and imposing them on the clients was highlighted. Therapists were guided to enter into the clients' world through experiencing the clients' attitudes thus enabling deeper understanding. If therapists were diagnosing or interpreting their clients this was cautioned as it could be potentially experienced as judgment by the clients, affecting the alliance negatively. Learning through experiences was considered superior rather than giving advice, diagnosing or evaluating the clients. Person centred therapists were advised not to control or manipulate the clients, rather Rogers (1951; 2012) depicted an empathic attunement with each client, sharing information to the clients such as the emerging feelings, in a sensitive manner that was attuned to the clients in contrast to benefitting the therapists (Watson & Kalogerakas, 2011). In contrast to Zetzel (1956), Rogers did not address developmental issues in therapy, though the internalised self-worth was thought to be related to internalised experiences with early attachment figures (Watson & Kalogerakas).

Zetzel (1956) extended Sterba's (1934) explanation and defined the therapeutic alliance, noting the rational, conscious aspects that the clients brought to analysis beyond Freud's emphasis on the unconscious and transference process. Zetzel made distinct the therapeutic alliance and the neurotic transference, the therapeutic alliance being more rational, whilst the neurotic transference contained resistances. She described the therapeutic alliance as intuitive and useful, and likened it to that of parent and child. The effective parent in the analyst client relationship was seen as paramount and therapeutic. In 1958, Zetzel, expanded her explanations of therapeutic alliance to include the analyst patient working relationship being a natural progression in analysis which provided stability to the clients (Shaughnessy, 1995). She acknowledged that a certain ego strength was required to enable a therapeutic alliance to develop. The alliance was a requirement for stabilising those with neurosis, helping them to handle high anxiety, to minimise acting out behaviours, and to prevent them dropping out of therapy. The stabilising effect of the alliance was considered a buffer to ego regression in sessions. It was thought to be particularly important to those clients with borderline

personality pathology, counteracting their disrupted relationships in childhood (Hausner).

Schafer (1959) expanded Zetzel's stance explaining that as the analyst gets to know the clients more deeply, the analyst builds an identification with clients through the sharing of emotional experiences, introjections and memories. This familiarity was thought to create a solid space from which to share associations. The analysts developed a sense of knowing of the clients which was necessary to deepen the understanding of the clients. This depth in relationship was similar to Winnicott's (1956) description of the alliance being like a mother with her child, and that getting to know each other more intimately occurred naturally in therapy. He described that a "calm demeanor and empathic attunement contributed to a holding environment" for clients in the 1960's (Winnicott, 1964).

Schafer (1959) emphasised the importance of the therapists themselves feeling the clients' bodily and emotional experiences to enable understanding. He described swinging between observer self and merging with the clients in order to empathise deeply, yet maintaining separateness in self. To offer interpretations without empathy was considered a risk for eliciting negative feelings in the clients, exaggerating negative transference and disrupting trust. This could occur if an interpretation was not timed correctly, was offered without feeling or was too intellectualised (Hausner, 1998; Schafer, 1959). Both Zetzel (1956) and Schafer defined the importance of the alliance as a requirement to precede analytic work. However, neither explained in depth of detail how this might occur (Hauser, 1988).

Greenson (1965) elaborated on the conditions required for an effective working alliance to be established, after hearing from clients who had had negative experiences with other psychoanalysts which had resulted in dropout and limited therapeutic progress, sometimes over long periods of therapy. He found with the exception of Zetzel's therapeutic alliance that psychoanalysts failed to give the alliance adequate attention. Greenson stressed that the working alliance was as equally important as the transference in psychoanalysis, and that progress would be hindered without it. He emphasised the active role of the clients, and the therapeutic stances required by the therapists for good working alliances to be established. The clients needed a capacity to form object relations and to be willing and able to access regressive states. During regressive states it was important for the clients to still be able to maintain a present

relationship with their therapists. Therefore the working alliance was considered to involve both rational and irrational parts of therapy, the clients forming object relations with the analysts (transference with analyst as a parental figure) while also being able to split off an observing ego, and therefore communicate feelings and words to the analysts. The clients also needed to be able to hear and understand the analysts. Except for the transference, this was all considered to be working alliance. Thus he emphasised the importance of addressing the working alliance throughout the sessions, while in or out of regressive states, while always maintaining an attitude of concern and respect for the clients.

Greenson noted that therapists had different personalities and chose to take on therapeutic stances sometimes aligned with their personality while at other times opposing. For example sometimes an easy going character would take a more rule bound approach. He simply noted that therapists varied in the way in which they were motivated, some in congruence with their personality, while others “used their patients to discharge repressed desires” (1965, p98). He contemplated which characteristics of the therapists and their therapeutic stance that would deliver good working alliances, while asserting the importance of a consistent therapist. He challenged an authoritarian, aloofness as negatively affecting the working alliance, due to the risk of the clients’ transference of a cold parent figure and therapist, therefore the therapists being interpreted as uncaring. He noted that some psychoanalysts had taken mirroring and the rule of abstinence too far in their intention to protect the transference emergence in sessions, thus affecting the clients negatively. He asserted the importance of balancing humanness and deprivation, emphasising “compassion, concern and therapeutic intent” (p100). He believed the therapists needed to behave respectfully to the clients, giving explanations rather than rigidly imposing rules and regulations on them. The caring, more compassionate approach was thought to preserve the working alliance while also using insight and a sense of work with the clients. Regardless of personality type of the analysts this was what was considered essential for good working alliance and therefore effective therapy (Greenson; Hausner, 1998). Greenson’s suggestions aligned with Rogers’ person centred conditions of humanness and genuineness. It seemed that these concerns related to the alliance were written about from early days within psychoanalysis, however the neutral, more distanced stance between therapists and

clients for many years was strongly emphasised within the therapeutic encounter within the psychoanalytic method (Paivio & Pascual-Leone, 2010).

Later Strupp (1973), a German psychologist, elaborated on client factors in the alliance, stressing the notion of clients' behavioural change that could occur through manipulating and controlling the clients to face fears in the therapist client relationship. The clients were motivated to engage through pleasing the therapists. Strupp described three ingredients needed for change in the relationship between client and therapist as; first, a helping relationship much like a parent-child relationship. It required "respect, interest, understanding, tact, maturity, and a belief that that therapy can help"; second, the use of therapeutic techniques to influence the clients, "suggestions, persuasions", facilitating open communication, "self-scrutiny and honesty", (p1), manipulation through use of rewards; and third, client factors. Some clients were naturally able to engage in the therapeutic relationship, others needed to be taught, and still others were untrainable due to an inability for insight.

Strupp (1973) valued therapists' personal qualities as important rather than a theoretical orientation as such and valued therapy both as an art and a science. In the early days of psychotherapy it was thought that if two therapists were given identical training then they would be equivalent therapists. Strupp (1978) was the first to challenge this notion, emphasising the importance of the humanness of the therapists. He thought that therapists needed to have had their own personal experiences to be able to be compassionate to their clients, otherwise they would be purely technical. Therapists' self-awareness was integral for clients' safety and therapists were considered dangerous for clients if therapists had unresolved countertransference reactions in sessions (Strupp). He emphasised compassion, "the deeply felt understanding of another human being suffering, coupled with gentleness and tenderness" (p 315) and advocated resonating with the child within the clients. He believed that the most effective therapists had strong clinical skills as well as empathic understanding and that the therapists themselves were more important therapeutically than the psychological orientation used. He did not however believe that Rogerian conditions alone were enough, asserting that empathic understanding was insufficient to navigate past the human defence mechanisms.

In alignment with Strupp (1978) Yalom in *Existential Therapy* (1980) described the humanness and transparency of the therapists' selves as important saying that,

"The therapist who is to relate to the patient must disclose himself or herself as a person. The effective therapist cannot remain detached, passive and hidden....A therapist who is to know a patient must do more than observe and listen; he or she must fully experience the patient. But full experience of the other requires that one open oneself up to the other; if one engages in the other in an open and honest fashion, one experiences the other as the other is responding to that engagement" (p411)

Later approaches by Bordin became increasingly objective about the alliance with less emphasis on humanness and compassion.

Bordin (1979) formalised and expanded Zetzel and Greenson's proposals and developed an operational definition of the working alliance involving bond, goal agreement and tasks in therapy. He emphasised the importance of purposeful goal directed activity, established together between therapists and clients, with agreement on goals and tasks, beginning early and continuing throughout therapy. Furthermore, the bond between therapists and clients enabled trust that allowed the work to proceed. He noted different types of therapy would require varying depths of bond to be successful, behaviourally oriented therapy requiring less depth of trust than more feeling focused therapies. Although acknowledging this, he made basic mention of empathy without detailed elaboration of how the therapists interacted with the clients to facilitate trust. He supported the need to address alliance strain and rupture in maintaining a strong working alliance. Bordin's emphasis was placed on the therapists' contribution to creating a good working alliance rather than characteristics of the clients (Hatcher & Barends, 2006).

During the 1970's within the psychoanalytic community, some analysts challenged Bordin's working alliance theory, and argued that it was needless. Brenner (1979) proposed that analyst interpretations were the priority (Hausner, 1998) and insisted that for the benefit of the clients all material should be analysed whatever it was, and he failed to see a purpose for alliance as a concept. He asserted if a therapist and client were getting along, then it was helpful to analyse why that was (Shaughnessy, 1995). Hausner challenged Brenner's stance by suggesting that if the therapists do not acknowledge and work with the alliance then we do not become deeply familiar with

the clients and that the therapeutic encounter lacks meaning. He emphasised that it risked being a method of introjects from the analysts rather than a mutual encounter (Hausner). Regardless of Brenner's resistance to the working alliance concept, it proceeded in psychoanalytic and other therapeutic modalities and also in research (Shaughnessy).

More recently Bordin's (1979) definition of alliance was further challenged due to the lack of attention to the relationship between therapist and client. He emphasised the alliance as the relationship in therapy affecting the goals and tasks. As a result he arguably overlooked significant relationship issues such as; humour, guilt, shame, hostility, and seductiveness (Hatcher & Barends, 2006). It was further scrutinised in overlooking the unconscious processes within the clients and the alliance, thus simplifying the alliance to purely conscious processes. Finally, Bordin conceptualised the alliance as a technique, overlooking the interaction between the alliance and technique (Hatcher and Barend). Hatcher and Barend extended Bordin's theory by emphasising the importance of collaboration between therapists and clients, such collaborative work enabling the formation of a strong alliance.

More recently, Hatcher and Barrends (2006) highlighted the interaction between intervention and alliance as fundamental, emphasising that the alliance was dependent on the intervention. How the alliance was delivered was accentuated, for example with warmth and attunement to the clients, aligning more with Person Centred Therapy and Attachment Theory. Also knowing how to deal with clients' withdrawal, and how to engage the clients in interventions were considered important, highlighting the need for collaborative tasks for the therapists and clients to engage in together. Hatcher and Barrends also wrote that the individual clients' or therapists' behaviour could affect the alliance differently. Some therapists maintained a focus to tasks well, while others were better able to tolerate clients' criticism. They also highlighted the clients' contribution to the alliance. For example, how clients differed in their ability to remain present to their painful feelings affected engagement in tasks and alliance.

Complexity in the alliance has emerged over the years, and how we engaged or reengaged with individuals in therapy, at a deeper more client specific level has been questioned (Hill and Knox, 2009). It has been emphasised in some psychotherapeutic methods (e.g., Emotion Focused Therapy, Emotion Focused Therapy for Trauma, Schema Therapy) more than others. Recent neuroscience studies now also support the

significance of factors important in the alliance (Allison & Rossouw, 2013; Siegel, 2009). Before expanding discussion in the areas of psychotherapeutic methods and research, an explanation of recent definitions of childhood trauma and common problems survivors of complex trauma frequently encountered is outlined.

1.1 Definition of Adult Survivors of Childhood Trauma

Adult survivors of childhood trauma have been renowned for high dropout rates in therapy, and were frequently labelled as having ‘borderline’ processes and being difficult to work with (van der Kolk et al., 2005). There was a tendency for mental healthcare workers and systems to “invalidate and silence” (Kezelman & Stravropoulos, 2012, p44) these individuals. Problems experienced by this client group were commonly in relationship to self and others, reinforcing the need for a strong therapeutic alliance (Herman, 2001), Paivio & Pascual-Leone, 2010; van der Kolk et al.), and therapists who managed difficulties in the therapeutic relationship effectively with clients. Furthermore, the depth of therapy and discomfort in the process of exposure work required substantial alliance to ensure initial engagement and ongoing persistence (Paivio & Pascual-Leone; van der Kolk et al.). Survivors of childhood abuse tended to present with a unique array of symptoms (Briere, 2004; van der Kolk et al.) that did not fit neatly into the DSM IV categories and as a result the definition of Developmental Trauma Disorder was developed (van der Kolk et al.). Controversy continues to exist as to whether and how to distinguish PTSD and complex PTSD are two separate and distinct categories or not for the purpose of diagnostic definition and developing trauma treatment guidelines (Cloitre, 2015; Keely, Reed & Roberts et al., 2015).

Van der Kolk and a team of trauma specialists (2005) at the Complex Trauma Taskforce of the National Child Traumatic Stress Network collaborated and developed a definition based on a complex, yet predictable pattern of behaviours, emotional responses, and cognitions presenting in adults as a result of repeated childhood abuse. The definition of Post Traumatic Stress Disorder (PTSD) as defined in DSM IV, was historically developed for acute trauma survivors and war veterans, and recognised to apply to adult survivors of childhood trauma in the 1980’s (Herman, 2001). In DSM V, some more recent additions have broadened the definition to include emotional regulation, self and interpersonal experiences (Cloitre, 2015). Developmental Trauma Disorder expanded the definition of PTSD further, applied specifically to individuals

who have experienced repeated interpersonal trauma in childhood including; betrayal, abandonment, sexual, emotional, and physical abuse, witness to domestic violence or death, or threats to the body. The subjective experience during the trauma contained a shame and fear base, with a sense of betrayal, and resulting in a giving up and a sense of defeat (van der Kolk, et al., 2005). The term complex trauma has been more commonly used over the past two decades and has been used for definition in this paper.

Van der Kolk and colleagues (2005) identified and defined a series of responses commonly encountered by these children, which were often carried through into adulthood. Characteristically these individuals tended to exhibit extreme emotional responses with avoidance behaviours. Anger and shame based feelings were thought to cause extreme discomfort with an impaired ability to emotionally regulate and self soothe, resulting in the avoidance of situations, events and experiences, so as to minimise the re-experiencing of these intense feelings (van der Kolk et al.). Survivors of childhood trauma often developed cognitive schemas portraying the world as unsafe, others as unreliable, unpredictable or dangerous, and subsequently misinterpreted events as threatening. Fear, aggression or freezing responses were used to protect themselves from perceived threat (van der Kolk et al.). Experiential avoidance was thought to be developed as an adaptive coping mechanism for the child, however often became problematic as an adult, due to interruption of accessing and transforming trauma material (Paivio & Pascual-Leone, 2010).

Childhood abuse frequently resulted in over control or under regulation of emotions. Beneath emotional over control often lay hidden high levels of distress. Clients may have had either over control or under regulation, or a swinging between the two depending on their situation. When these problems occurred in children, the developing child, teenager then adult tended to develop dysfunctional patterns of managing emotions that occurred repeatedly and caused difficulties in relationships and in general functioning. For example, it could lead to susceptibility to depression, anxiety, problems with anger management, numbness, low self-esteem and relationship difficulties (Paivio & Laurent, 2001).

Research confirmed that most survivors of childhood abuse developed an insecure attachment style (Lyons-Ruth & Jacobvitz, 1999) including difficulties with mistrust, negative beliefs and expectations about relationships (Keller, Zoellner & Feeny, 2010). These individuals often became hyperaroused easily when in perceived

threatening situations and were renowned for having problems with emotional regulation (Kinsler, Courtois, & Frankel, 2009; van der Kolk et al., 2005). These factors all impeded the development of trust in the alliance (Doukas, D'Andrea, Doran, & Pole, 2014).

Therefore trust and developing secure relationships for these clients was found to be difficult, including within the psychotherapeutic setting, however research has shown that strong alliance was possible (Cronin, Brand, & Mattanah, 2014; Keller et al., 2010; Price, Hilsenroth, Callahari, Petretic-Jackson, & Bonge, 2004). Insecure attachment styles have been shown to have the potential for change (Mc Lewin & Muller, 2006) as well as developing changes in relational interactions (Tummala, Kallivayalil, Singer, & Andreini, 2012). Managing the dance of distance and closeness in the mistrusting clients, however was known by researchers and practitioners alike to be a careful and complex task (Courtois, & Ford, 2013; Herman, 2001; Tummala et al.).

Researchers and practitioners have described therapy with complex trauma clients as “tumultuous and challenging relationships that test the client and therapist alike”, (Kinsler, Courtois, & Frankel, 2009, p83) at different times throughout the therapy process. Therapists needed to be able to work with difficult and intense relationship challenges, clients’ difficulty with trust, emotional dysregulation and neediness. Therapists need to know how to work with this in ways that were helpful and productive therapeutically (Chu, 2011).

Managed well, the therapeutic alliance provided the opportunity for secure attachment to form between therapists and clients, containment of anxiety, expression of emotions, and a space to explore relational issues and an opportunity for validation of clients’ experiences (Kinsler, Courtois and Frankel, 2009). Complex trauma treatment can then proceed to address emotional regulation through self-soothing and stabilisation techniques and then to process traumatic memories (Cloitre, Bryant, & Schnyder, 2015; Paivio & Pasucal-Leone, 2010; Rothschild, 2000). These clients can learn how to approach rather than to avoid emotion, and to tolerate difficult emotional states (Kinsler et al.; Paivio & Pasucal-Leone).

1.2 Neuroscience and Complex Trauma

Neuroscience studies are now found to support subjective findings about complex trauma survivors through medical imaging (Schore, 2012). Neuroanatomical changes in the brain development occurred in survivors of childhood trauma as a result of unmet needs in basic safety, attachment and control as children, and supported the definition of complex trauma described above with scientific evidence (Rossouw, 2012; Siegel, 2014). Differences have been found in the right brain of individuals meeting borderline personality criteria (Meares, Schore & Melkonian, 2011). Abusive environments have been found to activate the survival response in the limbic region of the brain, resulting in a constantly hyperaroused system. When the fear response was activated, the pons, amygdala, basal ganglia, hypothalamus, and pituitary and adrenal glands release corticotrophin releasing factor (CRF), adrenocorticotrophic releasing factor, adrenalin and cortisol (Rossouw, 2013). Furthermore as a result of trauma, closed feedback loops within neural systems can develop inhibiting access to the higher cortical regions of the brain (pre-frontal cortex), and inhibition of release of brain chemicals, interruption of neural pathways connectivity and neural sprouting, responsible for learning and growth (Rossouw, 2015). Areas of the hypothalamus may become wasted in the limbic area that could result in increased difficulty emotionally regulating (Bradley, Weston, Mercer, Binder, Javonovic, Crain, et al., 2011; Rossouw, 2015), and cognitive and emotional development could become interrupted (Rossouw, 2015). With survivors of childhood trauma the limbic system could also become sensitised and as a result small stresses may cause a large release of cortisol. These individuals needed to work harder in order to emotionally regulate (Siegel, 2009), and in order to down regulate the distress response activated in the amygdala (Rossouw, 2015).

Current neuroscience research is also finding objective evidence that relationships have the ability to change neurobiology through development of new pathways and changing neurotransmitter release and uptake (Cozolino, 2005; Kezelman & Stravropoulos, 2012; Rossouw, 2013; Siegel, 2012), with opportunities for growth and healing (Allison & Rossouw, 2013; Schore, 2012; Siegel, 2009, 2012). It reinforced how fundamental it was for therapists to address the alliance and to provide safety for clients within the therapeutic encounter, in order to be able to learn effectively through

regulation of the primitive fear responses that reinforce and maintain avoidance patterns (Allison & Rossouw; Siegel).

Safety was regarded as a basic requirement at the beginning and throughout every session of therapy to enable therapeutic effectiveness (Allison & Rossouw, 2013; Siegel, 2009, 2012). Through establishing safety in the therapeutic relationship, opportunities for neural growth and thriving become possible as clients moved away from survival behaviours and fixed brain patterns. Safety enabled an opportunity for secure attachment to occur through a positive relationship between therapists and clients, which was thought to open opportunities for neural firing, growth of new neural pathways, maintenance of neural plasticity and ultimately neural integration (Allison & Rossouw; Siegel). This neurobiology of attachment aligned with Attachment Theory in supporting the significance of the development of the self and identity in early years through emotional attachment in the relationship with primary caregivers (Schoore, 2012; Siegel).

According to Schoore (2009), there has been a shift in Freud's psychoanalytic theory from "an intrapsychic unconscious to a relational unconscious whereby the unconscious of one communicates with the unconscious mind of another" (p190). Trauma stemming from the empathic failure of the primary caregiver led to learned dissociation in children as a means of coping with unbearable painful feelings that are related to the child being child abused. This can result in elements of trauma being separated, and as a result the development of fragmented aspects of self (van der Kolk, 1996). Within neuroscience trauma was being shown now to be a deficit in the right brain development, with deficits in affect regulation in the limbic system (Schoore, 2009).

1.3 Complexities in Researching Complex Trauma and Alliance

Most trauma research excluded comorbidity in the selection criteria in order to improve rigour (Najavits et al., 2009). National guidelines (e.g., Australian Centre for Post Traumatic Mental Health (CAPMH), 2013) recommended Trauma Focused Cognitive Behavioural Therapy (TFCBT) and Eye Movement Desensitisation Reprocessing (EMDR) amongst other recommended treatments for PTSD. However, these have been written to apply to single incident PTSD rather than complex PTSD resulting from childhood trauma, which has been acknowledged as having more

complex requirements. The complexities of childhood trauma were simply not addressed adequately in most therapeutic guidelines (Cloitre, 2015).

Systematic, evidence-based research for treatment of adults, both men and women, for all types of childhood trauma remains limited (Foa, Keane, Friedman, & Cohen, 2009; Paivio & Nieuwenhuis, 2001; Paivio & Pascual-Leone, 2010). Evidence based research targeting treatment efficacy for PTSD began in the early 1980's after the introduction of the Post Traumatic Stress Disorder diagnostic category in DSM III. Finding evidence based practice for survivors of childhood trauma through research studies was complicated due to high levels of clients' comorbidity, which almost always resulted in elimination from selection criteria for randomised controlled studies. Narrowing goals to a set of symptoms for the purpose of standardised and rigorous research was also problematic as clients presented with complex and widespread problems that affected numerous aspects of their lives, with symptom reduction not always a priority in therapy for this cohort (Foa et al.).

Nonetheless of the empirically supported approaches developed for treating adult survivors of childhood trauma, emphasis and consensus generally has been reached around the importance of creating safety before processing traumatic memories, developing emotional regulation and enhancing a sense of self (Courtois & Ford, 2013; Herman, 2001; Kinsler, Courtois, & Frankel, 2009; Paivio & Pasucal- Leone, 2010; Valory, 2007). Sometimes approaches were heavily focused on accurate and comprehensive assessment and treatment methods aligning with a medical model, and the alliance tended to be overshadowed (e.g., Weathers, Keanne & Foa, 2009). Other trauma specialists were beginning to give increasing focus to the alliance as a treatment strategy (Cloitre, Bryant, & Schnyder, 2015; Courtois & Ford, 2013; Elliot et al., 2004; Paivio & Pascual-Leone) however they often assumed required levels of therapist skill in developing an alliance and delivering empathy with the clients, with the main emphasis on specific treatment techniques (e.g. Cloitre, et al., 2015; Courtois & Ford; Hayes, Strosahl, & Wilson, 2003). Details of how the alliance may be managed with this complex cohort was less often explained or researched.

Only a few studies have examined broad client groups for subjective experience of the alliance (Bedi, 2006; Curtis et al., 2004), asking clients what they considered as important, and with survivors of childhood trauma this was even rarer. Survivors of

childhood trauma had complex presentations and multiple problems. They were highly sensitive to relationship dynamics and presented with high dropout rates in therapy (Paivio & Pascual-Leone, 2010; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005) highlighting complexities in the therapeutic alliance with this cohort.

From a Functional Analytic Point of View (FAP) any intervention or meaningful self-disclosure or goal agreement could be relevant, however what mattered in these interventions was the functional relations between what the therapists and clients did (Vandenbergh & Aquino, 2005). The influences between therapists and clients were considered bi-directional and integral in considering what it was that made the treatment work, and how, and was related to therapists' responsiveness and clients' behaviours. This involved complex relationships that were idiosyncratic (particular to the individual) and difficult to predict (Vandenbergh & Aquino). This concept aligned with the importance of attunement and tracking of the individual clients as emphasised in Emotion Focused Therapy (Elliot, Watson, Goldman & Greenberg, 2005; Greenberg, Rice & Elliot, 1993; Paivio & Pascual-Leone, 2010) and Attachment Theory (Bowlby, 1988).

1.4 Attachment Theory, Alliance and Complex Trauma

Whereas neuroscience is concerned with the neural connectivity, Attachment Theory addresses the behavioural and emotional responses of the child (Rossouw, 2015). It describes the development of secure or insecure attachment depending on the child's early attachment experiences with primary attachment figures. Attachment Theory was originally developed in the 1970's by John Bowlby, Ainsworth and Main (Kezelman & Stravropoulos, 2012). Bowlby's (1988) original definition emphasised the need for all human beings to feel attached and be comforted by significant others in early childhood which then shaped the emotional development and wellbeing of the child. For example, if a distressed child called for his primary caregiver and did not receive a response, then the child could become increasingly agitated and stressed and desperately and noisily try to alert a response. Eventually if no response occurred, he would give up, become silent and disconnect. This signal of calling out was a survival mechanism. If the adult responded in a comforting and gentle manner the child most likely developed into a confident individual, who trusted others and confidently explored the world, whilst also learning to be empathic. A parent who responded

begrudgingly and perhaps in a delayed time, produced a child distrusting that reliable attachment figures would be available, and thus became anxious and ‘clingy’ to the caregiver, not trusting that they would respond when they needed them. Alternatively, if the parental figure behaved in such a way as to reject the child, avoidance patterns of behaviour mixed with anger and a confusion of wanting contact while at the same time avoiding it, emerged in the child (Bowlby).

These insecure attachment styles were named anxious ambivalent and avoidant respectively by Mary Ainsworth through her Strange Situation research procedure in which infants were separated from their parent for a short period of time, and their responses were examined when the child was reunited with the mother. Ainsworth (1979) developed the categories of secure and insecure attachment (anxious ambivalent and avoidant) from these early studies (Ainsworth; Bowlby, 1988). Mary Main later in the 1990’s added a disorganised insecure attachment category (Kezelman & Stravropoulos, 2012).

Neuroscience studies have now confirmed the longevity of attachment styles from childhood into adulthood (Kezelman & Stravropoulos, 2012). A secure attachment to a therapist can enable insecurely attached clients to confront emotionally painful experiences rather than avoid them (Holmes, 2014; Paivio & Laurent, 2001). Insecure types had difficulties with trust and relationships. Insecure ambivalent adults tended to be fearful of closeness to others in relationships, with concern that they were unloved by the other and so found ending relationships extremely upsetting. Avoidantly attached adults had difficulties with intimacy also presenting as emotionally distant and withholding of thoughts and feelings (Holmes; Mikulincer & Shaver, 2007).

From an integrative approach it was thought that this same attachment system occurred between therapists and clients. Distressed clients came to seek a secure base. A secure attachment enabled insecurely attached clients to confront emotionally painful experiences rather than to avoid them. The therapists provided a haven with security for exploration (Holmes, 2014; Johnson, 2004). This was the creation of the therapeutic relationship (Holmes). The therapeutic environment facilitated clients’ openness to express their emotional experiences, to which the therapists gave comfort, reassurance and soothing support, facilitating emotional regulation (Elliot et al., 2005; Holmes; Johnson; Paivio & Laurent, 2001). This occurred at the beginning of therapy and

throughout. The therapists responded during the session to heighten clients' arousal, while also soothing the clients through empathy, and so acting as a secure attachment figure for the clients (Elliot et al.; Holmes; Paivio & Pascual-Leone, 2010).

The therapists' alliance was thought to be similar to a good mother attuned closely and sensitively to her child, responding with warmth and empathy, with respect and acceptance of all aspects of the individuals. Whilst tracking closely and attentively the clients' experiences, the therapists also managed clients' avoidance through gentle redirection. The clients and therapists shared the lead depending on where the clients were at. Patience and compassion were given to the clients if they expressed attachment distress reactively, for example during periods of therapists' absence, and this was explored non-judgmentally (Bowlby, 1988; Elliot, 2005; Paivio & Pascual-Leone, 2010). The therapists were guided to make their final decisions related to boundaries around affection and contact outside sessions, so as to meet the needs of the clients whilst also protecting them from misconstruing sexual intent (Bowlby).

According to Attachment Theory a secure base was thought to be dependent partly on the therapist's ability to provide a secure base but also on the clients' attachment system (Bowlby, 1988; Mikulincer & Shaver, 2007). A positive association has been found between clients' secure attachment and session exploration (Mallinckrodt, Porter & Kivlinghan, 2005). More secure clients were better able to manage anxiety in new situations and were more open to self-disclosure and exploration in the therapy process (Bowlby; Mikulincer & Shaver). They have also been found to integrate material from the past more effectively and to recall clearer relationship histories (Mikulincer & Narchshon, 1991). Therefore, when working with survivors of childhood abuse with insecure attachment, additional attention was needed related to the alliance due to past experiences interfering with the clients' ability to develop trust. The therapists needed to carefully and skilfully facilitate a safe therapeutic space to enable exploration and transformation of painful material (Allison & Rossouw, 2013; Elliot et al., 2005; Paivio & Pasual-Leone, 2010; Siegel, 2009).

Children who experienced repeated trauma were significantly more likely to present as insecurely attached as a result of primary caregivers being unavailable and/or abusive during childhood (Carlson, Cicchetti, Barnett, & Braunwald, 1989). As a result of insecure attachment these individuals were more likely to have difficulties opening

up in the therapeutic relationship, disclosing distressing material (Mikulincer & Nachshon, 1991), and forming strong bonds (Paivio & Pascual-Leone, 2010), thus interfering with their ability to access and transform childhood trauma material. Correlation and regression analyses showed securely attached individuals, those who were more at ease with closer, more intimate relationships, were more able to trust others and develop stronger alliances. Conversely, fearful, anxious, avoidant and dismissive clients had greater difficulty trusting and depending on others, thus developing weaker alliances (Bachelor, Laverdiere, Meunier & Gamache, 2010; Eames & Roth, 2000; Mallinckrodt et al., 2005).

Therapists bring their own attachment styles into therapy, both secure and insecure attachment styles. Avoidant therapists have a greater tendency to deactivate during attachment need (Diamond et al, 2003; Holmes, 2014) and more commonly anxious ambivalent therapists hyperactivate (Holmes). Therapists need to adapt their attachment stance for the presenting clients, initially to attune to the clients and later in a more challenging growth enhancing way. For example, therapists may have been more intellectual with an avoidant client initially until they became increasingly able to express emotions in therapy (Holmes; Mallinckrodt et al., 2005). Anxious clients may have been given more boundary flexibility initially, then tightened and challenged once alliance and security was established (Holmes).

Tummala et al. (2012) suggest that the dance in tension between anxiety related to relationships and the desire for closer connection was ever present when working with complex trauma clients. Some psychotherapeutic approaches (EFT, EFTT, Schema Therapy) have integrated Attachment Theory into their models and provided some guidelines on how to work with clients with insecure attachment styles in the therapeutic encounter.

1.5 Alliance and Complex Trauma Guidelines

As well as using interventions in trauma healing the alliance has been increasingly recognised as being therapeutic in and of itself, as a ‘vehicle of change’ (Kinsler, Courtois & Frankel, 2009, p187) and is gaining increased attention in complex trauma models, though they continue to be brief (e.g., Courtois & Ford, 2013; Kezelman & Stravropoulos, 2012; Kinsler et al., 2009). The Adults Surviving Child Abuse (ASCA) guidelines were written in Australia in 2012 as a guide for practitioners

working with survivors of childhood trauma, developed by 27 trauma specialists and four trauma based organisations, worldwide. Safety, affect regulation, attachment and developmental deficits were highlighted. It was now consistent across trauma therapy models to initially stabilise the client through creating safety and secure connection before commencing trauma memory work (Herman, 2001; Kezelman & Stravropoulos, 2012; Kinsler et al., 2009; Pavio & Pascual-Leone, 2010).

Five key domains were outlined in the ASCA guidelines; safety, trustworthiness, choice, collaboration and empowerment. The alliance was explained broadly asserting a caring, respectful attitude from all staff with clear rationale and goals, and was considered an “essential component of psychotherapy” (Kezelman & Stravropoulos, 2012, p84). Collaboration with the client and maximisation of control given through choices in appointment times were advised. A sense of mutuality was encouraged rather than an expert stance as therapists, while empowering the clients as experts of themselves. Listening effectively was also asserted. Therapists were guided to be aware of boundaries and of their own self care through mindfulness practice to assist in making decisions such as handling client affection and sharing of personal information. These issues were ‘red flagged’ as important, as well as the need to attune to attachment issues. However, minimal detail was given related to how to deliver the alliance recommendations. It was assumed that therapists knew what to do in all of these areas. Empathy was not emphasised specifically, however a caring attitude was delivered in the manner in which the document was written.

Courtois & Ford (2013) emphasised humanness, responding to each client as unique and being flexible with interventions, although not foregoing them altogether, or too much. Empathic attunement through verbal and non-verbal body language and voice was mentioned as important. A differing empathic ability was recognised amongst therapists and supported by research. Accurate empathy, not too much or too little for the clients was reinforced with empathic errors seen as potentially harmful to the alliance. Therapists were encouraged to manage the dance of distance between themselves and their clients, which may change over time with increasing trust (Courtois & Ford). The importance of repairing any alliance ruptures was advised as trauma clients could have strong reactions and dropout if they were unattended to (Courtois & Ford; Kinsler, Courtois, & Frankel, 2009).

Kinsler, Courtois and Frankel (2009) contributed a whole chapter of their evidence based approaches book on the alliance when working with complex trauma. Non-judgmental therapists were guided to avoid blaming or judging clients of their manipulative behavior or symptoms but rather to understand them as emerging from a context where these behaviours in childhood as a means of coping and protecting themselves. Therapists were guided to 'contain rather than react' to their clients (Kinsler, Courtois, & Frankel, 2009, p97).

Kinsler, Courtois and Frankel (2009) cautioned therapists not to 'rescue' clients and to maintain clear and firm boundaries so as not to develop an unhealthy dependency or boundary less clients who rang while therapists were on leave, at all times of the day and night and with endless suicide calls. These therapists were thought to be at risk of burnout and/or acting out reactively to the clients. Advice was given to protect the therapists through taking a firm stance. Therapists were encouraged to give clients boundaries and to take responsibility for their feelings and actions with less emphasis on empathy than in other researchers and practitioners (e.g. Elliot et al., 2004; Paivio & Pascual-Leone, 2010). Therapists needed to be able to manage their own feelings during the trauma work also, often being exposed to self-harm behaviours and invalidation of self in sessions which could cause vicarious traumatisation (Kinsler, Courtois and Frankel, 2009).

The therapeutic alliance was often not made explicit when describing empirically supported treatment interventions for complex trauma, however was sometimes demonstrated through case examples and it was assumed that the therapists would envelop the warmth, kindness and understanding in their interaction with their clients. Some therapists were more direct with drawing out trauma content whereas others waited for their clients to bring the trauma out (Cloitre et al., 2015). More recently, the alliance was gaining increased attention and focus in trauma based approaches, however it was often overshadowed by method, and incorporated a few factors relevant to the alliance, mentioned only briefly. (e.g. Courtois & Ford, 2013). Therapists were encouraged to be open and responsive to each individual and to treat each relationship as unique. Working flexibly and collaboratively while problem-solving, so as to meet the individual clients in a 'customised' way was advised by researchers and experts in the field (Elliot et al., 2004; Kinsler, Courtois, & Frankel, 2013; Paivio & Pascual-Leone, 2010).

In more detail, Briere and Lanktree (2012) outlined the importance of maintaining safety in the alliance when working with youths and young adults through being aware of being non-intrusive of showing visible positive regard, being reliable and stable through being available and on time; being transparent, dealing with transference issues to ensure the therapy was about the clients and that therapists managed their own internal experiences and emotions. A willingness to understand and to accept the clients through attunement, empathy and acceptance, and being patient while connecting emotionally was supported (Briere & Lanktree, 2012). They asserted the importance of genuine empathy though did not have the scope for depth or detail on how to achieve this.

Firm, clear boundaries generally were asserted within trauma guidelines (Kezelman & Stravropoulos, 2012; Kinsler, Courtois and Frankel, 2009) however, Gutheil & Brodsky (2008) gave support to the importance of therapists' transparency and flexibility through their qualitative enquiry with complex trauma clients in which the therapists agreed to shake the hand of a client who requested a hug. Generally though, therapists were cautioned to enforce boundaries strictly with this client group to protect themselves and their clients.

1.6 Psychotherapeutic Approaches and Complex Trauma

1.6.1 Trauma Focused Cognitive Behavioural Therapy

Trauma Focused Cognitive Behavioural Therapy has been a growing area of research in the past 10 years (Galovski & Gloth, 2015). Different interventions have been examined in therapy to compare outcomes with PTSD symptoms within time limited therapy (usually 9-12 sessions) targeting specific goals. Numerous evidenced based studies have found support for the effectiveness of Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Cognitive Therapy (CT) in alleviating symptoms of depression and PTSD. Prolonged Exposure developed by Foa and Kozak (1986) involves a theory of emotional processing which describes how fear structures are reactivated upon cues from external stimuli which are similar to the actual trauma event. These fears are thought to require processing through activation of the fear within a safe environment. Breathing to manage anxiety, and an exposure based therapy with either exposure to the actual stimuli (in vivo) or accessed through guided imagery, gives

access to the emotions to enable processing. From here, a corrective experience and new information can be gained.

Prolonged exposure has been found efficacious in the treatment of PTSD in a number of random controlled studies comparing treatment groups with waitlists or minimal treatment groups. For example, Feske (2008) examined the clinical effect of PE compared to a usual treatment group with 21 clients who suffered physical and sexual assault. They found that significant improvements in symptom reduction were gained in the treatment group only. Nacasch, Foa, Huppert, Tzur, et al. (2011) compared 30 survivors of combat or terror and found similar results.

Cognitive Processing Therapy developed by Patricia Resick (2010) envelops meaning making into the cognitive component to understand and resolve the development of PTSD. In this therapy clients are guided to recognise unhelpful thoughts and beliefs that can become fixed as a result of the traumatic incident. For example, blaming oneself for the rape or viewing all men as dangerous. Together the client and therapist challenge these thoughts through the use of Socratic questions (Galovski & Gloth, 2015). Emotion may be processed as it arises through this process, however it is not emphasised. CPT effectiveness has been shown in studies of survivors of rape (Resick, Nishith, Weaver, et al., 2002; Resick, Williams, Suvak, et al., 2012), military veterans (Monson, Schnurr, Resick, et al., 2006) and in military survivors of sexual assault (Chard, 2005; Surís, Link-Malcolm, Chard, et al., 2013) when compared with waitlist or supportive psychotherapy groups.

Numerous studies have examined more general CBT interventions as a means to reduce symptoms of PTSD including psychoeducation, coping strategies, relaxation strategies, exposure, cognitive therapy, and behavioural interventions with survivors of car accidents (Beck, Coffey, Foy, et al., 2009), survivors of combat trauma (Schnurr, Friedman, Engel, et al., 2003) and survivors of interpersonal trauma (Kubany, Hill, Owens, et al., 2004; Mc Donagh et al., 2005). Occasionally studies found more functional outcomes including improvements in overall psychosocial functioning through exposure therapy (Falsetti, Erwin, Resnick, et al., 2003).

One of the concerns with the CBT interventions has been the high levels of client dropout rates. A meta-analysis by Swift and Greenberg (2014) determined dropout rates for clients receiving treatment for PTSD. Whilst undergoing CBT

treatment, 28.5 per cent of clients discontinued, for PE 23.2 per cent and for CPT 23.2 per cent. Integrative approaches, EMDR, relaxation training, CT, and supportive approaches were somewhat lower at 12 to 17 per cent. This difference is thought to be as a result of the exposure involved in CBT, PE and CPT approaches (Swift & Greenberg, 2014).

1.6.2. Mindfulness

Mindfulness involves coaching of the clients in the skill of noticing present moment thoughts, feelings and behaviours with an attitude of acceptance and non-judgment. It entails an allowing of the experience to be there rather than avoiding it. It was therefore thought to be applicable to trauma clients (Siegel, 2014) who frequently had patterns of avoidance of painful and uncomfortable present moment experiences.

Mindfulness originated in Buddhist tradition, being thousands of years old (Kabat-Zinn, 2003). It involved a focus of attention on the present moment, a non-judgmental awareness, and a remembering to be aware (Kabat-Zinn; Siegel, 2014; Thich Nhat Hahn, 1987). It overlapped but differed from Carl Rogers' notion of being present with the clients and their experiences that encouraged the therapists to reflect back these experiences of their clients, in the moment, with a profound depth of acceptance (Siegel). Researchers have differentiated two aspects of mindfulness; facilitation of the clients becoming aware of themselves in the moment, with an attitude of acceptance of that present experience and increased noticing of mental events. Secondly, it involved an attitude of interest and curiosity with an acceptance and openness (Bishop, Lau, & Shapiro, 2004).

Mindfulness practice was thought not to be able to be taught without therapists practising it themselves (Kabat-Zinn, 2003). Although there has been no empirical evidence of the association between the alliance and mindfulness (Wyman, 2011) it has been hypothesised that this would increase therapists' capacity to be remain present with uncomfortable feelings and to be less avoiding and more able to tolerate painful bodily sensations and in this way improve affect tolerance of the therapist during therapy. This enabled the clients to be able to be more present with thoughts, images or bodily experiences rather than to avoid them (Hayes, Strosahl, & Wilson, 2003). Without avoidance the bodily experiences and emotions were noted to come and go, once fully experienced. Emotions were thought to be less powerful and short lasting

when unaccompanied by thoughts. Mindfulness helped us to distance from our thoughts, and to focus on the conscious awareness (Hayes et al., 2003; Kabat-Zinn), whereas Cognitive Behavioural Therapy (CBT) attempted to separate and to change thoughts. Mindfulness and Acceptance and Commitment Therapy (ACT) guided practitioners to create distance from and to observe thoughts and as such individuals learned to be more present to painful feelings without the accompanied thoughts intensifying and exaggerating their experiences (Siegel, 2014) which could be overwhelming. Hidden aspects of selves may then have emerged within this therapeutic space (Siegel, 2014). Characteristic of mindfulness based practice was an involvement with non-attachment to outcome, a rarely encouraged concept in our time limited evidence based world (Kabat-Zinn).

Research has supported the therapeutic benefits of mindfulness for conditions such as anxiety and relapse prevention in depression (Baer, 2003) and more recently one study of childhood trauma and dissociation (Perona-Garcelán, García-Montes, Rodríguez-Testal, et al., 2014). Mindfulness has been incorporated into some therapeutic approaches (e.g., ACT; Dialectical Behaviour Therapy (DBT) whilst also having the potential to be integrated into most psychotherapeutic approaches.

1.6.3 Acceptance models and validation of clients

Acceptance models have been supported by empirical research generally (Hayes, Strosahl & Wilson, 2003). Through acceptance of clients' feelings, there is no need to hide, dissociate, defend or exclude them from awareness (Kinsler, Courtois and Frankel, 2009). In some models such as DBT and ACT acceptance has been emphasised heavily as a therapeutic stance. However, further research was required in knowing "how best to establish acceptance or the best conditions under which to use these strategies" (Hayes, Strosahl & Wilson, 2003, p282).

Linehan (1993) developed the DBT treatment for Borderline Personality Disordered (BPD) clients finding empirical support for its effectiveness with this cohort (Harned, Korslund, Foa, & Linehan, 2012) and emphasising the alliance as particularly important with these clients. Although not designed specifically for complex trauma it is now known that most clients with BPD have experienced childhood trauma (Middleton, 2012). In DBT, Linehan (1993) addressed the various stages of treatment, taught self-regulation, mindfulness, skills training and used exposure for memory work. Linehan

emphasised validation of the clients' emotional experiences as essential in alliance building. If the clients' subjective experiences were accepted and understood, it assisted the clients to handle experiences that were usually unbearable. It also contributed to hope in the midst of anguish and despair. The emotional experiences were normalised within the context in which they occurred past and present. Validation could relieve distress and loneliness and soften self-blame. It was a platform for problem-solving. All of this was thought to grow the therapeutic alliance and consequently clients' engagement in treatment (Schechter & Goldblatt, 2011).

ACT also emphasised acceptance. From an ACT perspective alliance was defined as an "equal, vulnerable, genuine and sharing point of view" (Strosahl, Hayes, Wilson, & Gifford, 2004, p53). It provided a stance between self and other that may be 'curative', and gave an opportunity to model acceptance of another through loving feelings, respect and openness. When done effectively, ACT relationships were said to be "intense, personal, and meaningful" (Hayes, Strosahl & Wilson, 2003, p280). There was an absence of "arguing, lecturing, coercion or convincing the client" (Hayes, Strosahl, Wilson & Gifford, 2004, p53). Good alliance was thought to assist in the delivery of the ACT interventions; the exercises, paradoxes and metaphors applied within treatment (Hayes, Luoma, Bond, Masuda & Lillis, 2006; Hayes, Strosahl & Wilson, 2004).

ACT is a behavioural intervention which involves addressing experiential avoidance through the use of mindfulness and acceptance to increase effective client action in line with goals (Follette, La Bash, & Sewell, 2010). Acceptance is developed partly through mindfulness practice. Acceptance of painful thoughts and feelings are thought to lead to increased behavioural flexibility. Exploring clients' values guides the clients towards meaningful action (Follette et al., 2010).

ACT has been thought to be appropriate to trauma clients due to the interventions focused on managing avoidance behaviours and feelings, and through the accepting stance of the traumatic narrative (Varra & Follette, 2004). The therapists' acceptance of the traumatic experiences of the clients gave an opening to disclose further details of the abuse without fearing judgment or therapists' avoidance. Therapists need to manage their own desires to avoid painful material that would interfere with clients' progress. In ACT done well the therapists are also aware of and

manage their own desires to direct the clients in particular directions (Follette et al., 2010).

Linehan's (1993) mindfulness, interpersonal effectiveness, emotional regulation and distress tolerance skills in DBT were thought to be a useful adjunct to ACT if the client was emotionally dysregulated or was at high risk of retraumatisation. ACT aligned heavily with CBT in the emphasis on cognitions impacting on dysfunctional behaviour. It was a top down approach that was reliant on client willingness to change. The alliance was thought to be important in client motivation and engagement in treatment (Varra & Follette, 2004).

Kohut (1984) in Self Psychology valued validation as an important factor to enable the growth of self, highlighting therapists' empathic understanding and acceptance of the clients' experiences as important. Validation of the clients' contribution to self acceptance was elaborated (Schechter & Goldblatt, 2011). Kohut's work was expanded in Schema Therapy (Young, Klosko & Weishaar, 2003), an approach also designed for Borderline Personality Disorder (BPD) and Narcissistic Personality.

1.6.4 Schema Therapy

Schema Therapy was developed by Dr Jeffrey Young in 1990 to provide a framework when working with Borderline Personality Disorder and Narcissistic Personality. These clients were thought to be more complex to work with using general cognitive behavioural methods due to their fixed cognitive patterns and resistant negative beliefs related to self, usually stemming from childhood trauma (Kellog & Young, 2006). Young's work followed Kohut's Self Psychology, which emphasised the disruption to the development of self as a result of childhood trauma. Young examined the disruption to the early development of self and how this emerged in adulthood as personality pathology (Kohut & Rogers). His schemas involved interferences of individuals' behaviour and thoughts related to their sense of self and how they presented themselves in the clients' world as adults (Kellog & Young).

Personality disorders were seen to complicate the therapeutic alliance, creating complexities in gaining trust, and making accessing of memories through exposure work more difficult. In Schema Therapy when working with Borderline Personality Disorder, compassion for the individuals was highlighted especially during times of

crisis, in contrast to therapists attempting to control the destructive behaviour, which could elicit a sense of abandonment, lack of perceived care, and a risk of either dropping out of therapy or exhibiting acting out behaviours. It was assumed that therapists knew how to be empathic, and that some therapists were more empathic than others (Young et al., 2003).

With Narcissistic Personality Disorder therapists were guided to set assertive limits with the clients if they behaved in such a way that devalued the therapists, similarly to disciplining a child. Empathy was emphasised here also, however was balanced with direct feedback to the clients, carefully conveying how their self-centred behaviour could be impacting on others. Empathy used during confrontation to the entitled behaviour was thought to assist the clients to hear feedback and in feeling understood (Young et al., 2003).

Therapists were encouraged to display their own vulnerability to the clients as role models in the alliance in this model. Therapists' vulnerability relevant to emotions emerging naturally in sessions, without the therapists breaking down or expressing too much vulnerability too soon, which may be perceived as weakness by the clients, was thought to be beneficial to the alliance. Working through of resistances, for example when asked to access imagery of a childhood memory, was implemented gently and persistently (Young et al., 2003).

Kohut described the importance of the effect of mirroring for the clients when sitting in front of therapists. The therapists did not make it happen, it was allowed to emerge as part of transference of "revival of an early self-object tie" and was to be accepted and explored (Kohut & Rogers, 1985). There was an absence of power domination or overt expert stance from the therapists. Emotional Schema Therapy, a more recent adaptation to Schema Therapy, although supporting the diagnostic categories, generally cautioned against pathologising clients judgmentally and encouraged understanding of the human experience (Leahy, 2015).

Emotion Focused Therapy (EFT) was incorporated in Schema Therapy, however EFT emphasised more depth of empathy as an intervention and as a psychotherapeutic stance from which to implement the tasks in interventions.

1.6.5 Emotion Focused Therapy

Emotion Focused Therapy (EFT) is an integrative therapy which blends person-centred, gestalt and existential therapies, and was developed by Greenberg, Rice, & Elliot, (1993) from 25 years of process research and was designed to assist individuals to understand, access and transform emotions linked with unprocessed experiences, and to increase emotional intelligence (Elliot et al., 2005). The approach has taken a person centred, relational stance with exploration of client experiences within a safe, non-judgmental space. Previously inhibited emotion is accessed for experiencing and expression to assist clients with transforming emotions and to assist in finding meaning in their experiences, which facilitated growth and change. Within this approach, the alliance is considered a task in itself, guided by task specific markers (Elliot, et al., 2005). For example, clients' vulnerability is addressed through empathic conjecture. A chapter titled *Empathy and Exploration* guided the practitioner to the importance of empathy as an active ingredient to facilitate change, a stance from which to increase understanding and exploration of worldviews, and to help clients to emotionally regulate. This stance was also used to enhance alliance through promoting safety (Elliot et al., 2005). Elliot et al. (2005) also addressed alliance formation problems through the use of marker identification and steps guided towards repairing of ruptures.

Empathy and attunement to clients' experiences, stemming from humanistic Person Centred Therapy (PCT) originally was integral in client therapist interactions (Elliot et al., 2005; Greenberg, Watson, & Bohart, 2001; Paivio & Pascual-Leone, 2010). Greenberg, Watson, and Bohart (2001) summarised,

“Empathic therapists assist clients to symbolise their experience in words, and track their emotional responses, so that clients can deepen their experience and reflexively examine their feelings, values and goals. Therapists need to help clients access as much internal information as possible. To this end they need to attend to what is not said, or what is at the periphery of awareness as well as what is said and is in focal awareness” (p383)

Paivio & Pascual-Leone adapted Emotion Focused Therapy for Trauma (EFTT) to specifically address the needs of survivors of childhood trauma. EFTT is an empirically supported treatment based on process research, specifically tailoring therapy to male and female survivors of all types of childhood trauma and neglect. It was developed through more than 20 years of change process research (Paivio & Laurent, 2001; Paivio & Pascual-Leone, 2010). Its focus on the therapeutic relationship is based

on empathy and responsiveness, and exposure based tasks for resolving issues with perpetrators, often attachment figures (Paivio & Pascual-Leone, 2010). As well as trauma knowledge, EFTT is grounded in current emotion theory and research, as well as neuroscience (Paivio & Kunzle, 2007).

Similarly to DBT and ACT, EFTT also addressed acceptance of internal experiences and exposure to them, and heightening of insight into emotional states using a non-judgmental stance. However, EFTT differs in that it strongly emphasises and incorporated empathy as a means to assist the clients to self soothe and to emotionally regulate, rather than teaching the clients skills to manage feelings. It also has a stronger focus on making sense of and finding meaning in the experiences and the impacts of trauma on the self, rather than having a goal of habituation and basic acceptance of the internal experience as described in ACT and DBT (Paivio & Pascual-Leone, 2010).

Recognising that relationship problems between self and others were frequently experienced by survivors of childhood abuse, Paivio & Pascual-Leone (2010) developed a chapter of their four phase approach on the alliance. The depth of therapy and accessing of distressing material required to process traumatic experiences was thought to require a strong alliance to enable trust, engagement and persistence with this complex client group (Paivio & Pascual-Leone).

The first three sessions of EFTT are focused on developing an empathic, collaborative therapeutic relationship. This was intended to facilitate a safe space in which to explore past experiences of trauma, likely to evoke difficult memories, emotions and sensations. The safety within the therapeutic encounter was thought to counteract fear around beliefs and emotions related to trauma as being harmful. It also provided a corrective opportunity for childhood attachment injuries (Paivio & Pascual-Leone, 2010).

Paivio and Pascual-Leone (2010) emphasised that the alliance needs to be attended to throughout therapy and integrated into each intervention. The bond and the collaboration of the goals with a high level of empathy applied non-judgmentally to the client were also stressed. This allowed for emotional regulation and emotion processing at the optimum level of arousal, providing a comfort and support and a sense of togetherness, in contrast to isolation frequently experienced in childhood trauma.

Validation normalised clients' experiences within the context of the trauma, and this counteracted a sense of being flawed, which was often internalised in this client group. Therapists were guided to explore clients' experience tentatively and to attend responsively with empathy and validation (Paivio & Pascual-Leone).

EFTT also focused on attending to subjective internal experiences, consistent with trauma treatment generally. This focus allowed for opportunities to access new information from traumatic experiences, including exploration and transformation with the emergence of new meaning and more positive perceptions of self (Briere, 2004; Elliot, et al., 2005; Paivio & Pascual-Leone, 2010; van der Kolk, 1996). It also encouraged an attitude of acceptance, which differed to DBT and ACT because their emphasis was to teach acceptance based strategies, to manage and minimise avoidance of internal experience rather than a focus on therapists accepting stance (Paivio & Pascual-Leone, 2010).

Studies involving masters and doctoral students as therapists have shown positive outcomes in EFTT with survivors of childhood abuse. Paivio and Nieuwenhuis (2001) found significant positive effects with 33 clients across numerous categories with follow up gains lasting at least six months post treatment. Therapeutic alliance and emotional engagement were found to be related to better outcome in EFTT using imaginal confrontation (IC) (Paivio & Nieuwenhuis, 2001). Furthermore Paivio et al. (2010) compared outcomes with IC and empathic exploration (EE) exposure techniques in EFTT among 45 clients who were found to maintain lasting significant gains in a randomised controlled trial. Dropout rates were higher for IC (20%) compared to EE (7%). Although EE and IC were found to have similar levels of experiencing, client engagement and subjective client distress, EE had lower emotional arousal levels than IC. Although EE may appear as a preferred method, IC was considered a superior method by Paivio and Pascual-Leone (2010) as it was thought to "evoke more multimodal experiential memories" (p173) accessible for processing and change. The structure and originality of IC may have assisted with remembering and processing post session. EE was recommended as a default method if the client refused IC, or if the client was unable to manage distressed feelings or dissociation. With either method, a strong alliance was considered fundamental. The client needed to be given choice, however sometimes needed encouragement to persist, and the alliance preceded specific techniques at any stage throughout the process. As such the therapist was required to be

flexible and to interrupt an intervention, and modify it in order to attune to the clients in the moment (Paivio & Pascual-Leone).

Further research is required to investigate clients' experiences during trauma based therapy (Middleton, 2012). Process research examines what happens in therapy in contrast to what happens after therapy (Hill & Knox, 2009). This may involve therapists' behaviours, clients' behaviours and the relationship between the therapists and clients during treatment. This is a useful way of researching what specific clients respond better to, answering the question of how we improve or 'develop' the alliance (Hill, 2005). Overall, empirical studies are required to substantiate and expand humanistic and experiential theories to continue to deepen knowledge on change processes and on what it is in the alliance that allows therapy to occur therapeutically (Elliot, 2010; Paivio & Pascual-Leone, 2010).

With complex trauma clients, Paivio & Pascual-Leone (2010) emphasised early alliance difficulties including problems developing a secure attachment due to therapists' lack of 'warmth and intimacy' (p124). With this cohort acknowledgement was given for a disrupted attachment history explaining some difficulties in establishing an alliance, however the emotionally distant stance of the therapist was highlighted as being problematic. Being an observer rather than being emotionally involved was outlined as limiting the alliance. In contrast to the psychoanalytic neutral stance, Paivio & Pascual-Leone also reinforced the importance of genuineness and transparency with this cohort to enhance trust and safety.

Therapists were also warned off being too controlling and directive, as this can be triggering for complex trauma clients. Therapists needed to be tentative and responsive, adapting themselves to each individual client who presented. Therapists were warned to be aware of their own avoidance patterns which may inadvertently give clients messages of their trauma being shameful, thus retraumatising the clients (Paivio & Pascual-Leone, 2010).

1.7 Empathy and Alliance

Arguably, most if not all psychotherapeutic approaches mentioned empathy and caring within their model, however empathy was found to be a complex construct, and

emphases and definitions across different theories and therapeutic approaches varied (Greenberg et al., 2001; Paivio and Laurent, 2001). As mentioned previously, Rogers was the first theorist to describe empathy in depth (Norcross, 2002; Rogers, 1951; 2012; Weiner & Bornstein, 2009). His writing had warmth, sensitivity and an emotional tone. Rogers (1980) defined empathy as,

“The therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, to adopt his frame of reference” (p85)

Empathy has varied in its definition and measurement (Lei & Duan, 2014). A positive correlation was found between therapeutic alliance and empathy (Kivlington, Patton, & Foote, 1988; Lei & Duan, 2014), however causality has not been tested as to practise psychotherapy without empathy was thought to be unethical, hence making random control trials (RCT) inappropriate (Elliot, Bohart, Watson, & Greenberg, 2011). Meta-analyses however were considered valid as an alternative method of research (Berman & Parker, 2002). In their meta-analysis of 47 studies on empathy between 1961 and 2000, Greenberg, Elliot, Watson and Bohart (2001) found four factors that correlated with empathy and improved outcome. Empathy as a relationship condition was the first of these. This referred to the clients feeling understood by therapists that was likely to improve motivation in therapy and therefore elicit a better outcome (e.g. increase compliance with CBT); second, empathy as a corrective emotional experience. Empathy was thought to enable strengthening of the self through therapists' presence and overcome clients' sense of aloneness (Bohart & Greenberg, 1997). It gave the clients an opportunity to feel worthy, heard, respected and to have their feelings understood. This helped the clients to express needs and wants, transferred into relationships outside of therapy. Third, cognitive and affective processing entailed empathy that assisted the clients to make sense of and find meaning in their experiences. This assisted the cognitive understanding of their situation. Finally, the clients were actively involved in the therapeutic process, with an openness and adherence to therapy. Empathy was thought to facilitate clients' active engagement in the healing process (Greenberg et al., 2001). It was also thought to assist therapists to choose treatment appropriate for the individual (Hubble, Duncan & Miller, 1999). Having their feelings understood by their therapists was found to be the most prominent factor related to improved outcomes (Elliot, Bohart, Watson, & Greenberg, 2011), reinforcing the

importance of making responses that conveyed understanding in sessions (Greenberg et al., 2001).

In the 1970s there was debate over whether empathy was predominately cognitive or affective (Bachelor, 1988). Psychotherapeutic approaches have varied in emphasis with the psychoanalytic approach historically having had a strong focus on the cognitive aspect of empathy (Elliot et al., 2011). Although authors such as Greenson (1967) wrote about facilitating both cognitive and emotional understanding of the clients, the emotional empathy described tended to be focused on cognitive understanding of what the clients were feeling in contrast to feeling into the clients' emotional experiences. Interpretations presented to the clients deepened the clients' understanding and facilitated long term change. Increasingly over time and the history of psychotherapy, clients have become more of an active, collaborative aspect of the therapeutic encounter (Maltzberger, 2012).

Neuroscience has expanded the definition of empathy beyond the concept of mirror neurons to three distinct sub processes stemming from three different areas of the brain (Eisenberg & Eggum, 2009). The limbic system is seen as responsible for the mirroring of the other persons' bodily experiences (Decety & Lamm, 2009). The prefrontal and temporal cortex lit up with conceptual or perspective taking brain processes (Shamay-Tsoory, 2009). Finally, the orbitofrontal, prefrontal and right parietal cortex were activated when emotional regulation and soothing occurred in response to clients' anguish (Decety & Lamm, 2009). These neuroscience findings underscored the complexity of empathy as a construct, and perhaps gave a partial explanation for the differing levels of empathy offered by therapists to their clients.

Therapists differing in their ability to empathise has been highlighted since the 1970's (Rogers, 1967; 2007; Strupp, 1978). Guntrip (1971) wrote that some therapists had an innate ability to be empathic, which also has been currently emphasised by neuroscience experts (e.g., Schore, 2012; Siegel, 2009, 2012). It was thought possible to teach empathic technique, however Strupp (1978) did not believe it was possible to change a person to become therapeutic.

Empathy was utilised as a method to access underlying core affective experiences in some psychotherapeutic approaches (e.g. EFT, EFTT, Emotion Focused Therapy for Couples (EFTC). Empathic statements have been found to deepen

emotional experiences, sometimes ‘bypassing’ content. For example, “That’s so sad. Can you stay with that feeling a little longer”? Empathy has been shown empirically to assist with emotional regulation, and to increase insight into emotional experiences (Paivio & Laurent, 2001, p223). Empathy has been used to reduce fear and avoidance of experiences both external and internal to the clients (Elliot et al., 2005; Paivio & Pascual-Leone, 2010).

A group of psychiatric colleagues gathered in Switzerland in 2000 and collaboratively developed guidelines, later written in the form of a book relating to the therapeutic alliance and suicidal clients. The psychiatrists named the approach Aeschi. It had a specific focus on empathy in the alliance. Maltzberger (2012) wrote,

“The central characteristic of a therapeutic alliance is respectful supportive listening to the patient’s narrative by the interviewer. The listener is empathic and promotes active participation in the telling of the story-the life experience is the patient’s after all- who knows it better? From the beginning the interviewer fosters the establishment of a therapeutic alliance by paying particular attention to the patient’s subjective emotional experience and to his own reactions to what the patient says and does. It is an application not dominated by any particular theoretical perspective, and it might be called, alternatively, the application of intersubjective empathic attention” (p29).

1.8 Repair Work, Alliance and Complex Trauma

Across numerous researchers and practitioners relational repair work was considered fundamentally important in developing secure relationships (Elliot et al., 2005; Hill, Knox, Thompson, Williams, Hess & Ladany, 2005; Paivio & Pascual-Leone, 2010; Schore, 2012). Bringing forward the alliance difficulty openly within session has been highlighted as essential by trauma specialists, to discuss with the clients rather than ignoring the problem (Aguirre McLaughlin, Youngstrom, Keller, Feeny, & Zoellner, 2014; Kinsler, Courtois and Frankel, 2009; Paivio & Pascual-Leone). Rupture repair research has been currently limited, however it has involved task analytic studies, random controlled trials (RCT) and naturalistic observation studies. Rupture was found to be common across complex PTSD clients as well as more general clinical population (Aguirre McLaughlin, et al., 2014).

A rupture in the therapeutic relationship is characterised by a problem experienced by the client related to the therapy and interaction between self and therapist. If the relationship rupture is not addressed and managed effectively there is a high risk of client discontinuing sessions. Ruptures can occur for a number of reasons for example; as a result of the client not making perceived adequate progress, personality difficulties between therapist and client, too much rigidity in the therapist, issues related to goals and direction of therapy (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996). Clients have been found to respond to alliance problems through either withdrawing quietly or confronting their therapist through challenging or critically attacking them (Hill & Knox, 2009; Paivio & Pascual-Leone, 2010; Safran & Muran, 2000).

Therapists have been found to be most effective when ‘open and non-defensive’ whilst also taking responsibility for their part in the problem (Barber & Muran, 2010, p88). Therapists have needed to be able to admit errors, show remorse and apologise for successful resolution (Elliot et al., 2005; Kinsler, Courtois and Frankel, 2009; Paivio & Pascual-Leone, 2010). Interestingly, therapists who are more open to conflicted emotions have been found by clients to be more empathic (Peabody & Gelso, 1982). Resolution of ruptures has been found to yield benefits in positive changes once the rupture was resolved across various studies (Barber & Muran).

The process of resolving problems with the alliance has been outlined by various researchers in several models that have been developed through task analyses involving a number of steps and an involved process of exploration and repair (e.g. Bennett, Parry & Ryle, 2006; Elliot et al., 2005; Safran & Muran, 2000; Safran, Muran & Shaker, 2014). Safran and Muran defined a four step model of repairing alliance ruptures. The first step was recognising that an alliance problem was present, characterised by the client either silently withdrawing or confronting the therapist directly. The second step involved examination of the clients’ experience of the rupture. Thirdly, the client was encouraged to explore avoided areas, for example related to fear or anxiety that explained the withdrawing or aggressive behaviour. Finally, with increased client understanding, unmet needs or wants of the client that emerged preceding the rupture were made overt to the therapist verbally.

Elliot et al. (2005) outlined five steps in the alliance repair process which was similar to Safran and Muran's (2000) model, however the process elaborated on Rogerian conditions of empathy and non-judgment, and emphasised the importance of validating the clients' comments during the alliance discussion. The first step that was described involved recognising that there was an alliance issue, and empathising with the client about what had happened while maintaining a non-defensive stance of listening, without arguing with the client. The second step involved an open, non-judgmental exploration of what happened during the rupture to increase understanding. Third, both therapists and clients shared experiences in a dialogue that was characterised by tentativeness, openness and sharing of responsibility between therapists and clients. Fourth, an exploration of how clients' patterns were related to past relationships and events was explored. Finally, therapists asked their clients what it was that they needed.

Managing the withdrawal and confrontational ruptures have been characterised somewhat differently. With withdrawal ruptures the therapists facilitated the gradual bringing forward of material related to the discontent during the repair process. Whereas in confrontational ruptures which involved client overt anger initially, shifted to underlying hurt, disappointment and vulnerability of the client during the repair process. The procedure for either presentation involves an honest discussion about the issue, and hearing both parties experiences with an absence of defensiveness (Elliot et al., 2005; Kinsler, Courtois and Frankel, 2009; Paivio & Pascual-Leone, 2010). An understanding was developed about what happened, with possible unmet needs identified and asserted. From here a problem solving process occurred (Elliot et al.; Kinsler et al.; Paivio & Pascual-Leone).

Differences in the depth of effects of ruptures and time taken to resolve has been noted previously (Safran et al., 2014). Elliot et al. (2005) reinforced the need for a solid resolution in which this process explored feelings and experiences thoroughly and deeply, to ensure resolution was effective. The approach was emphasised as one that encouraged mutual respect and the deepening of trust.

Repairing ruptures in the alliance was seen as an opportunity to deepen the alliance when repair work was implemented through the alliance productively, enabling a corrective relational experience (Safran & Muran, 2000; Safran et al., 2014). Some

authors have highlighted the need to attend to the alliance throughout therapy because at any stage, even though the alliance may be strong for some clients it could still fluctuate (Elliot et al., 2005; Hersoug, Monsen, Havik, & Hoglend, 2001; Paivio & Pascual-Leone, 2010). More recent recommendations from researchers and experts in trauma involved talking openly about the alliance in sessions to clients as a means to detect alliance difficulties. A questionnaire could be used (Cloitre et al., 2015; Errazuriz, Constantino, & Calvo, 2015; Miller, Duncan, Sorrell & Brown, 2005) particularly for insecure clients who were less likely to disclose as openly (Errazuriz et al.).

1.9 Research Studies on Alliance and Complex Trauma

Numerous empirical studies and reviews have shown the alliance to be beneficial within the therapeutic process to improve treatment outcomes, reduce undesirable symptoms, and increase interpersonal functioning (Castonguay, et al., 2006; Errazuriz, et al., 2015; Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin, Garske, & Davis, 2000,). More specifically complex trauma clients have also been shown to improve in outcomes with stronger alliance (Paivio & Barr, 1998; Paivio & Patterson, 1999; Cloitre, Stovall-Mc Clough, Miranda, & Chemtob, 2004). Furthermore, strong alliance has been shown to be correlated with increased adherence to treatment with PTSD clients (Aguirre, McLaughlin et al., 2014). In one study involving complex PTSD clients good early alliance was found to predict improvements in affect regulation and PTSD symptom reduction after treatment (Cloitre, et al., 2004). Strong alliance has also been found to be a mediator of key psychotherapy processes and outcomes (Doukas, D'Andrea, Doran, & Pole, 2014). Nonetheless, there are few studies examining the alliance when working with survivors of childhood trauma, particularly involving hearing from the clients themselves.

There were however, an abundance of studies researching factors that contributed to good alliance generally, supporting Wampold's (2001) stance. Therapists' behaviours; exploring issues, reflecting back to the clients, highlighting positive changes, making interpretations correctly, accessing and expressing emotion, focusing on clients' experience, self-doubt and personal attributes (openness, concern, warmth, flexibility, honesty, respectfulness, trustworthiness) have been found to be associated with good alliance (Ackerman & Hilsenroth, 2003; Constantino, Castonguay,

Zack, & De George, 2010; Nissen-Lie et al., 2010). Empathy, positive regard, congruence, goal consensus and collaboration, client feedback, repairing ruptures, and managing counter transference have all shown positive effects in therapy across research studies (Hatcher & Barends, 1996; Norcross & Wampold, 2011). More recently, genuineness, flexibility with interventions, effective listening, and appropriate use of humour were found to contribute to developing a good alliance with war veterans (Laska, Smith, Wislocki, Minami, & Wampold, 2013). Therapists' rigid adherence to interventions, hostility, lack of empathy and mistimed interpretations were found to impact negatively on the alliance (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Therapists who develop stronger alliances have been found to produce improved outcomes (Baldwin, Wampold, & Emel, 2007). Weak alliances have also been correlated with increased client dropout (Samstag, Batchelder, Muran, Safran, & Winston, 1998), with findings supported in a recent meta-analytic review (Sharf, Primavera & Diener, 2010). These studies were largely based on outcome studies, determining the impact of the treatment on the clients as a result of therapy. Although these studies were extensive and informative, they were also somewhat limited by self-report methods (Fitzpatrick, Janzen, Chamodraka, Park et al., 2006) that may be overlooking important deeper understandings of clients' experiences, answering the question of how the alliance was developed.

Client factors have also been shown empirically to influence the alliance (Errazuriz et al., 2015). Clients who were warmer, more agreeable and engaged developed stronger alliance than those who were more hostile, negative and oppositional (Constantino et al., 2010). Positive client expectation of changes, being emotionally engaged in therapy and having insight all attributed to a more positive alliance (Constantino et al., 2010; Errazuriz et al., 2015). Furthermore client attributes such as attachment style affect alliance development (Eames & Roth, 2000; Goldman & Anderson, 2007; Romano, Fitzpatrick & Janzen, 2008; Smith, Msetfi & Golding, 2010) with insecure attachment associated with weaker alliance (Errazuriz et al., 2015).

Recent biochemical research has found increasing client control reduced client distress indicated through measuring glutamate levels (Bryant, Flemingham, Das, & Malhi, 2014). Twenty nine participants had their glutamatergic levels measured before

and after having an electric shock and being exposed to aversive and neutral visual material. Glutamatergic measurement occurred because acute stress has previously been found to result in the release of glutamatergic acid into the ventromedial prefrontal cortex. Half of the participants were led to believe that they had control over the electric shock by being able to push a button to extinguish it. The results indicated that participants with an absence of perceived control were found to have higher glutamatergic levels than the participants who had perceived control. All participants were also exposed to neutral and aversive images. The participants with perceived control over ending the images were found to sustain viewing the images for longer while both groups were found to record the same length of time for neutral images. The outcome of Bryant et al.'s study gave strong support to empowering complex trauma clients with control during the often evocative and aversive process of trauma work, regardless of which treatment approach was being used. They support the notion of collaboration being fundamental and readily offering opportunities for choice and control to clients as useful towards instilling trust and safety for the clients. Research has not yet explored these areas of the alliance with complex trauma clients (Cloitre et al., 2015).

Most of the alliance studies involved early alliance (Errazuriz et al., 2015) and there were relatively few studies that had taken into consideration clients' subjective understanding (Bedi, 2006; Curtis, Field, Knaan-Kostman, & Mannix, 2004; Tummala-Narra, et al., 2012). Current alliance theory has been based on practitioner and researcher knowledge. For example, the most commonly used alliance instruments the Working Alliance Inventory (Horvath & Greenberg, 1989) was developed based on Bordin's (1979) theory without direct feedback from the clients (Bedi, 2006). Research around the therapeutic alliance has therefore been limited to what practitioners and researchers think they know, without having consulted directly with the clients themselves (Bachelor, 1995; Bedi, 2006). Recent studies exploring clients' subjective experiences of the early alliance have resulted in outcomes that supported the notion that alliance theory and research to date may have been overlooking important variables in the therapeutic alliance, such as clients' self-understanding and counsellor friendliness (Bachelor, 1995; Bedi, Davis, & Williams, 2005b; Bedi, 2006).

Supporting this notion, numerous studies have found that clients and therapists have reported differences in strength and quality of the alliance in self-reports (Bachelor, 1995; Bachelor & Salame, 2000; Cecero, Fenton, Frankforter, & Carroll, 2001; Fitzpatrick et al., 2006; Horvath & Symonds, 1991; Horvath & Luborsky, 1993), although other studies have found moderate correlations between therapists' and clients' rating (Horvath et al., 2011). Some researchers have suggested that it makes theoretical sense that a difference occurred between therapists' and clients' alliance ratings given the unevenness within the psychotherapeutic relationship, hence indicated the need to gather both clients' and therapists' perspectives regarding the alliance (Errazuriz, Constantino, & Calvo, 2015).

Clients' understanding of the alliance has been found to be independent of therapists' clinical orientation (Horvath, 2001; Horvath & Bedi, 2002; Horvath & Luborsky, 1993). Furthermore, Duff and Bedi's (2010) findings gave evidence of the predictive validity of clients' perspectives on the alliance. A meta-analysis by Shick Tryon, Blackwell and Hamel (2007) also gave support to the significance of understanding the alliance from the clients' perspective, underscoring what was useful or hindering in the development and maintenance of the alliance from the clients' viewpoint. The meta-analysis of 53 studies examined the client-therapist alliance ratings and whether they were the same or not. They found that a medium to large effect size between therapists' and clients' ratings, the clients rating higher alliance than the therapists. On closer analysis they found that clients with more severe problems and substance abuse clients had less discrepancy in alliance than their therapists. However, clients with less severe issues and the substance abuse clients were receiving a free service which may have accounted for some of the differences. No studies were found that questioned the reasons for alliance differences (Shick Tryon, et al., 2007).

A handful of preliminary studies have examined clients' subjective experiences in early stages of the alliance, giving support to the notion that counsellors' and clients' understandings of the alliance present differently (Bachelor, 1995; Bedi et al., 2005b, Bedi, 2006, Mohr & Woodhouse, 2001). Each of these qualitative studies involved between nine and 47 clients who were in or who had recently had, a positive experience of therapy with a counsellor. Analytical methods differed amongst studies ranging from phenomenological content analyses of self-report questionnaires (Bachelor, 1995) to semi-structured interviews using a critical incident technique (Bedi, et al., 2005b; Bedi

at al., 2006) and essay writing with self-report (Mohr & Woodhouse). Results mostly yielded similar findings. Each of the studies found that clients perceived the therapists as mainly responsible for the alliance, contrasting with the collaboration and mutuality emphasised in alliance theory, with the exception of Mohr and Woodhouse who found a challenging, collaborative alliance as one of two main factors chosen by clients. However, forty-three per cent of the 47 participants had not yet commenced therapy, and it was possible that this may have impacted clients' perceptions of helpful aspects of the alliance.

Analyses of these studies (Bachelor, 1995; Bedi et al., 2005b, 2006; Mohr & Woodhouse, 2001) yielded some basic, common factors in the alliance, ones that were generally not accentuated in alliance theory (Bedi, 2006). For example, variables such as; counsellor's body language and non-verbal behaviour (expression of positive affect, eye contact, smiling, warmth), simple counsellor behaviours and gestures (punctuality, going beyond expectations, personal attributes, personal greetings) and qualities of the environment (how the room was set up, friendliness of reception staff), as well as general micro skilling (tracking the process, paraphrasing, identifying client feelings, encouraging the client, reference to previous session) emerged. Overall these results highlighted basic counselling skills and simple therapists' and environmental variables as important contributions to establishing a good alliance (Bedi, 2006).

To increase depth of understanding of clients' subjective experiences, Bedi (2006) expanded his earlier studies to explore clients' meaning systems. Forty participants were interviewed and asked to recall retrospectively what was most useful in developing the relationship between themselves and their therapists in the first six sessions of therapy. Bedi's study was advanced through allowing clients to categorise variables, reducing researcher bias. Common factors emerged similar to his earlier studies (Bedi et al., 2005b) as well as finding that the alliance formation may have begun before therapy had even commenced, through factors such as therapist attire, body language and administration staff interactions. He also found that therapy techniques such as providing emotional support, validation and challenging assisted clients with alliance formation.

Bedi, Cook and Domene (2012) advanced the earlier research studies through video assisted recall of 12 students in their third or fourth session of counselling. They asked participants to identify factors thought to be negatively affecting the alliance in

therapy. Students categorised factors and gave reasons for responses. Seventy-four items identified by participants, were clustered into six groups by the participants. These included; reserved or non-genuine client engagement, unwanted counsellor directness, erroneous counsellor statements, counsellor disengagement communicated non-verbally, inattentive or distracted counsellor, and unresponsiveness or inappropriateness in counsellor. These results reporting on negative alliance supported prior research (Bachelor, 1995, Bedi et al., 2005b, Bedi, 2006; Mohr & Woodhouse, 2001) indicated the need to expand current alliance theories to include clients' subjective experience of important variables such as; level of engagement with clients (not too directive or too disengaged), counsellor micro-skills (how the counsellor interacts with clients) and non-verbal behaviour. Clients were also found to give more responsibility to the counsellors for the alliance development rather than collaboration with the therapists, conflicting with established alliance theories.

Myer's (2000) conducted qualitative analyses of five clients, students at the university aged 25 years or older all of whom had had personal counselling with the same two therapists, one male and one female. Participants were chosen on the basis that they had established a strong alliance and possessed an ability to reflect verbally. Participants described in writing what they thought was important in being listened to empathically. Results yielded factors such as feeling safe, an active and genuine interaction, therapists' ability to handle painful material, and therapists extending clients beyond what they already knew (Myers, 2000).

Fitzpatrick et al. (2006) explored how the alliance developed early in therapy. These researchers interviewed twenty participants, counselled by Masters students, who identified critical incidents in early alliance development. Meaning was probed as to how each incident assisted the alliance formation. Positive meanings were found to lead to increased openness in two ways; disclosure of further material; and secondly, receptiveness to new information. An emotion-exploration spiral was developed theorising that clients' openness to exploration and positive emotional responses to counsellor behaviours, were contributing positively to alliance development.

Later, Fitzpatrick, Janzen, Chamodraka, Gamberg, and Blake (2009) applied research to a clinical group of 15 depressed clients, counselled by experienced therapists using the same method. Fitzpatrick et al.'s findings highlighted the importance of attending to clients' experiences and therapists' factors. The results aligned with past

studies correlating alliance and therapists' characteristics (Ackerman & Hilsroth, 2003; Hyman, 2011). Results from Fitzpatrick (2006, 2009) contrasted with Bedi's, (2005b, 2006) findings as clients and therapists collaboration emerged as important to the participants. This difference may be as a result of research analyses method used. Participants in Fitzpatrick's (2006, 2009) studies were asked specific questions regarding clients' contribution to therapy, with the same researcher hypothesising that clients may not consciously think of discussing the collaboration with therapists (Fitzpatrick et al., 2009). Further investigation was warranted to clarify these issues.

Overall there is a reasonable body of research supporting the importance of clients' subjective experiences in developing the therapeutic alliance, however these studies and alliance literature as a whole largely focus on less severely distressed clients (Fitzgerald, 2009; Horvath & Bedi, 2002), novice clients (Fitzgerald, 2009) and on establishment of an early alliance. Most of these studies used Masters or Doctoral students as therapists, with only a few using experienced practitioners. Longer term clients and more experienced therapists may have offered greater depth of understanding and insights around what was useful in the therapeutic alliance, particularly in more complex cases.

Of the studies examining clients' subjective experiences of alliance, only a few involved a clinical population or established clients who were survivors of childhood abuse (Curtis, Field, Knaan-Kostman, & Mannix, 2004; Dalenberg, 2000; Fitzpatrick et al., 2009). There was a need to have greater clarity around how and why the alliance worked, and how it was maintained (Cronin, Brand, & Mattanah, 2014; Errazuriz et al., 2015; Hill, 2005; Norcross, 2002). A gap has been shown to exist in the research on the manner in which we manage complex trauma survivors, and in what was useful in their long-term recovery (Kezelman & Stravropoulos, 2012). Understanding the alliance when working with more complex clients who have sustained more painful, evocative, intense therapy, and the conditions that allowed revealing of vulnerable material, has been an area that was found to be currently under researched.

1.10 The importance of the Present Research Study

Improving psychological functioning, symptomatology and well-being of adult survivors of childhood abuse is considered a complex and important area of

psychotherapy. It was intended that the present research study would deepen understanding of the alliance and work towards a reduction in dropout rates and improve sustained engagement and trust in safe therapy for clients who were particularly prone to relationship difficulties and retraumatisation during therapy. Strong evidence indicates the importance of the alliance in therapy generally however, there has been a lack of evidence based research in the area of alliance with survivors of complex trauma. The present study had the potential to offer the rare opportunity to hear directly from a number of both survivors of childhood trauma and therapists in the field of trauma, through an evidence based research approach. Results were expected to add knowledge and depth to current alliance theory, and to provide guidance on how to work therapeutically with these clients, with practical applications to practitioners across a number of psychotherapeutic orientations.

CHAPTER 2 METHOD

2.0 Overview of the Research Design

The choice of a qualitative method of semi-structured interviewing of experienced psychologists and their clients, adult survivors of childhood abuse, will be explained. Furthermore details of the sample and method will be outlined, with guidelines on the special ethical and methodological considerations taken into account for the duration of the project, which was designed to maximise safety of these vulnerable participants.

2.01 Qualitative Method and Philosophical Underpinnings

In order to analyse the following questions in a clinically meaningful manner, a qualitative study was implemented examining subjective experiences of survivors of childhood abuse and also their psychologists. How do survivors of childhood abuse build trust in the therapeutic alliance to allow disclosure? What do experienced psychologists do to facilitate this process? How do complex trauma clients who have difficulties with trust and experiential avoidance remain in therapy?

The decision to use qualitative or quantitative methods of research depends on the research question being asked (Elliot, Fischer & Rennie, 1999). Both types of research have differing purposes. Qualitative research answers different questions to quantitative research. In quantitative research causality or hypotheses are tested from discrete variables that fit into psychological measures, and that are generalisable across groups. In qualitative research the broad aim is investigation, interpretation and deepening understanding of real life experiences (Schneider, 1999). Survivors of complex trauma largely present with comorbidity and a complex array of problems, which are less suited to random controlled trials (Cloitre, 2015). Researchers seek to understand participants' perspectives, define phenomena in relation to what it means to the participant, and develop theory (Elliot et al., 1999; Wampold, 2001). An emphasis is placed on understanding this experience through consultation with the participants themselves (Elliot et al., 1999). In the current study it was not considered useful to simplify or contain variables in specific groups enabling easier measurement, because the nature of the alliance when working with survivors of childhood trauma was complex. Depth of knowledge around *how* trust develops required research that allowed

for exploration of the complexities of the human experience, beyond causality or prediction (Elliot et al., 1999; Hill & Knox, 2009).

Qualitative research has an extensive philosophical framework that is embedded in understanding the complexities of human beings through language, context, experience, and detail (Elliot et al., 1999). It describes depth and meaning of participants' lived experiences and is about understanding the individual and collective internal experience for a phenomena of interest, and how participants intentionally and consciously think about what has happened, valuing subjectivity and connection with the self and world (Hayes & Singh, 2011). It is known that researchers cannot be totally objective, however it also recognises that researchers can set aside their existing knowledge and biases to objectively understand from the eyes of the individual (Elliot et al., 1999). An awareness of their own prior knowledge of theory, pre-existing ideas and expectations is required (Smith & Eatough, 2007).

2.02 Why use interviewing?

Interviews were expected to gather a collective of perspectives, gathering participants' knowledge and understanding of the alliance during therapy, and exploring meaning in the participants' experience. This approach sought to find variations of experience of the phenomena being investigated (Johnson & Rowlands, 2012; McLeod, 2001). With a sensitivity to detail, harmful and beneficial effects are able to be explored through this method (McLeod, 2001). This was deemed particularly important given the vulnerable nature of the clients. Interviewing was considered a more superior method to self-report, because participants tended to be reluctant to provide negative feedback towards their therapists (Levitt & Piazza-Bonin, 2011), potentially confounding results. It was also considered to be an ethical approach that respected therapists' and clients' time.

This approach was congruent with my experience as a psychologist, integrating existing knowledge and practice into research, and naturally seeking to understand the client's world within therapy. The researcher's preexisting experience with the complexities and sensitivities around maintaining client safety and empathic engagement, reduced the risk of retraumatisation of this vulnerable client group through the interviewing process. Researching an area that was familiar and accessible has been

also been found to be advantageous, in increasing the likelihood of understanding the meaning and complexities in the research data (Johnson & Rowlands, 2012).

In the current study, clients who were survivors of childhood abuse and their psychologists were interviewed through a semi-structured approach. An unstructured interview could have yielded findings that were not comparable across participants, as questions may have varied among participants. A structured interview with yes/no, question/answer responses, asked in a routine way tends to standardize the interview process (Roulston, 2012), however this would have limited questioning of deeper aspects of experiences deemed important in the study. The semi-structured interview, through asking participants a series of open-ended questions, allowed for flexibility to probe further with additional questions as the interview progressed. This was likely to yield greater depth and detail of data (DiCicco-Bloom & Crabtree, 2006; Hill, Knox, Thompson, Nutt Williams, Hess & Ladany, 2005).

In-depth face to face interviewing was chosen over telephone interview, survey or groups even though this involved more time and was less cost effective, due to the study seeking richness of data of the participants' personal experience in therapy. Face to face interviewing was expected to enable increased alliance and trust in the researcher-participant relationship, important for the disclosure of sensitive material (Johnson & Rowlands, 2012; Knox & Burkard, 2009). This type of interviewing was considered appropriate in qualitative research that asks "how" and "what" in relation to the descriptive or exploratory research rather than "why" (Johnson & Rowlands, 2012).

Participants were interviewed once. It has been suggested that a second interview can allow for ideas to emerge in between interviews that may otherwise be lost, including greater depth in meaning behind participants' experiences (Knox & Burkard, 2009), and by the second interview the participants can also feel increasingly comfortable to reveal important information due to increased familiarity and trust with the researcher (Adler & Adler, 2002). However, in consideration for this particular client cohort, it was deemed inappropriate and intrusive to interview a second time. A single interview was chosen in consideration for both clients and psychologists. Psychologists were stretched in time and resources, and it was expected that access to relevant information would be possible in one interview given that they were experienced practitioners. Secure email was given as an opportunity for follow-up ideas once transcript summaries had been sent to participants. This was to allow the

participants a chance to convey ideas that may have emerged after the interview was completed. A few participants, both psychologists and clients provided added information through email. The researcher was available before, during and after the interviews to respond to questions or concerns from the participants (Seidman, 2006).

In this study, hearing from the clients and psychologists through semi-structured interviews, separately and confidentially was predicted to gather rich and meaningful data, which cannot be captured through randomised clinical trials predicting causal relationships (Balmforth & Elliot, 2012; Elliot, 2010). Semi-structured interviewing was used to investigate what was happening during therapy with adult survivors of childhood abuse, from the psychologists' and clients' viewpoints, with the intention of further understanding the complexities involved in the therapeutic alliance when working with this population.

We know from alliance research to date that there is more happening to clients in sessions than the therapist knows about (Rees, Hardy, Barkham, Elliot, Smith & Reynolds, 2001). Furthermore, studies have shown clients to be resistant to giving therapists feedback due to fear of being judged, or due to concern in upsetting the therapists or in wanting to protect the therapeutic relationship (Levitt & Piazza-Bonin, 2011). Hence, the method described was predicted to provide an opportunity to explore usually withheld significant moments that added to clinical and theoretical approaches in therapy with survivors of childhood abuse.

2.1 Participant Sample

A Criterion sampling was utilized for this research project; participants were chosen because they met the pre-determined criteria (Hays & Singh, 2011), either adult survivors of childhood trauma or experienced psychologists who were expert in working with these clients therapeutically. The criterion for each group of participants is elaborated below.

2.1.1 Experienced psychologists

The sample consisted of thirteen experienced psychologists, specialised in working with survivors of childhood trauma. They had at least five years of counselling experience and were considered experts in the field of complex trauma, working in and around Melbourne in private practices, using a range of theoretical orientations. The

experienced psychologists will be referred to as psychologists and names altered for confidentiality (e.g. Felicity (P)). Psychologists were approached by the researcher to participate in the study through discussion or phone calls with an explanation of the project given verbally and in written material.

Of the thirteen psychologists, three were male and ten female, aged between 40 and 63 years, with an average age of 51 years. Four of the psychologists were general psychologists, nine counselling and two clinical psychologists. Two psychologists belonged to both counselling and clinical streams. Psychologists had from six to thirty years counselling experience with a mean of 17 years. All 13 used a humanistic approach with clients, while five also used psychodynamic methods and three cognitive behavioural approaches. Falling under these umbrellas were; Emotion Focused Therapy, Schema Therapy, Psychodrama, Attachment Focused Therapy, Mindfulness, Trauma Focused Therapy and Systemic Therapy, as preferred methods used.

Colleagues who worked in the same workplace as the researchers, with frequent interpersonal contact, were excluded to assist in protection of confidentiality of data and objectivity by the researcher. Psychologists were recruited if they agreed to participate in the project and had clients at the later stages of therapy.

2.1.2 Complex trauma clients

Thirty complex trauma clients and their psychologists were interviewed. Clients met research criteria of having had a history of physical, sexual, emotional abuse or neglect during childhood, and had been engaged in therapy to work through those issues with their therapists. Clients were only recruited if they were at the stage of decreasing their counselling appointments beyond fortnightly sessions, and were deemed stabilised enough for interviewing judged by their current therapist. All clients' names have been changed to ensure anonymity (e.g. Edward (C)).

Of the thirty clients two thirds were female and one third male, aged between 32 and 64 years, averaging 49 years. Twenty-four of the participants were reported to have experienced multiple areas of (sexual, physical, emotional, neglect) abuse, four were noted as sexual abuse only and two neglect. Half of the participants had completed year 12 schooling or above with 20 per cent up to year 11 and, 27 per cent finishing school between year six and 10. One third of clients had no further training post school, 13 per cent completed a trade or apprenticeship, 30 per cent a diploma, bachelor or post

graduate degree, 20 per cent masters or PhD and 7 per cent partially completed professional training. Two thirds of these participants identified themselves as Caucasian while the other one third aligned with an alternative ethnic group. Seven aligned with European, two with Asian and one African culture. All except one participant had experienced counselling prior to their current psychologist, many with negative experiences to report. Nine individuals suffered medical conditions outside mental health issues. The average number of sessions with their current psychologist was 48, with a range from 24 to 325 attendances. Three of the thirty participants presented with the concern of childhood trauma, the others initially came with stress, depression, anxiety, workplace problems, addictions or behavioural or emotional problems.

2.2 Procedure of the Study

The procedure of the research process will now be outlined, beginning with selection criteria and recruitment method, followed by the semi-structured interview process and strategy for analysis of the data.

2.2.1 Participant selection, recruitment and initial contact

Psychologists were given selection criteria for appropriate clients who were survivors of childhood trauma, and who were emotionally stable enough to be able to benefit from a reflective experience of being interviewed by the researcher. The practitioners were asked to give suitable clients a brief explanation of the project, and if agreeable to hand an envelope to the clients with research project details and researcher contact details (secure Swinburne University email and mobile phone number). The research project was explained fully to the participants in clients' and psychologists' information sheets, including time requirements, interview method, and protection of confidentiality (See *Appendices C and D*). Potential clients were asked to contact the researcher directly if they were willing to participate in the study. Interview questions were also included in the package. Having a copy of the interview questions for participants in advance was intended to assist participants' understanding of the goal and focus of the research project, namely exploring the relationship between therapists and clients. It also gave participants time to consider their responses to the alliance related questions prior to the interview which was expected to add richness to the data (Hill, Knox, Thompson, Nutt Williams, Hess, & Ladany, 2005). The process was

carefully designed to minimise client coercion, and to assist the participants to make an informed decision to partake in the research. Confidentiality was explained and maintained by the researcher for all interviews, including between clients and their psychologists.

Participants were informed of the voluntary choice to participate and given the option to cease involvement at any period of time during the project (Hays & Singh, 2012; Seidman, 2006). Information was supplied outlining that participation would contribute to trauma research and assist future practitioners and clients (Hays & Singh, 2011; Seidman, 2006).

Once the researcher had been contacted by the clients who were willing to participate, a mutually convenient time and venue was arranged. Accommodating the clients' wishes and needs, depending on where they felt most comfortable for the interview process to occur was considered. More specifically the option of psychologists' rooms, clients' homes or researcher's rooms was offered and a time was established, usually within the next week. The communication of the researcher with the clients was delivered with a high level of sensitivity and empathy to assist a sense of safety for the participants and to initiate the development of trust with the researcher. Minimising the effects of power imbalance was important to maintain participant emotional safety. Participants were encouraged to make contact if needed prior to or after the interview with the researcher with questions or concerns. This occurred with a few participants who wished to change appointments or venues.

Psychologists were contacted once a client interview time had been arranged to confirm room availability if this was undertaken in their rooms, and to make times for the interviewing of the psychologists, which on most occasions was within one week of their clients' interviews. All except one of the interviews with the psychologists were conducted in the psychologists' rooms.

2.2.2 Client measures

Demographic data was collected through questionnaires completed by clients before arrival or prior to the commencement of the interview. These included details on clients' age, date of birth, sex, occupation, education, ethnic group, previous counselling and reasons for seeking counselling.

2.2.3 Psychologists measures

Psychologists provided data prior to commencement of the interviews, detailing date of birth, sex, education, title, years of experience, main theoretical orientation, number of client sessions, main presenting client problem and details regarding the type, timing and frequency of the abuse of their clients.

2.3 Semi-Structured Interviews

One hour, face to face, semi-structured interviews were conducted with each participant, psychologists and clients separately. On most occasions the clients were interviewed first followed by the interview with their psychologist, usually within the next week. Some psychologists were interviewed once while those who had numerous clients participating were interviewed separately for each of their clients, up to five times (*See Appendix L*). Introductions and a brief warm-up ‘chat’, collation and completion of demographic questionnaires and informed consent forms occurred before the interviews commenced (*See Appendices I and J*). Each interview was audiotaped to assist with accurate analyses.

The researcher was guided but not restricted to the seven or eight research questions related to the therapeutic alliance, and factors that affected the clients’ ability to trust and disclose to the psychologists (*See Appendix A and B*). These questions were elaborated on and expanded during the interview, as the researcher probed for further relevant details.

A person-centred stance was used to facilitate an environment of non-judgment (Rogers, 1967) to protect participants and to minimise fear of being judged by the researcher (Adler & Adler, 2002). The interviewer was aware of the sensitivities and issues to consider in maintaining safety during the interviews, as well as providing support to the participants emotionally if that was needed. It was necessary to validate participants’ experiences and to identify signs of distress and discomfort, and to provide support and holding as intense emotions emerge (Haverkamp, 2005). In this way the participants were supported through the research process (Knox & Burkard, 2009). This was particularly important with the vulnerable complex trauma client population. Strong emotions did emerge in some clients and it was essential that the researcher knew how to assist them to regulate their emotions (Knox & Burkard, 2009).

The researcher interviewed the participants mindfully, facilitating disclosure of relevant research related material, however, not probing into sensitive personal or trauma material. Some of the clients chose to share aspects of their story in order to make sense of their alliance experiences. The researcher listened fully to the clients' narrative and responded accordingly.

Being a therapist prior to becoming a researcher meant that careful attention needed to be taken to not become a therapist during the research. The researcher needed to be in a role as if she was learning from the participant, who was informing and advising the researcher of the experience (Johnson & Rowlands, 2012). Clear role boundaries guided the researcher to support the participants, and to carefully probe and access relevant information that may have been concealed, or gave meaning and reasons beneath the superficial responses (Johnson & Rowlands, 2012). This encouraged elaboration on relevant experiences, without using strategies that deepened emotional processes through psychotherapeutic methods. The participants' well-being was a priority throughout the research process. Managing issues of "power, influence, coercion and manipulation" (Havercamp, 2005, p152) was needed throughout, including phone calls initially and greetings prior to the interview commencing, during the interviewing and in any follow-up contact.

The researcher was required to bracket existing knowledge and to maintain a neutral stance during the interviews to maintain participants' confidentiality, and to avoid skewing data. This was particularly pertinent during psychologists' interviews that were implemented largely after the clients' interviews. No information could be transferred from the clients' interviews to the psychologists' interviews, or vice versa. The researcher used a person centred stance of non-judgment, empathy and acceptance of the clients and psychologists in order to facilitate safety and minimise the risk of traumatisation of clients and to minimise feelings of incompetence in the psychologists.

Maintaining an awareness of the researcher's bodily responses and judgmental thoughts to the clients' critical comments about their psychologists, assisted the researcher to refrain from defending or protecting the psychologists by giving a hypothesised explanation or justification. Instead the researcher listened with openness, interest and non-judgment and maintained an observer stance. Also minimising the researchers surprise at the occasional unexpected comments was important in sustaining a neutral enquiry and protecting the client psychologist relationship. Although the

researcher may have experienced her own judgment around psychologists' behaviours at times, it was inappropriate to express these thoughts or feelings within the interview.

On occasions, the researcher was required to reassure the psychologists of their expertise, of the enquiry process and the open-ended nature of the method, as the lack of structure in some instances instilled doubt regarding their own performance. Furthermore some participants were concerned that they had not been given enough information.

On a few occasions, issues arose during the interviews with the clients about the alliance with their current psychologist. In these instances the clients were encouraged by the researcher to discuss the concern with their psychologist directly if possible, with the benefits of likely resolution of the concern explained. The potential for a positive outcome of improved alliance with the client's psychologist was explained (Hill & Knox, 2009; Safran, Muran & Shaker, 2014). Reassurance was given to the clients of the unlikely chance that the psychologist would judge them for speaking openly about their concerns.

A small, non-intrusive audio recorder was used to record each interview. Participant consent was received during initial phone calls, through participant consent forms (*see Appendices E and F*) and before commencing recording. Audio recordings were kept locked away securely to be kept for seven years for legal purposes and then destroyed. Transcripts were summarised and sent via secure email to participants with a request for any alterations or discrepancies that may arise to be conveyed to the researcher.

2.4 Analysis of Interviews and Transcriptions

Sixty hours of interviews were transcribed across 30 client participants' and 13 psychologist participants' one hour interviews. All audio recordings were transcribed within one week of interviews, then summarised and grouped into broad themes. Analyzing the data at the same time as gathering the data was thought to enhance researchers' understanding of the research question (DiCicco-Bloom & Crabtree, 2006). Psychologists were paired with one to five of their clients. Analyses involved identification of the emerging themes and patterns in each participant's experience of the alliance, which was written into summaries for each transcription. Data was paired

comparing outcomes from psychologists and their clients, and between psychologists and clients. Two research supervisors with a background in qualitative enquiry oversaw the entire process. This included discussion about the interview process and problem solving any of the researcher's concerns, and reviewing all of the summaries with regular discussion around emerging themes. This enabled researcher's blind spots to be addressed and to enhance the reliability and validity of the research (DiCicco-Bloom & Crabtree, 2006). A strong theoretical background of the researcher in the treatment of complex trauma was thought to be a requirement of the process of allowing the themes to emerge through the analyses. This aligned with the researcher's previous years of experience with the topic and working with complex trauma clients. However the researcher needed to be open to allow the themes to emerge without influencing or biasing the participant responses.

The audio recordings were transferred to a secure electronic file once they were transcribed. Hard copies of transcriptions were kept securely locked, and both will be destroyed after seven years. In order to match data, participants' information was coded with letters, with all names removed to maintain anonymity and confidentiality. Participants will be informed of electronic links to published papers via email, to be forwarded on completion of the project.

2.5 Ethical Considerations

Prior to commencing the research ethics approval was obtained from Swinburne University of Technology Higher Research Ethics Committee for project 2013/112.

Participants were informed of the voluntary choice to participate in the study and that they could cease involvement at any period of time (Hays & Singh, 2011). It was reasonable to explore the client's initial concerns or fears about the research briefly. It was also essential to respect and support any clients' decisions not to participate. Due to the nature of qualitative research emerging over time, consent needed to be regularly reviewed throughout the process (Hays & Singh, 2011).

Contributing to trauma research to assist future practitioners and future clients aligned with beneficence, doing research that gave back to participants and others (Hays & Singh, 2011; Seidman, 2006). A number of participants were motivated by their own desire to help others, while the interview process was also expected to offer a useful,

reflective process to the clients and psychologist participants (Di Cocco-Bloom & Crabtree, 2006).

The timing of the semi-structured interviews was intended to occur after the majority of the childhood trauma therapy was complete, minimising the chance of interruption to the therapy relationship during the most evocative part of therapy, and also maximising the likelihood of the interviewing process being a positive reflective experience for the clients. The clients were then less vulnerable, and also more able to make an informed decision to participate.

Due to the vulnerable nature of the clients, substantial attention was taken around protecting the participants from retraumatisation, and from disrupting the precious relationship between the psychologists and their clients in this research project. This aligned with nonmaleficence meaning not harming the research participants (Hays & Singh, 2011).

To minimise power imbalance choice was given to participants during the first contact regarding time and venue to meet, opportunities to change, cancel, and reschedule an appointment. During the interviews clients contributed towards the order of events, pace and seating arrangements. (Hays & Singh, 2011). All communication was delivered empathically and in a consultative, sensitive and respectful manner.

Furthermore the researcher needed to be attuned to detecting distress early and skilled in offering emotional support as needed during the interviews. Delivering the interviews, maintaining a researcher role rather than being a therapist, was essential to maintain role boundaries, as well as drawing on counselling skills as needed to support the clients during the interviews, and to psychologically hold clients when intense emotions emerged.

Once the clients and researcher met, more choices were given in seating and order of events, for example; filling out the demographics at the beginning or end, explaining the recording process, demonstrating the recording device and its position, and informing the participant of the commencement of the session. Transparency of the process was maximised each step of the way. Flexibility was also required as interruptions occurred sometimes from animals, friends or partners, and unexpected visitors or noises. Researcher tolerance of the interruption reassured clients. The clients were encouraged to deal with the matter (e.g. Bring the animal into the room). The

researcher respected and communicated with the client's animals and this was found to assist in developing trust during the interviewing process.

It was unethical for the researcher to become a counsellor to any of the research participants or their family members and to avoid multiple relationships after the interviews were completed (Hays & Singh, 2011). It was the responsibility of the researcher to manage this kind of situation if it arose, and to give alternative options for referral if appropriate. The clients and psychologists were sincerely thanked for sharing their time, knowledge, wisdom and experiences.

CHAPTER 3 ADVANCED EMPATHY

In this chapter, research findings from the data analyses were summarised. An advanced level of cognitive and emotional empathy emerged as a key factor that enabled survivors of childhood trauma to develop and maintain trust in the therapeutic relationship. Numerous areas emerged that were related to empathy. Although overlapping occurred across the areas, they have been separated into six subheadings for the purpose of clarity and understanding for the reader. These are; cognitive empathy, deep emotional empathy, empathy and secure attachment, individualised empathy, non-verbal and paralinguistic behaviours, and instilling clients' responsibility while managing avoidance. The findings of the present study have been discussed and compared to previous research and literature.

3.0 The Centrality of Empathy

The findings of the present study indicated that when working with survivors of childhood abuse a deep emotional empathy and cognitive understanding with the client was required, extending beyond basic empathy skills often described in general counselling texts (e.g. Egan, 2002) and mentioned briefly in most psychotherapeutic approaches. Deep emotional empathy was less often emphasised as typically instructions on practising skills such as non-verbal behaviours and active listening skills were found to be the most salient (e.g. Egan, 2002). There was a complexity in defining the subtle and complex relationship skills that were required for effective counselling (Moloney, 2016).

Clients in the present study were clearly able to articulate what was important for them regarding their experience of empathy that had assisted them to trust in the therapeutic relationship, regardless of age, gender, level of education, ethnic orientation, and number of sessions in counselling. Not surprisingly, the information given varied in depth depending on the clients' level of insight, training in the area of mental health, and years of counselling, however the importance of empathy emerged as consistent across all participants. Most clients had a vigilance in noticing details of their therapeutic relationships with their therapists and other health professionals that enabled them to comment on many details, both positively and negatively, yielding rich and meaningful data. Empathy helped them to feel safe and to trust their therapists, both

deep emotional and broad cognitive empathy, delivered with warmth, acceptance and humanness. Non-verbal factors were identified as important in reinforcing or negating therapists' genuineness and intentions by clients.

The information gathered through the interviews with the psychologists matched the clients in most areas. Psychologists demonstrated through the interviewing process an advanced level of emotional and cognitive empathy for their clients, as well as being able to explain the process in more complex psychological language. Psychologists were attuned to individual clients and adapted the delivery of empathy accordingly to maximise safety and to meet clients' needs. Deep empathy was counterbalanced with clear boundaries and a firmness by the psychologists in instilling responsibility, often with a high level of sensitivity to the clients, in relation to managing avoidance.

3.1 Extensive Cognitive Empathy

Feeling understood by their psychologists was deemed important by all clients interviewed in the present study. For clients, it increased their perception of psychologists' knowledge, confidence in their skills, sense of knowing them deeply, and reassured them of their professionalism; all factors that contributed to client safety and trust. Understanding was conveyed in a variety of ways by the psychologists. Some clients were reassured by their psychologists' explanations of clients' feelings and having a context provided for their experiences. For example Eleanor (C) explained;

“She is really good at explaining why I feel the way I do, so I can make logical sense of the physical, physiological and psychological reactions I have...Yeah. This is what's happened to you, so this is good at explaining why, like this. Um. You know explaining how the brain works. That sort of thing. I can make logical sense of it then” (Appendix K, p198)

Dennis (C) felt deeply understood and this created safety to share his story. He said,

“Without going into a lot of detail, I have issues with my family, in particular with my father that goes back to my early childhood. She was very early able to tune into some of my behavioural issues relating to that. And that, for the first time in my life I found somebody who understood me. And so it was very easy to open up” (Appendix K, p 283)

Tracy's (C) comment also demonstrated the importance of being understood,

“I guess from her comments, the way that she was just able to help me go through things and understand them and to be able to identify feelings and to release them and to process them. I knew she must understand, because I wouldn’t have been able to do that otherwise” (Appendix K, p226)

Hannah (C) liked that Cathy (P) understood the impact that others had on her. She said,

“It was she heard it. Ok then. My reaction from other people in my life, she understood that” (Appendix K, p257)

Belinda (C) appreciated Adriana’s (P) understanding of her feelings within her childhood context, which counteracted her self-perception of being flawed,

“She allowed me to do it. Because I had a great need to understand feelings. I didn’t understand feelings...I didn’t know what they were...And ah. Learning what was going on inside and the reactive, what I describe as reactive or reactions....She was able to put them in context for me. That these were actually normal. I always saw myself as being flawed or abnormal” (Appendix K, p 7)

Ken (C) also appreciated Irene’s (P) ability to understand her childhood trauma that was covert. He said,

“She, it has really been her skill in being able to untangle quite a complicated set of circumstances and personalities...Who have influenced my life. And she has been able to really understand, sort of what sort of people my parents really were. Um in a way that interestingly my great friend from school relates to, but I doubt very much that most other people would, because my parents and my ex-wife for that matter had the ability to kind of portray this kind of um, normalness” (Appendix K, p105)

The context of her experiences and physiological responses helped Laura (C),

“And also making you understand also that through years and years of being treated a certain way, that your mind goes in a different path, automatically, than what other people that hadn’t been through that experience and the counselling process is about retraining the mind to react differently and not just automatically think bad things about yourself. So that you can cope” (Appendix K, p145)

Therapists’ understanding helped to reassure their clients and to validate their experiences. Daisy (C) said,

“Part of that in there was that she really believed that my childhood was really traumatic and she said that to me...No one had really said that to me before either...I mean, some, said oh yeah that was pretty traumatic (softly) but she (Felicity (P) was quite firm about that and I said, “No, I don’t know about that”, and then she told me that people who have traumatic childhoods often deny it, that is really common, um, and they say exactly what they say you are saying now, and I didn’t know that either” (Appendix K, p66)

Clients liked professional therapists who were humble and tentative in their knowing. Psychologists were not expected to know everything and many clients commented on appreciating psychologists’ speculative enquiry. For example, Tina (C) summarised by contrasting a previous therapist who avoided misunderstood areas. She said,

“Whereas Georgie (P) adopts the stance, I think that I don’t know what could underlie that issue”. Yes, I think Georgie (P) comes from that position that client is expert of their point of view” (Appendix K, p138)

Numerous clients reported favourably about their psychologist’s ability to intuit what the client was feeling or experiencing in the moment, interpreting the non-verbal behaviours and making sense of clients’ worlds without the client having to explain every detail. Clients found this removed some load or pressure to convey their situation in its entirety and left the client feeling deeply understood by their therapists, both cognitively and emotionally. Cas (C) said,

“She seemed to get the level of emotional distress that I was feeling...I didn’t have to labour a lot for her to see that she got what I was trying to express to her. Yeah, she spoke the language” (Appendix K, p263)

Tracy (C) said,

“There was an intellectual process there. I think through the work that she does, there is that unravelling and going through, and making sure that you are ok. Because a lot of the work I was doing might be internal. I wasn’t necessarily saying things out loud. In my mind, I would be saying things, talking or shouting or screaming or whatever, processing stuff and she knew that that had to be done. So that as well was good. Giving me that space” (Appendix K, p226)

Therapists’ ability to see behind their clients’ masks was a relief for clients and reinforced to the clients the psychologists’ empathic understanding of them.

During the interview, the psychologists in the present study conveyed comprehensive understanding through a process lens and a thorough knowing of their clients. This focused their understanding of their clients extending it beyond their words, to more fully establish clients' experiences and to make sense of them, within their contexts both present and past. They were aware of their clients' and their own emotional experiences while maintaining an open and empathic presence. Rather than simplifying client symptoms into diagnostic categories, psychologists explored the meaning behind clients' experiences and narratives, making sense of each unique client's struggle. As a result, psychologists empathised deeply with their clients.

Rowena (P) explained,

“And sometimes it's just give her a little bit of that narrative, in terms of this will be really intense and will trigger all the other stuff. So you have your current stuff and what it means linked with all this other stuff. I think that has been helpful” (Appendix L, p175)

Felicity (P) also described understanding of her clients within their family of origin context,

“But also working with Daisy (C) and understanding her perspective, her position in the family and her family has invalidated her experiences, like you're all too young, you couldn't remember anything...Her, there's a lot of stuff about being different, she's the kind of strange one.... and she's probably the sanest one actually, in the family system” (Appendix L, p53)

Adriana (P) described understanding Belinda's (C) past and present relationships and how they intertwined,

“The shame, withdrawal, social anxiety, low confidence and of course the impacts of the childhood trauma in terms of the developmental stuff, was all enormously affected. Relationships, trust” (Appendix L, p169)

Psychologists reported being able to resonate with the child aspect of their clients, and to see within the clients, beneath the defences to the deeper attachment meanings or underlying reasons that explained behaviour. It assisted psychologists to be highly responsive and attuned to clients' vulnerability and inner feelings, which guided their interventions, and deepened compassion for the clients. Irene (P) for example, said,

“So I guess from an early stage, as a therapist, you have an inner resonance of a person. I don’t know if this is just me. I remember years ago, in the psychodynamic world, a great deal of emphasis is placed on your impression of the first session and the countertransference you first experienced. And with Ken (C) it was this frightened, mumbling, almost paralysed little boy and that is what I work with I suppose.... Almost inarticulate about his own experience and bereft of care and hope and belief. So I knew I was very important to him....Even though he was quite an articulate sort of man, I could see the scared little boy and I guess I was really meeting him in kind and so conceptually talk about the work role” (Appendix L, p90)

A further example was with Sam (P) who said,

“I understand that that is part of the issue (alcohol), but it sounds to me like you were really hurting on Thursday” (Appendix L, p292)

Many psychologists described understanding what their clients needed through determining what their primary attachment figure in childhood failed to be able to provide. For example, Georgie (P) described accommodating Tina (C)’s social anxiety and compensating for parenting deficits from her mother. She said,

“She had been really negated by her mother. It was really important to be able to cultivate a lot of interest and curiosity about her perspective. You know she suffered quite a bit of social anxiety and was very shy. It was really validating. For me that was one of the key things to foster in our relationship. It was to really pay a lot of attention, unpacking, not assuming things. Not going yes, of course I understand that and sort of, really allow her elaborate as much as she felt comfortable” (Appendix L, p112)

Liz (P) described Antoinette’s mother as invalidating, critical and judgmental and therefore Liz (P) focused on avoiding repeating these behaviours, to maintain safety and prevent attachment injury.

“No judgment, no irritation...No, um, punishing for speaking up about her feelings, um, and I don’t know if I did this, this early, but at some stage I have had several conversations with her about attachment and transference. So I spoke to her about how early attachment is formed and the fact that her mother is so critical and that part of what we are doing is engaging that attachment system in order to, um, modify it or lay down a secure attachment system. I did because at different times I have felt that she has had more capacity to understand it and she is curious about therapeutic processes and

she, I think was confused about the intensity of her reactions, so I think it is normalising (of her feelings)” (Appendix L, p98)

A broad understanding was gathered by the psychologists of their clients’ past and present lives, which married together, created a deep level of cognitive empathy, which all of the clients experienced and considered important. Understanding and having compassion for the client’s behaviours as perhaps being reflective of a younger person’s developmental stage, also deepened flexibility and reduced therapists’ reactivity. Georgie (P) summarised,

“There’s not as much leeway with a trauma client to deviate, because they can’t accommodate you as a human being as having a life. So if you are running late, they are probably not going to give you the benefit of being late. You almost, not be perfect, but you can’t expect them to have insight about you, sometimes” (Appendix L, p119)

Georgie (P) explained with a high level of sensitivity,

“Because a lot of time the trauma client has regressed to childlike states and as mothers we know that just a little bit of reassurance at the right time can really save a lot” (Appendix L, p120)

Psychologists assisted clients to understand their feelings. Jenna (P) said,

“I would have given her a lot of empathy to show that I understood what was happening to her and help her make sense of that. Understanding that that was ok, that there wasn’t something wrong with her. You know that critical attack on herself. Yeah and helped her to understand her own emotional processing” (Appendix L, p223)

Felicity (P) endeavoured to understand shame within a past context and responding to counteract that in the present moment. She said,

“So I’d say listening and providing containment to what was going on for him....And also he has a kind of high level of shame, about his behaviour and about, just the person that he feels he is. Um, so kind of having to meet the shame. He was in a state of shame as if I would be judging him too. Which continues really. So I think helping him to understand that these behaviours have a context to them, and that we can understand what they mean” (Appendix L, p236)

Jenna (P) differentiated primary¹ and secondary² emotions with her clients,

“I think really understanding emotions and general emotional processing because with someone like her it’s really easy to get lost in secondary emotions of guilt and not to be in the shame and sadness and so forth.....So to really know the difference between primary and secondary emotions and to really separate the shame and guilt, which can be really overlapping and confusing. Yeah, to help her to be able to stay with the primary emotion, I think and to know that that is ok and not to feel guilty about that” (Appendix L, p232)

Psychologists assisted clients to understand the physiology of their experiences.

Adriana (P) said,

“And understanding the physiological response to that. So she has worked enormously hard and exposure. So she was a very touch trigger. Incidental touch. Any touch. You know, closeness. And she probably from memory hasn’t used dissociation now for 2 years. She hasn’t had to. She doesn’t go there now... There has been a lot of work around the trauma symptoms themselves, from an exposure point of view...And understanding” (Appendix L, p164)

Cognitive understanding was emphasised in the present study as important across all of the psychologists and clients. Historically there have been differing views of empathy in psychotherapy. Duan and Hill (1996) reviewed and summarised research separating some early researchers who defined empathy as a cognitive understanding of the client (e.g. Barrett-Lennard, 1962; Kohut, 1977; Rogers, 1967; 2007) from other researchers who, for example, emphasised the emotional aspect of empathy when interacting with the client. A third group contained both cognitive and affective aspects (Duan & Hill). The present study supported the latter in that both cognitive and emotional empathy were found to be fundamental when working with survivors of childhood trauma.

The psychoanalytic approach has always emphasised cognitive understanding of the client with interpretations put forward to facilitate increased awareness of conscious material and to deepen the clients’ understanding (Bohart, 1991). Different feelings and

¹ “Primary emotions are here-and-now, immediate, and direct responses to situations” (Greenberg, Rice & Elliot, 1993, p75)

² “Secondary emotions are responses to more primary emotions and thoughts” (Greenberg, Rice & Elliot, 1993, p75)

The secondary emotions tend to mask the primary emotions. For example, for someone who was brought up with vulnerability being unacceptable, anger may be expressed hiding the underlying scared or sad feelings.

defences emerged in the relationship with the therapists that may be attributable to family members and childhood experiences. The therapists assisted the clients to become aware of transference reactions, and to access them for material to work with, develop awareness of and to understand themselves (Corsini & Wedding, 2005). Although not all psychologists in the present study used a psychoanalytic approach, understanding the clients within a context of their childhood experiences was deemed important, both to be able to capture a sense of the clients themselves as well as sharing this understanding with their clients for therapeutic purposes. Clients in the present study appreciated this.

A traditional, neutral psychoanalytic stance was not supported in the current findings. Psychologists actively shared their understandings of their clients in an interactive process, in which the humanness of the therapists emerged, sometimes covertly and other times more overtly as they shared their experiential understandings and responses with their clients. Clients appreciated connecting with another human being who had either had the same experience or who seemed to show deep understanding through their comments to them.

Robyn (C) appreciated a deep level of understanding that was beyond theoretical underpinnings, knowing that her therapist had experienced some of the same life difficulties. This gave her increased trust in Miriam (P). Robyn (C) said,

“It’s an identification...yeah, rather than talking about it from a purely intellectual level. She’s walked the walk. Both have four kids. Not all of them are fabulous. All of those basic, mundane. She is not a perfect Mum. Yeah, relationship problems. All of that every day, mundane stuff that you have to wade your way through” (Appendix K, p372)

Tracy (C) also commented on the experiential knowing of her psychologist,

“Well it made me feel really connected and there was this understanding that she really did know what it was like for me. That she had actually had some experience herself. It might have been a different experience, but she had been through something similar. She had that inside understanding of what that is, which I don’t think anyone else really can. They can have an empathy. But to actually have that real understanding. It’s different if you have actually been through it yourself” (Appendix K, p221)

For Jake (C) there was a sense that Sam (P) had a cultural knowing. He said,

“I guess he (Tom (P) understands that American family history of post-world war two era. It seems to make a difference. Oh, just a sense that he understood” (Appendix K, p360)

In contrast, Kate (C) felt deeply understood by Tom (P), regardless of his previous experiences. She said,

“And possibly (Tom (P) never been sexually abused and therefore, you can talk and be all psychological about whatever effects are but unless you have been sexually abused you don’t really know. But he is the closest I have ever come to somebody understanding” (Appendix K, p46)

Kim (C), whose life story was complex and culturally very different to Miriam’s (P), found that even though she had been to various mental health specialists, Miriam (P) was the only one who listened effectively to her. She said,

Miriam (P) very respect me... Because she understand in my life. No one understand...I try to tell my story to someone, but no one want to listen. Even my children, they don’t want to listen and then I don’t know who I can talk, I can only talk with Miriam (P)” (Appendix K, p364)

Deep understanding did not seem to rely on the same direct experience, however the psychologists seemed to be able to resonate comprehensively with the clients’ experiences even if they had not had that experience themselves.

Clients appreciated a collaborative discussion, which differed from the traditional psychoanalytic stance of ‘client on couch’ and therapists offering interpretations from a position of neutrality. Many clients in the present study including Peter (C) appreciated a collaborative approach related to understanding, with Felicity (P) assisting him with integration of his experiences.

“So I’ve been ready, so that’s part of it, and Felicity’s (P) provided it, um, I call it the room of logic. Like once I am in the room, I am protected, I can say whatever I like, we make decisions on how to deal with things, that seem so logical. Like ok, I can see what you are talking about..... She um, I guess now have built up, we’ve got all the history down, so we’ve got all the issues. I don’t have to go back over and say remember how that links with that. She does that” (Appendix K, p23)

Bess (C) also liked the togetherness of the therapeutic process of understanding. She said,

“I love how, you are not just sitting here. I love her focusing, where she helps, this is my understanding. It’s like there’s a whole lot of electrical points happening in your brain and because of fight, flight and that was what I was so used to, she is helping me take those wires away from those (clicks finger)” (Appendix K, p170)

Psychologists also spoke about experiential understanding. Jenna (P) explained her own vulnerability in helping her to experientially understand her clients. She said,

“Also acceptance and understanding. As a person they are relating to, I am also just a person. And you know, broken too. I don’t have to pretend that I am not. That helps in my understanding of them. And that deepens their trust” (Appendix L, p252)

Sam (P) extrapolated parenting of his own children, to resonating with the inner child within the adult. He said,

“I think having children is a helpful lens into understanding processes of adults.....And sometimes I will make examples like with him. I will share with him...You know a particular idea, about the desire to be responded to, or the desire to be connected to” (Appendix L, p293)

The need to convey understanding actively and overtly as found in the current study was also made by Chu (2011) in response to the common tendency of survivors of childhood trauma clients to perceive their sense of self as boring or misunderstood (van der Kolk, 1996; Paivio & Pascual-Leone, 2010). Hence therapists were encouraged to make their perceptions explicit, rather than leaving the clients to make sense of their experiences and the relationship alone. Client perceptions were thought to be more likely negative than realistic (Chu).

Some authors have supported the findings of the current study in that the traditional psychoanalytic approach was thought to be unsuitable (Chu, 2011; Paivio & Pascual-Leone, 2010), as too much withholding by the therapists and lack of responsiveness through neutrality, can be misunderstood by the complex trauma clients as therapists’ disapproval or disaffection. Extreme client reactions can be disorganised, paranoid and overwhelming (Chu, 2011). In contrast the therapists were guided to be more active and mindful of periods of silence. Being less engaged and more neutral with clients was also seen as ineffective for this cohort due to the sometimes negative fixed beliefs that complex trauma clients may maintain about themselves or others, that required challenging (Chu; Elliot et al., 2005; Paivio & Pascual-Leone). A more

collaborative approach to understanding clients was indicated and supported by these researchers.

Young's (1990) Self Psychology differed to traditional psychoanalytic therapy in that it had a stronger focus on delivering empathy through the therapeutic alliance. Under the Self Psychology umbrella, Schema Therapy was an integration of psychoanalytic and humanistic psychology. He emphasised empathy to be used therapeutically (Young, Klosko & Weishaar, 2003), with an emphasis on understanding and acceptance of the clients' experience (Schechter & Goldblatt, 2011). The therapists were like mother figures aligning with Rogers' unconditional positive regard, acceptance, prizing, and valuing of the clients (Kohut & Rogers, 1985). Kohut separated empathy into areas of understanding and interpretations. Understanding was about making sense of the clients' current world, whereas interpretations referred to making links with childhood experiences of empathic failures by parental figures. Both were used therapeutically to develop a more balanced and connected self (Bohart, 1991), and examples were found in both as useful for the findings of the current study.

Deepened understanding with personality disordered individuals was conveyed through utilising Schema Therapy which assisted therapists to understand their clients' behaviours and their underlying childhood origins of the problems, which alleviated judgment and reactivity. Young, Klosko, and Weishaar (2003) described four factors of childhood origin related to abuse that contributed to the development of Borderline Personality Disorder (BPD) for example, namely; genetics and temperament, childhood experiences in and out of the family, interaction between the child's temperament and parenting styles, and reactions of caregivers. The family environment was found to be unsafe or unstable, emotionally depriving, and with parents who were highly punitive and rejecting (Kellog & Young, 2006). These individuals experienced neglect, and sexual, physical or emotional abuse (Lobbestael, Arntz, & Sieswerda, 2005). Occasionally in the absence of identified abuse, there was thought to be a parental mismatch between the parent and the child. Parents with authoritarian and rigid parenting who had difficulty handling intense emotions of the sensitive child, resulted in frustration and anger in the child, ending in disconnection (Young, et al.). This approach may have overlooked the failure of the client to self-disclose and to reveal the abuse either intentionally or through lack of awareness. Nonetheless, when working with survivors of childhood trauma an empathic and accepting attitude are considered

important to give messages of caring and to prevent eliciting a sense of judgment through pathologising, or eliciting feelings of abandonment that may lead to dropout (Young, et al.) as frequently experienced with this cohort (van der Kolk et al., 2005). The knowledge gained through Schema Therapy assists therapists to more fully understand their clients and to be able to empathise more deeply. This contrasts with pathologising clients or reacting negatively in response to them. Similarly, the psychologists in the current study presented with a broad depth of understanding of clients within their past and present contexts, with an absence of pathologising and deep sense of endeavouring to understand their past experiences, and with a consciousness not to retraumatise their clients through repetition of these events.

Barrett-Lennard (1962) defined empathy as,

“Sensing the immediate affective quality and intensity of the other’s experience as well as recognising its particular context” (p3)

This aligned with findings of the present study supporting early researchers in the area of cognitive and emotional empathy. Barrett-Lennard (1962) elaborated further to include the empathic knowing of the inner experience of the clients with an absence of the therapists’ own agenda, and as a human to human personal encounter. An acknowledgement that both client and therapist have feelings, self-perceptions and a position in the relationship were required (Barrett-Lennard, 1962), which seemed more aligned with the emotional and cognitive components of empathy. Understanding of emotional states defined through a cognitive lens was supported in the current study however, it was accompanied by deep emotional empathy, as discussed in the next section on emotional empathy.

In the late 1970’s and early 1980’s empathy was used in the context of helping skills training and research which was scarce in this area between 1975 and 1995 (Elliot, Bohart, Watson, & Greenberg, 2011). However, after this time there was a resurgence of empathy research and it has now been researched extensively. Empathy has been found to be a positive factor in the therapeutic alliance across therapeutic orientations, therapists and contexts (Bohart, Elliot, Greenberg, & Watson, 2002; Elliot et al.; Kivlington, Patton, & Foote, 1988; Lei & Duan, 2014). When empathy has been included as a relationship condition, it has been found to mediate good therapeutic outcome (Greenberg, Elliot, Watson, & Bohart, 2001).

The outcome of Greenberg and colleague's (2001) meta-analysis of 47 studies on empathy between 1961 and 2000, found four factors that correlated with empathy and improved outcome; being understood within the relationship; a corrective emotional experience; finding meaning through cognitive and emotional processing; and client factors such as being open to therapy and an active participant. The most prominent of these factors was that the client felt understood by their therapist (Elliot et al., 2011; Greenberg et al.), aligning with the present study. Being understood was thought to facilitate a sense of safety which enhanced self-disclosure, increasing the likelihood of the clients remaining in therapy and improving therapy satisfaction and compliance (Greenberg et al.). Similarly, in the present study cognitive understanding was found to relieve clients from confusion and uncertainty around intense feelings and physiological responses. It provided validation for what they were going through and a sense of togetherness. This was thought to provide safety for the clients to trust their psychologists. Psychologists were conscious of maintaining safety through not repeating patterns of abusive attachment figures, as a result of their comprehensive understanding of client experiences.

Person centred therapy also emphasised cognitive understanding and meaning making within the therapeutic encounter (Elliot et al., 2011). Their research extended explanations of empathy in the Person centred stance explaining details of how to implement empathy with clients and the importance of conveying understanding overtly and actively. They made recommendations for all therapists regardless of psychotherapeutic orientation. Therapists were encouraged to be emotionally attuned to their clients, translating their clients' experience into words, rather than simply repeating back clients' words and thus deepening clients' emotional experiencing. Also therapists were guided to assist clients to explore goals, values and feelings, stretching the clients to the edge of consciousness and bringing forward that which might not be yet quite conscious (Elliot et al.). Therapists put forward their tentative guesses about their clients' experiences (Elliot, Watson, Goldman, & Greenberg, 2005; Elliot et al.). They may or may not be accurate. The clients were thought to be the experts of their experience. Findings of the current study conveyed a deep sense of understanding that was actively and effectively conveyed to clients, by a humble and tentative therapist approach, with clients as experts of their experiences (See Chapter 6 on Power and Control). Comments from clients and therapists included metaphors (see Chapter 4 on

Acceptance) to describe clients' experiences and a level of understanding well beyond the words that the clients used in narrative. Clients in the current study appreciated the psychologists' intuitive knowing, not having to explain everything with effort, sensing that the psychologists understood sometimes without using words, and consequently they felt deeply understood. The exact notion of extending the clients slightly beyond their level of consciousness did not emerge specifically, perhaps because clients were not aware and the psychologists might have done this implicitly.

Deep understanding was developed through a process lens by the psychologists interviewed by finding meaning in their clients' current experiences and behaviour that went beyond diagnostic labelling. This tended to leave the clients feeling validated. Finding meaning with the client might have deepened psychologists' engagement and presence with the clients and assisted understanding. Meaning was considered by some "intrinsic to all therapies" (Holmes, 2014), although was emphasised more in some psychotherapeutic approaches than others (Paivio & Pascual-Leone, 2010). Suffering was thought to be relieved when we made sense of our experiences through a reframe (Elliot et al., 2005; Holmes; Paivio & Pascual-Leone), which emerged in clients' comments in the present study. Clients felt a relief that they were sometimes for the first time understood, in their responses, their relationship dynamics and in covert abusive environments. This reassured the clients and helped to combat feelings of being overwhelmed and alone. It frequently counteracted early childhood experiences of not being understood.

3.2 Deep Emotional Empathy

It was hard to capture in words the profound depth of humanness, warmth and caring shared by both psychologists and clients about each other in the present study. Both groups of participants depicted a deep, human to human, relationship with a high intensity of positive feelings towards each other. For example, Kate (C) said,

"He is involved with you...Every time you see him, he's glad to see you. He makes me feel special. I think that's what it is, I feel special" (Appendix K, p37)

Kristen (C) said,

"So she (Jenna (P)) is sensitive to what I am feeling, but she also has professional knowledge where I need to go, to heal what's in me....Yeah and she will do it in such a

loving way I guess, because she will say, this is hard stuff..... but it is going to bring a lot of healing, and it may not be today. It's a journey, and I trust her decision. And that is because she is sensitive. She acknowledges how I feel about, or about to feel. Because I can be oh, I really don't want to go there" (Appendix K, p280)

Tina (C) said,

"It is just her personality and nature to be very warm, and accepting and feeling again. All psychologists have that care and concern, but with her it seemed genuine, not just a professional.....so I think they are the most important things....and it's things that a lot of people give lip service to, and say yeah, I do that and not think about it too much more, but I think she really embodies those qualities" (Appendix K, p131)

Clients perceived the therapists' caring as genuine, rather than staged or artificial. They carefully watched, gathered data and analysed the depth of caring by the psychologists, determining whether their therapists' primary concern was the clients' wellbeing or their own predetermined agenda. The clients then either increased in trust, held back and defended themselves, or dropped out. For example, Jessica (C) said that she,

"Started to believe that she had my best interests at heart. She wasn't pushing her own agenda, and that fundamentally she was a good person. That made a difference. She was a good person that wanted to help me...And that made me feel safer" (Appendix K, p240)

Peter (C) said,

"But for the most part I actually feel like I am talking to someone, and that I'm not just a car put on a rack for a grease and oil change, I am actually having an interpersonal conversation and it just makes such a difference" (Appendix K, p24)

Clients had a sense that the therapists cared for them intensely regardless of self-perceived disgust related to trauma, appearance, cultural background, gender orientation or socio-economic background. For example, Valerie (C) stated,

"I had a sense of caring and that really struck me. It must have struck a cord and I kept coming back...I can be reliving something and crying, and snot running down my nose. It's really disgusting and she will come over and sit next to me" (Appendix K, p233)

Tracy (C) commented,

“It was like she, I know she didn’t experience with me, but she was there while I was experiencing it, and letting me know, that I was safe, that I was going to come through it, that it was ok for me to feel whatever it was that I felt. I didn’t have to pretend that I wasn’t feeling it”

Clients were affected by their psychologists’ expression of vulnerability, noticing their sensitivity and expressed emotion. The clients perceived the psychologists’ emotional experiences as affirming genuineness and caring for their clients, helping them to feel safe. Empathy was confirmed through the psychologists’ overt emotion and was interpreted by clients as trustworthy. For example, Josie (C) said,

“I don’t cry in front of anybody. Well I didn’t and I knew if I talked about it I would start crying. But she and I would start to tear up” (Appendix K, p330)

Jessica (C) said,

“I get a real sense that she really gets the pain of certain things and about how absolutely difficult it is” (Appendix K, p139)

Psychologists’ own fragility also normalised imperfections and making of mistakes. Edward (C) said;

“She showed me aspects of humanity, very vulnerable, very fallible, and we make a lot of mistakes” (Appendix K, p307)

In contrast, when the clients experienced the therapists as too neutral, distant, and not showing any of their own personality or self, clients found the experience cold and impersonal and the therapists were perceived as uncaring. Robyn (C) said,

“When her own personality is hidden behind a professional, and that is a very disconcerting approach because if you are not giving out, it is very hard for the person on the other end to be drawn in” (Appendix K, p371)

Brad (C) said,

“It was very cold and it seemed to be just a set of questions” (Appendix K, p337)

This resulted in the clients feeling too distant and removed from the practitioner.

In addition, Jessica (C) said,

“There are many things about other therapists. I got admitted once, I was only about 17. Yeah. It feels like years ago now, and the assessment process afterwards took months, and it was me alone in a room. I was quite a fragile person, as an outpatient, in a room with 2 people that were so cold and heartless, asking a battery of questions. And I hated that....That was definitely a very negative experience.....Yeah, it was very detached....you know, there was no humanness in it” (Appendix K, p243)

Aligning, Cas (C) said,

“Yeah, sometimes when I have seen psychologists or psychiatrists whatever, they are very hmm. Very distant....Sitting back and not meeting me on the same level. And she wasn’t too formal and stiff. It was just her catching up with a friend. It was that personable sort of character” (Appendix K, p262)

As indicated in the above examples, the less emotionally involved, distanced traditional psychoanalytic approach was not supported for developing trust with complex trauma clients. The psychologists remaining fully present and deeply concerned for their clients was significant to their clients, with an absence of distancing by the psychologists or feelings of repulsion towards the client. In contrast the psychologists were fully accepting and stayed emotionally close to their clients. Therapists’ presence is explained further in Chapter 4 on Acceptance.

Aligning with clients’ experiences regarding depth of caring and humanness, psychologists made selfless, profound remarks, typically said with warmth. Adriana (P) said,

“Be a natural human being again. Without words they will observe that, and the messages are clear that my love is just human to human” (Appendix L, p254)

Humanness was thought to assist clients to feel safe and to combat feelings of being manipulated and the significant others having ulterior motives. Jenna (P) explained,

“Because, she is so traumatised again about trusting people in the same way Edward (C) is, but when you show your humanness, they know you are being a person and they can relax. You know, are you being nice because you are a professional, or are you trying to manipulate me or whatever? So when you can get into that human element and show genuine acceptance” (Appendix L, p252)

Transparency created a sense of safety. Sam (P) said simply,

“He needs to know who he is talking to. He couldn’t talk to somebody who was hiding behind theory or a book” (Appendix L, p296)

Felicity (P) explained the importance of deep, presence when actively listening. She said,

“I kind of just spent a lot of time listening really to his story, and um exploring what was going on and um affirming his past therapy and the work that he had done and trying to maintain his relationship with his past therapist as well, I was respectful and mindful of that...Um, so I suppose a lot of it was in a sense empathic listening in a sense of hearing the story, you know setting up, explaining to him how I work” (Appendix L, p15)

The depth of Adriana’s (P) care was apparent in this statement,

“The phone call, yeah. She had terrible flashbacks, terrible flashbacks and awful nights, and after these sessions she would be absolutely exhausted and um I just needed to know she was safe and I felt she needed the umm, the uh, I guess the to know that I cared that she was safe” (Appendix L, p5)

Psychologists cared for the whole person. Irene (P) said,

“And I said I’d really like you to look after your teeth and you know, your knee and do some things for your fitness, you know, it’s your body, having a gammy back and aching every day is not what you would hope for you know, and you still have time to correct some of what is going on, and at least get it to its best shape, so she was going to, so she has been for a massage, which is huge for her, letting someone touch her body, and you know walking, so we kind of chipped away at things. From here, it is up to you, this is what I can see” (Appendix L, p78)

Psychologists reported finding aspects of their clients to connect with and like, which strengthened the bond, regardless of clients’ self-hatred, perceived lack of physical attractiveness, clients’ defensiveness, differences in beliefs, religious orientation, cultural backgrounds, and undesirable behaviours (such as lateness to an appointments, slowness in progress, low level of responsibility). Psychologists were consistent in their caring. Sam (P) was able to be compassionate toward a client who reportedly had difficulty being liked by others, giving off a strong pessimism and defensiveness in his demeanour. Sam (P) said,

“I think he is quite endearing in some strange ways..... So he is very guarded yet I kind of like him. I like his roughness. I like his guardedness. To me it seems endearing” (Appendix L, p295)

Sam (P) also commented on his empathic stance with Kate (C) and her negative self-perceptions. He said,

“Alongside with that there was this deep sense of shame and with that shame she would say something like, I am ugly, how could you like me? Are you going to get rid of me, that borderline sort of... and throughout this process, she would not tell me about the abuse? I knew it was there because she disclosed that she had been abused, but she didn’t want to talk about it because she thought that it was disgusting, that I would hate her, so basically I would go into more of a parental role with her and encourage her and prove to her time and time again that I wasn’t leaving, but not in a way that disempowered me” (Appendix L, p34)

Jenna (P) also made space for intense negative feelings that emerged. She said,

“By the events. The trauma in the room. The amount of emotion in the room. The amount of self-hatred. The fear of what would happen to the client after the session and so forth, so just tried to really make room for person to person empathy... Care and understanding of what she is experiencing” (Appendix L, p223)

Although as one psychologist articulated, there is a lot of pressure currently to be more “clipped and clinical”, all of the therapists interviewed, presented with professionalism balanced with humanness and humility. These qualities were appreciated by their clients. Arrogance and egotistical or a superior expert stance were perceived negatively by clients from previous practitioners, noted through the practitioner’s distanced or cold body language and tone of voice. Jenna (P) shared the fragile aspect of humanity by tactfully and subtly admitting her own weaknesses through words, which she found deepened clients trust. Jenna (P) explained,

“I very much had to be a person and myself because he was incredibly distrusting of people..... To build trust with him, I really had to show my human element. when you show your humanness, they know you are being a person and they can relax. As a person they are relating to, I am also just a person. And you know, broken too. I don’t have to pretend that I am not. That helps in my understanding of them. And that deepens their trust” (Appendix L, p252)

Clients and psychologists were profoundly emotionally affected by each other, as evident in the above examples. After many of the interviews with both survivor clients and psychologists, the interviewer experienced a strong bodily felt sense of deep caring, love and warmth reflecting and affirming the depth of emotion that the psychologists and clients felt towards each other. Further evidence of this was demonstrated through clients' and psychologists' language, tone of voice, tears and expressed emotion in dialogue about one another, which will be elaborated later in this chapter in the section on body language. Psychologists were deeply moved by their clients' stories, struggles and achievements and there was an absence of impatience, intolerance, criticism or pathologising. The researcher also noted a depth of openness, interest, respect and tolerance for their clients by psychologists, when they were discussing their clients.

The focused relationship conditions of unconditional positive regard, deep caring and genuineness described in Person Centred Therapy (PCT) by Carl Rogers were supported in the findings of the present study. Rogers (1967; 2007), described the need for a strong, close, mutual relationship with the clients and for the therapists to actively care and feel positively towards their clients as essential for therapeutic effectiveness. The attitude of unconditional positive regard described by Rogers (1967; 2007) involved maintaining a non-judgmental stance towards the clients despite difficult or negative content, undesirable behaviours or unpleasant thoughts. It was considered fundamental to effective therapy. Rogers' writing depicts a depth of caring and closeness with the clients (Kohut & Rogers, 1985). It has a deep emotional empathy similar to the findings in the present study. The high level of warmth and concern depicted by Rogers was not only expressed through the content of his views, but also through the manner in which he wrote with sensitivity, gentleness and respect towards the clients. For example, he said,

“To be of assistance to you I will put aside myself...and enter into your world of perception as completely as I am able. I will become, in a sense, another self for you-an alter ego of your own attitudes and feelings- a safe opportunity for you to discern yourself more clearly, to experience yourself more truly and deeply” (Rogers, 1951, p35).

Although Rogers' approach was typically thought of as a feeling approach Brodley and Brody (1990) questioned this trend, claiming that 70% of Rogers responses were in relationship to making sense or meaning making of client experiences, in

contrast to a focus on feeling (Elliot, et al., 2011). Rogers may not have labelled emotions within his approach, however he presented the Client Centred approach as a sensitive exploration of the client's world, with a goal of understanding experiences both through feelings and thoughts. Through the moment by moment experiences he empathically assisted clients to process material as it arose. Empathy assisted the client to develop self-compassion and through focusing on moment by moment experiences the client was able to express cognitive and experiential parts of self (Bohart, 1991). Arguably, both cognitive and emotional aspects of empathy were emphasised in Rogers Client Centred Therapy (Elliot et al., 2011).

Perhaps all practitioners would assert their care for their clients, and many current psychotherapeutic approaches made mention of Person Centred Therapy (PCT) characteristics (e.g., Acceptance and Commitment Therapy (ACT), Cognitive Behavioural Therapy (CBT), Emotion Focused Therapy (EFT), however as Rogers noted it was the depth of care and acceptance towards the client from the therapists as a "matter of degree" (Rogers, 1967; 2007, p243). PCT in its purity, and in some psychotherapeutic approaches with PCT underpinnings (e.g., EFT, Emotion Focused Therapy for Trauma (EFTT) the need for deep caring, openness, acceptance and genuineness by the therapist was emphasised as a way of being with the client, and the characteristics of PCT were prioritised as a fundamental attitude of the therapists (Elliot et al., 2005; Paivio & Pascual-Leone, 2010; Watson, 2016), which was found in the findings of the present study.

Even so, with survivors of childhood trauma clients the content can be distressing, repulsive or unpleasant, as it was revealed through the findings of the present study. The importance of the therapists being able to find a means to connect with and like their clients, in contrast to being repelled by them, also aligned with PCT (Rogers, 1967; 2007). Rogers likened the depth of caring as being similar to the parent towards a child, with an ability to love the child regardless of undesirable behaviours (Bohart, 1991; Rogers). He stressed the importance of genuine positive feelings towards the individuals, made explicit by the participants in the present study, who had radars for detecting signs of incongruence or pretence in their therapists. Aligning with clients' comments, the psychologists did not need to be perfect, rather the importance of humility and therapists' fallibility were found to assist clients to trust. This was described by Rogers and more recently Elliot et al. (2011), with the fundamental

importance of being honest and transparent emphasised in their literature. At the same time therapists were advised to be mindful of the depth and content of their own sharing, as outlined in more detail in Chapter 6 on Boundaries. Linehan (1993) encouraged therapists to greet their clients at the beginning of sessions as though it was pleasing to see them, instilling a sense that they were liked. Working on maintaining the liking of clients through understanding their sometimes extreme behaviours was considered a specific goal of supervision for therapists using Dialectical Behaviour Therapy (DBT) (Linehan).

The findings of the present study suggested that the depth of emotional empathy required for clients to develop trust and to sustain the therapeutic process, extended well beyond the early brief mention of therapist client bond depicted by Freud in the 1900's (Shaughnessy, 1995). Although Strupp's (1973) definitions of the alliance involved a sensitive and delicate understanding of the pain and difficulties of the clients' experiences, the psychoanalytic approach historically has had a stronger focus on cognitive understanding and therapists' neutrality rather than deep emotional empathy (Paivio & Pascual-Leone, 2010). Although authors such as Greenson (1965) wrote about facilitating both cognitive and emotional understanding of clients in the 1960's, the emotional empathy described tended to be focused on cognitively understanding what clients were feeling, in contrast to feeling into the client. Nonetheless, increasingly over the time and through the history of psychoanalytic psychotherapy, clients have become more of an active, collaborative participants in the therapeutic encounter in sharing their narrative in the psychoanalytic approach (Maltzberger, 2012).

In more recent years, moments of increased humanness in the psychoanalytic alliance have been noted. Hoffman (1994) referred to the therapeutic benefits of connecting more genuinely with the client,

“When the patient senses the analyst, in becoming more personally expressive and involved, is departing from an internalised convention of some kind, the patient has reason to feel special in this way. The deviation, whatever its content and whatever the nature of the pressure from the patient, may reflect an emotional engagement on the analyst's part that is responsive in a unique way to this particular patient...I would argue that there is something about the deviation itself regardless of content, that has therapeutic potential” (Hoffman, 1994, p189).

Stern, Sander, Nahum, Harrison et al. (1988) similarly described moments of meeting each other relationally. This contrasted with neutrality and making interpretations from a distance. Therapists and clients were considered outside their roles for that moment, as the therapists revealed a more personal aspect of themselves. This was thought to strengthen the therapeutic alliance (Stern et al, 1988). These moments of humanness and closeness between therapists and clients within the psychoanalytic field were thought to be brief deviations from the intervention, rather than being a more central way of being with the client as found by some authors (Elliot et al., 2005; Paivio & Pascual-Leone, 2010; Watson, 2016) and in the current findings.

In concordance with the findings of the present study, Linehan (1993) in Dialectical Behaviour Therapy described peak moments of validation between the therapists and clients as cementing the therapeutic alliance. By this she meant moments of deep genuineness, human to human interaction between therapists and clients which were honest and transparent. It could be a sharing of a positive proud or humorous moment or working through a difficult experience together in the alliance. The therapists revealed parts of themselves in the encounter. Furthermore Schechter and Goldblatt (2011, p 101) described that the therapists' "willingness to engage genuinely and spontaneously validated the patient as important".

The findings of the current study underscored the fundamental need for deep, emotional empathy when working with survivors of childhood trauma clients to facilitate trust within the psychotherapeutic encounter. Although empathy has had an abundance of research generally, and has been found to be a positive factor in the therapeutic alliance across therapeutic orientations, therapists and contexts (Bohart, et al., 2002; Lei & Duan, 2014), caring and genuineness have not often been differentiated from empathy generally. Humanness has been emphasised by complex trauma specialists as essential in the therapeutic encounter (e.g. Courtois & Ford, 2013; Elliot et al., 2005; Kinsler, Courtois, & Frankel, 2009; Pearlman & Courtois, 2005; Paivio & Pascual-Leone, 2010).

More recently, Elliot et al., (2011) defined three ways of expressing empathy therapeutically in more detail. Empathic rapport included; a caring attitude towards the clients while attempting to understand the client's world; secondly, the communicative attunement which involved moment by moment presence and tracking by the therapists to the clients' experiences, and being attentive to what the clients were conveying. This

involved giving empathic responses to convey to the clients that the therapists were present, as emphasised in Person Centred and Experiential Therapies; thirdly, empathy involving an integration of the client's past and present world in order to make sense of how the clients were feeling or what they were currently experiencing (Elliot et al.; Elliot et al., 2005) This latter category was often emphasised in the psychodynamic approach (Elliot et al.), and examples of all of the three areas were found in the current study as described in the quotes earlier in this Chapter.

Psychologists in the present study described stepping inside to feel into and to understand the clients, embodying the experiences of the clients, and conveying those back through empathic conjectures, in a skilled, authentic manner. A level of therapists' knowing extended beyond cognitive understanding to include a deep experiential knowing of the clients through the psychologists' own embodiment of the clients' present moment and trauma experiences (Elliot et al., 2011; Gendlin, 1978; 2007).

For example, Sam (P) said,

“Well it’s complex and trying to understand the client’s sort of what I call character style. It’s empathically trying to sort of feel what that would be like for me and to try and reach into the client and let him know that what’s happened is not so inhuman or dreadful. It sounds very human to me, like I might offer him a reframe around that. It sounds like you have been very lonely... so if I can understand him at that level, that’s a great relief to him” (Appendix L, p291)

There was an absence of impatience and a strong, gentle motivation to connect and understand their clients. Sam (P) said,

“With someone like Michael (C) I have been seeing for a long time, so if he did something I didn’t understand I’d say, I don’t get it. Why did you do that? (Said in a caring and inquisitive tone) I am trying to place myself empathically into that situation and to try and understand what was driving it in that moment. When I say I don’t understand, I don’t mean you have to convince me it was right or wrong, I mean I want to understand” (said in a very caring, gentle, calm manner) (Appendix L, p292)

Being present with their clients' bodily experiences and working empathically to facilitate self-compassion emerged in psychologists' comments. For example, Rowena (P) said,

“And one thing... she soothed....She loved it (putting her hand on her own chest). She puts her own hand on her chest. So without getting too caught up with the intellectual stuff, she is doing something to try and settle her body...It’s wonderful. It was like a light bulb moment. And I love it myself actually.....Soothing yourself, but its gabbling on a bit, but it’s like how do you get someone with so much abuse and trauma to be in their body and to also to just acknowledge it for what it is, in a kindly way” (Appendix L, p175)

Aligning with these findings and in contrast to the more conscious, cognitive understandings of empathy, Elliot et al., (2011) emphasised the therapists’ embodied emotional processes that occurred in the presence of their clients. It was thought by Elliot et al. that empathy needed to be experienced emotionally by the therapists in a bodily sense, and that it was insufficient to purely understand what the clients were saying through a cognitive framework (Elliot et al., 2005; Geller & Greenberg, 2002, 2012; Maltzberger, 2012). The therapists needed to be able to bracket any pre-existing judgments they may have had about the clients or content, and be fully open to the clients in the moment, learning about the clients’ world, as they explored their moment by moment experiences. It was argued that in order to be fully empathic therapeutically, therapists needed to understand their clients through their emotional experiences, as it was those which gave meaning to what had happened. The therapists needed to feel the clients’ experiences in a bodily sense. Identification of the area that seemed most intense emotionally in the moment for the clients was seen as the most relevant to work with therapeutically (Elliot et al., 2005; Pavigo & Pascual-Leone, 2010). Attending to bodily felt experiences specifically and using the focusing method was described by Gendlin (1978; 2007) in further detail. More recently somatic bodily experiences of the therapist have been supported as useful in research (Ogden & Fisher, 2009, Schore, 2003; Siegel, 2012).

Recent neuroscience research supported the importance of therapists’ empathically feeling into clients’ experiences, as found in the current study. These studies revealed greater complexity in regard to empathy than the original motor neuron findings (Decety & Lamm, 2009; Elliot et al., 2011). Our brains were thought to have somatic maps which were influenced by past experiences and stored as memories. Furthermore, bringing attention to bodily experiences can have the effect of deepening the experiential states related to the memory. The clients needed to experience “feeling

felt” by the therapists, in the moment, which elicited change at a neural level (Siegel, 2012, p170). In alignment, the Aeschi group trauma specialists asserted that,

“No patient can be fully understood, engaged and maximally helped until the examiner experiences something of what the patient experiences and then treats the patient as a whole” (Maltzberger, 2012, p34)

These findings as well as the findings of the present study all supported the notion of empathising deeply, emotionally and feeling the emotions of our clients through our own bodies as therapists.

There were differences across therapeutic orientations regarding not only the emphasis that empathy had, but also what to do with clients’ emotional experiences. Within an Acceptance and Commitment Therapy framework, remaining in contact with emotional experiences for too long was considered “emotional wallowing” (Hayes, Strosahl & Wilson, 2003, p279) and thought to be unproductive. This notion contrasted experiential approaches (e.g. EFT, EFTT) which encouraged a deepening of, and presence with, emotional experiencing, which facilitated emotional transformation and meaning making (Elliot et al., 2005; Gendlin, 1978; 2007; Paivio & Pascual-Leone, 2010). Not to remain experientially present to clients’ emotions was thought to be detrimental, either reinforcing avoidance of painful feelings, or invalidating the vulnerable aspects of client selves, with risk of retraumatisation. The findings of the current research supported these concerns (Elliot et al.; Paivio & Pascual-Leone). Clients appreciated the slow, deep emotional processing with the therapist’s presence. Moving away from the clients’ experiences by previous practitioners had been found to be rejecting, or recognised by the clients to be the therapists avoiding the clients. With survivors of childhood trauma this was found to risk eliciting unhelpful, negative perceptions of self. For example in the present study Henrietta (C) explained,

“I just knew at times when I was emotional, she’d tell me, she interrupted my crying and wanted me to be strong, so I kind of felt angry about being interrupted” (Appendix K, p159)

In contrast Hannah (C) said,

“It was like she, I know she didn’t experience with me, but she was there while I was experiencing it, and letting me know, that I was safe, that I was going to come through it, that it was ok for me to feel whatever it was that I felt. I didn’t have to pretend that I

wasn't feeling it... And it was nice to have that reaction...So yeah, it was nice" (Appendix K, p238)

From a psychologists viewpoint Jenna (P) stated,

"Not to pull her out away from what she is experiencing but to be with her and have that as the shining light....That I am with her. The person is caring for her. Not allowing her to be lost in that dark spaces that she would go into. Someone was there for her. Yeah. The despair, the trauma of what was happening to her" (Appendix L, p224)

Sam (P) clarified his non-reactive emotional presence. He said,

"Even encouraging him to be frustrated with me, um, noticing times when he might have bit of a passive aggressive tone to his voice, allowing him to explore that with me, without me being reactive to it, encouraging his vulnerability, because he is quite a measured person, so allowing him to sit in his sadness"(Appendix L, p65)

Empathy and emotional connection varied in emphasis within the complex trauma literature. It was often mentioned when describing empirically supported treatment interventions for complex trauma, however was not always made explicit through detail or depth (e.g. Courtois & Ford, 2009; Kezelman & Stravropoulos, 2012; Mooren & Stofsel, 2015) and was sometimes overshadowed by phases of treatment, and intervention strategies. In these instances, empathy was sometimes demonstrated through case examples, and it was assumed that the therapists would envelop the warmth, kindness and understanding with the client naturally, rather than being explained explicitly (Cloitre, Bryant, & Schnyder, 2015).

The importance of secure attachment and the importance of remaining emotionally present with the clients were given more attention by some trauma clinicians (Chu, 2011; Courtois & Ford, 2013; Paivio & Pascual-Leone, 2010). Paivio and Pascual-Leone (2010) particularly highlighted deep empathy as fundamental in all stages of trauma treatment. Watson (2016) argued that deep empathy was more likely an active ingredient for change, rather than a background condition to be used when implementing interventions. The research findings of the current study supported this notion highlighting that deep empathy warranted broader explanation and significant attention, alongside deep acceptance, issues related to power and control, and boundaries, all to be discussed in later chapters.

Some trauma researchers have continued to advise therapists to maintain emotional distance from clients' content, and to avoid too much identification with the narratives, to minimise vicarious traumatisation (Mooren & Stofsel, 2015). Others have differed in their opinions and asserted the risk of too much observation as therapist with an absence of emotional depth could interfere negatively with the alliance (Chu, 2011; Paivio & Pascual-Leone, 2010). This was due to the potential to repeat childhood experiences of aloneness (Bachelor, 1988; Chu; Paivio & Pascual-Leone). With a lack of emotional depth, the therapists could potentially convey a lack of genuineness which may have interrupted secure attachment. In 15 years of research involving watching of therapy videos of Emotion Focused Therapy for Trauma, a high level of compassion and care towards clients' pain and struggles, and also a therapist sense of feeling sorry about what has happened to the client was found to be essential when working with complex trauma clients (Paivio & Pascual-Leone). The findings of the present study supported the latter, more involved approach while also managing an objective stance and not becoming overinvolved. A balance was required in being empathically emotionally involved, and objectively understanding what was happening (Chu). Further elaboration is made in this area in Chapter 6 on Boundaries. Jenna (P) articulated this succinctly,

“There’s a lot of bodily experiencing because she allows herself to really go in that black hole and experience um bodily, emotionally, philosophically, she really experiences them and describes what’s happening to her and so I myself am experiencing all that. You know, what’s the word. I am experiencing it myself but part of me then has to not be in that to stay out and be the guiding hand as well” (Appendix L, p224)

Psychiatrists in the Aeschi team also actively promoted attending to the clients' subjective emotional experience and asserted that,

“The only observable instrument we have for studying subjective phenomena is the empathic introspection of observer as activated by patient descriptions” (Maltsberger, 2012)

This team of psychiatrists highlighted that if we want to move beyond assessment of clients for treatment and healing then we need to explore clients' inner experiences which require an attuned empathic relationship (Maltsberger, 2012). The information conveyed by the group aligned with the findings of the present study,

supporting the essential need to attend to clients emotionally, through focused, deep empathy.

Bordin's (1979) alliance theory involving an operational definition of the working alliance through the therapist client bond (liking, care, respect and trust), goal agreement and tasks in therapy, included important basic characteristics of the empathic therapeutic alliance, however the depth of emotional investment required for working with survivors of childhood trauma extended beyond a basic level of empathy, as indicated by the findings of the present study. Arguably, aligning with Maltzberger's (2012) stance, Bordin's alliance theory did not capture this depth of emotional empathy.

A small number of qualitative studies have explored clients' subjective experiences related to emotional empathy. Dalenberg (2000) studied trauma clients and discovered that they wanted more transparency from their therapists, because without knowing, they were otherwise left guessing about what the therapists felt. Myers (2000) analysed the writing of five clients, students at a university aged 25 years or older, all of whom had had counselling with the same two therapists, one male and one female. Participants were chosen based on reported strong alliance and ability to reflect verbally. They were asked to describe what it was that they thought was important in being listened to empathically. Results yielded factors of feeling safe in an active and genuine interaction as one of most important variables, highlighting how genuineness of the therapist was important. Curtis et al. (2004) analysed questionnaires from 75 psychoanalysts about their own therapy experiences, finding that therapist genuineness and openness were the factors reported as most useful. These findings were supported in the present study.

Furthermore, in Bachelor's (1988) qualitative study of empathy in therapeutic relationships, 27 clients in therapy and 25 no longer in therapy were asked to complete a self-report in a phenomenological enquiry into how clients perceived empathy in their therapeutic relationship. He examined whether the clients were able to receive empathy and feel understood, revealing four types of empathy received by the clients. These were; cognitive, affective, shared and nurturant empathy. He found different clients emphasised different aspects of empathy as important for them. Cognitive empathy was defined as verbal or non-verbal messages capable of being understood by the therapists, through paraphrasing, asking questions or interpretations with a positive effect of increasing client's self-disclosure and self-understanding and positive contribution to

personality change. Affective empathy was preferred by some clients, in which the clients responded to whether and how the therapist was feeling the same feelings as them, sometimes entirely non-verbally. Perceived shared empathy was a more interactive, shared communication experience in which the client felt at ease with the therapist and responded to his or her genuineness. This resulted in the clients feeling that they were not alone. Lastly, the nurturant empathy was about the sense of security and comfort that the clients felt with the support and presence of the therapist (Bachelor). The findings of the present study supported the multi-faceted nature of empathy generally, and aligned with the notion that some clients showed increased insight and access to emotions compared with others. However, the clients interviewed in the present study appreciated both cognitive and emotional empathy regardless of personality or insight. This may be explained by the duration of therapy being more long term in the present study compared to Bachelor's study which involved clients who had at the minimum only experienced four sessions. For more cognitive clients this may not have been long enough to develop enough trust and ease with therapy to be ready for greater emotional depth. Bachelor's outcomes also reflected a single written therapy moment, which may have altered the breadth of empathy revealed through his results. Nonetheless the findings of the current study found that therapists varied the delivery of empathy to their individual clients. This is discussed further in the next section.

3.3 Deep Empathy through Secure Attachment

Deep active listening while tracking the clients' experiences was described as a cognitive and emotional experience by clients and therapists that enabled understanding and safety. It confirmed and increased clients' perception of therapists' empathy and deepened trust. For example, Cas (C) said,

“So it was more, oh she is really listening..... it soothes your heart” (Appendix K, p265)

Ken (C) felt fully heard by Irene (P). He said,

“No, I think the fact that, what I realised at the time, was what I said to you before was that she allows me to feel that I am heard, and what she was doing right back when we first met, was just that. And I didn't realise that at the time” (Appendix K, p114)

Many clients commented on the therapists being attentive, responsive and with genuine concern and emotionally sensitivity. This depth of focused attention helped them to trust. For example, Michael's (C) commented,

"I think it was his sensitivity to the event that allowed me to trust him. He has never pushed me on anything. Sometimes he will push me on specific things going on inside my head or where I am at emotionally, but this particular one, as soon as I feel upset or am unable to express how I am feeling, he pulls me up almost immediately. So he never pressures me" (Appendix K, p344)

Jessica (C) said,

"She listened and understood. She heard that I was furious at the world. She knew that I was hurting, struggling and then she came out about that line. That is more likely a protection around a sadness (rather than feelings of anger)" (Appendix K, p249)

Georgie (P) commented from a therapists' position,

"I just needed to be really gentle and just take the time..... So she needed the experience from a woman that was reliable, sensitive to her needs, aware of what her opinions are, what her point of view is.....Her feelings are, and not going to be negated and not to be overlooked, and so yeah, I think there were quite a lot of those elements" (Appendix L, p119)

Psychologists also described an *active* listening and attuned approach, noticing verbal and non-verbal behaviours. They commented on how important it was to be fully present and open to their clients. Liz (P) said,

"Really listen to whatever it was that she came with" (Appendix L, p99)

Adriana (P) allowed Belinda (C) to take time to tell her story,

"I think that what has been very important in this relationship is the consistency. Going with listening to her, letting her, it's her story not mine" (Appendix L, p169)

Rowena (P) said,

"So perhaps if I was more detached and clinical and was looking at the more external stuff rather than being relationship safe and supportive, um, it may have been my awareness or my ability to see that level of distress going up over time... So that would make a good listener, I am not sure..... So when I am listening and trying to enquire in a nice way and trying to see what she wants" (Appendix L, p174)

Irene (P) used intuition to attune and accept Ken (C),

“She’s that sort of, needing that wrestle with you, so something I suppose isn’t there, an essential something that you take in....And you find a place with it. It does need to have a little bit of an abrasive edge sometimes or it’s too stark.....But it has to be fond enough and on the money enough.....So how do you judge these things? Well you just do, don’t you?” (Appendix L, p95)

One psychologist also explained the deleterious effects of poor therapist listening and the absolute importance of listening deeply to survivors of childhood abuse. She said,

“Well, it was important that I knew that her two previous experiences of therapy had been....she wasn’t seen, she was invisible, they weren’t really listening to her, she was boring, she wasn’t important, they didn’t really value her, um, also that they probably didn’t feel any of that, but I think you know that the first therapist I think, fell asleep in the middle of the session.... So if you have someone with complex trauma history and real emotional neglect, like lack of protection from paternal figure and hideous sadistic abuse by the paternal figure, um, it would just confirm all those unhelpful, insecure attachment beliefs” (Appendix L, p125)

Listening without responsiveness was seen as negative and perceived as not caring, too distant or the clients feeling too alone. For example, Bess (C) stated,

“I am just trying to reflect to other friends who have been to a psychologist who have nothing come from them. Like they have just been a stone. And when they tell me, what they have gone through, I said, you have got to be kidding me. They say I am sitting there crying, I am doing this and that, and I am not getting a response from that other person” (Appendix K, p168)

Jake (C) also had a similar experience,

“He was there taking notes, and I tried to get some feedback out of him, and he was no, you are alright was pretty much his attitude....And it’s like you are alright after what you have been through and it’s like thanks, I’ve heard all that before” (said sarcastically) (Appendix K, p359)

When asked how Kim (C) knew that a previous practitioner was not listening to her, she replied that it was through her body language,

“Because when I look at her and the way she listen...And not help me anything. And then I stop. I not go anymore” (Appendix K, p366)

Psychologists in the present study described an attentive, focused attunement to the clients during sessions. Tracking of clients carefully and respectfully, regardless of their psychotherapeutic orientation was reinforced by researchers (Elliot et al., 2005; Moloney & Andrew, 2016; Paivio & Pascual-Leone, 2010) to establish what their clients were really saying.

The results of the present study closely aligned with modern Attachment Theory, particularly related to emotional connection, attunement and safety provided to the clients within the therapeutic alliance. Many clients appreciated how attuned their therapists were to them, which assisted them to feel secure. For example, Tracy (C) felt safe knowing her psychologist was closely tracking her,

“I felt like she really walked along side me...I never got the sense that she wasn’t on track or didn’t know what was going on, she was right there” (Appendix K, p226)

Andrew (P) articulated how the attunement assisted the clients to feel safe and emotionally held by their therapists, assisting access to vulnerable material and combatting a sense of isolation,

“I think the tracking of someone is how you facilitate, so the attunement is really crucial because it keeps their anxiety at a low enough level so that they can then um, bring up that material that is quite anxiety provoking and go to those places where there is shame or there’s scary parts or there’s vulnerable parts or things like that. So their attunement of kind of feeling that they are gotten, or that the person is tracking really closely the process, facilitates it So there’s a sense of not being on your own and if there is, it becomes misattunement” (Appendix L, p143)

Andrew (P) continued by adding that,

“When you are visiting these more primal experiences, it almost like you have to be really attuned to be able to walk in them and to be able to walk out again. It’s vital I think. It’s like operationalising the working alliance in the very moment” (Appendix L, p144)

It was essential for the clients to feel safe and held during the evocative trauma processing. Georgie (P) said,

“She found even though it was very, very difficult and really challenging, she was able to go there and know that she was held and felt safe enough” (Appendix L, p183)

The findings of the present study reinforced the importance of a secure attachment through attunement, tracking and responsiveness from a consistent and reliable therapist. This notion has been described in Attachment Theory, with elaboration in emotional depth found more recently (Holmes, 2014). According to Attachment Theory the emotional connectedness and closeness of a caregiver were considered essential in establishing the essential secure base (Holmes; Siegel, 2012). Empathic responsiveness to clients’ vulnerability or distress also facilitated a secure bond (Elliot et al., 2005; Holmes; Paivio & Pascual-Leone, 2010; Siegel). Therapists’ availability, reliability, consistency, ability to instil a sense of mastery, and skills in repairing disruptions to emotional connections (Tronick, 1998; Holmes) were also important. All of these factors were congruent with the findings of the present study. Repairing alliance ruptures is to be discussed in Chapter 7 on Repair work.

In early Attachment Theory, Winnicott (1974) described the mothers’ interaction with their children. The mother was like a mirror to the child, reflecting back to the child the emotional expression of the child in her facial expression. This was thought to assist the child to identify emotions within a context and to learn about who they were, and was referred to as contingency. The child learned to see and own their feelings (Holmes, 2014). Furthermore, when the child expressed an affect, the caregiver responded by mirroring back the emotion with empathic resonance. She helped the child by either exaggerating back a response; stimulation if bored, or reducing the arousal through soothing if the child was hyperaroused. This resulted in a mutual “pleasure and playfulness”, a secure base from which the child learned to develop a sense of self (Holmes, 2014, p149). This attachment framework can be applied to the therapeutic encounter between therapist and client, which more recently has had greater attention to emotional regulation, a factor now agreed upon as paramount by most trauma specialists, and supported by neuroscience studies (Rossouw, 2013; Schore, 2012; Siegel, 2012). Establishing an ability to manage difficult emotions before proceeding with memory reprocessing work was considered paramount to client safety by trauma specialists (Courtois & Ford, 2013; Kezelman & Stravropoulos, 2012; Paivio & Pascual-Leone, 2010; Rothschild, 2000).

A secure attachment between the therapist and client enabled insecurely attached, distressed clients to confront emotionally painful experiences rather than continue to avoid (Holmes, 2014; Mikulincer, Shaver, Bar-on, & Ein-Dor, 2010; Paivio & Pascual-Leone, 2010). The therapists needed to have a “capacity to offer security, and a soothing, exploratory companionship” according to attachment specialist Jeremy Holmes (2014, p 147). The therapists provided an environment that facilitated clients’ openness to express their emotional experiences, to which the therapists gave comfort reassurance and soothing, supporting the clients to emotionally regulate (Holmes; Paivio & Laurent, 2001; Rossouw, 2013; Siegel, 2012). This occurred at the beginning of therapy and throughout, in which moments in any session elicited heightening of clients’ emotional arousal, to which the therapists responded empathically, acting as secure attachment figures for their clients. The sensitivity to clients, and the importance of the secure attachment, was supported by the present findings. In the current study it emerged that clients were affected by perceived moments of abandonment by their therapists almost resulting in dropout during moments when attachment between therapist and client was compromised or threatened. Examples were given from the present study in this area in Chapter 7 on Repair work.

According to Attachment Theory and trauma specialists, past attachment experiences influenced how the clients perceived the therapists as attachment figures. Survivors of childhood trauma frequently have negative expectations as to how the therapists were expected to respond to clients’ vulnerability or distress (Holmes, 2014). Clients may bring perceptions of attachment figures as having narcissistic traits and of being untrustworthy when in the presence of vulnerability and of failing to have an awareness of the clients’ feelings. In contrast, when the therapists offered a corrective experience of a secure base, identifying and responding to attachment needs, and soothing to assist with emotional regulation, a corrective secure attachment was possible (Holmes; Paivio & Pascual-Leone, 2010). Therapists who engaged in insecure behaviours, who were non-responsive, inconsistent, or unreliable may have a detrimental influence on the clients by reinforcing insecure attachment systems (Holmes). Secure relationships were thought to provide “acceptance and non-shaming inducing processing of negative affect” (Elliot et al., 2005; Holmes, 2014, p158; Paivio & Pascual-Leone) which were necessary for trauma recovery. The secure relationship

enhanced tolerance of differences and open communication (Holmes; Johnson, 2004), which aligned with the findings of the current research.

In EFTT, the relationship was thought to elicit change in two ways. Firstly, through collaboration with the clients and using empathy to deepen clients' experiences when accessing trauma memories. The alliance enabled enough safety for this to occur (Courtois & Ford, 2013; Paivio & Pascual-Leone, 2010); secondly, the alliance was a corrective emotional experience that 'combated' earlier parental failures of safe and secure attachment (Courtois & Ford; Paivio & Pascual-Leone). The internalisation of the safe and secure relationship was thought to increase clients' trust in themselves and with others, enhance self-development and heal the interpersonal connectedness that was disrupted in childhood, thus aligning with Attachment Theory and psychodynamic approaches (Paivio & Pascual-Leone).

Recent neuroscience studies have been finding biological support for the importance of safety within the alliance and so reinforcing Attachment Theory and the importance of emotional regulation and secure relationships (Elliot, et al., 2011; Watson, 2016). Managing primitive fear responses has been found to be necessary preceding new learning or the development of new neural pathways (Allison & Rossouw, 2013; Siegel, 2009). Safety created access to the prefrontal cortex and the stabilisation of the limbic system (Henson & Rossouw, 2013). This was particularly relevant to survivors of childhood trauma who were prone to exaggerated fear responses as a result of disrupted limbic system development, as a result of their early exposure to trauma (Siegel, 2012). These individuals frequently presented with insecure attachment styles (Carlson, Cicchetti, Barnett, & Braunwald, 1989; van der Kolk, 2005). Safety within the alliance hence became more complicated and fundamental, as it opened opportunities for the development of a secure attachment, enabling new neural pathways to grow and integrate (Allison & Rossouw; Siegel). These findings aligned with the present study that supported how easily survivors of childhood trauma became triggered into fear responses, and also how responsive they were to their therapists' voices, empathy, acceptance and actions. Remarkable positive changes over time also supported the ability of the brain to change within a secure, consistent, safe relationship. Several examples emerged in the findings of the current study. For example

Hannah (C) said,

“I think the past six years have changed who I am and how I react” (Appendix K, p253)

Cas (C) highlighted,

“Just the awareness in myself rather than a constant state of torture. Just the knowing” (Appendix K, p267)

Edward (C) articulated,

“I was not confident that counselling would be effective due to previous experiences. It has opened many doors. It has given me a sense of worth, that it is ok to make mistakes. It is ok to love without fear or repercussions..... That I now see my parents and everybody in fact in a different light. That I know see the human frailties. I can now understand what it is to live without guilt or shame. That people are quick to forgive..... I suppose you could have described me in the past as a little boy trapped in an adult body. Jenna (P) has shown me what it means to have joy and to live life with hope” (Appendix K, p309)

Kate (C) came from feeling like ‘filth’ to now being able to glow,

“What I put out now is I almost radiate, I am more of me. I don’t leave my body like I used to” (Appendix K, p46)

These incredible changes described by the clients within their therapeutic relationships were life and arguably brain changing, highlighting the potential of healing that was possible within a secure attachment relationship.

Coan, Schaefer & Davidson (2006) implemented a neuroscience study which demonstrated the profound positive effect of secure attachment. Participants were told to anticipate a mild shock during the experiment. In the first group individuals were alone, in the second group the participants held a stranger’s hand, and in the third group individuals held hands with their spouse during the time that they were expecting to be given a mild shock. Using medical imaging they found that the participants who were alone had increased hypothalamus activity and decreased activation of the prefrontal cortex, compared with the participants who had their hand held. The participants who held their spouses hand had the least activation of the hypothalamus and had the least interference to the pre-frontal cortex (Coan, et al.). This was referred to in neuroscience as relational regulation or the social brain (Schore, 2009; Siegel, 2009; Siegel, 2012). These findings were evidence for increased openness to negative emotions and truthfulness when we have secure attachment (Coan, et al.; Holmes, 2014), a necessary

requirement to proceed with trauma reprocessing. Secure attachment was needed for co-regulation, supporting biologically what researchers have proposed in Attachment Theory for years, and also the findings of the present study.

Mc Cluskey (2005) found that purely mirroring emotional states back to our clients as described by Winnicott was insufficient for therapeutic effectiveness. He elaborated that the clients needed affect regulation. The therapists in his study absorbed the affect, shared a facial expression and modified their tone of voice to amplify or soften the clients' emotional experience in the moment. For example, a soft emotion of annoyance in the clients may be amplified, whereas a heightened, manic state may be calmed, by the therapists' soothing voice. There was a managing of the clients' emotional experiences through the therapists. This had the effect of reducing clients' anxiety and coupled with the clients' experience of being heard, assisted the clients to emotionally regulate and to feel understood. Safety was established and an opportunity for openness, exploration and meaning making within the therapeutic encounter became possible (Holmes, 2014; Paivio & Laurent, 2001; Paivio & Pascual-Leone, 2010; Siegel, 2012), aligning with the findings of the present study. Further examples of the effects of the therapists' soothing voices are given in the following section on body language.

PCT described tracking moment by moment client experiences empathically with the goal of the clients to be learning experientially how to process their experiences, to enhance a sense of self (Bohart, 1991; Elliot et al., 2005; Paivio & Pascual-Leone, 2010). Empathy was used during tracking of the moment by moment experiences with the clients to enable processing (Gendlin, 1978; 2007). Empathy was described by Bohart (1991) as like a "spotlight" which facilitated maintaining a focus on the here and now. Information that emerged was worked on (Bohart, 1991, p39; Rogers, 1967; 2007).

Many researchers emphasised attunement to the client (Briere & Lanktree, 2012; Courtois & Ford, 2013; Kinsler et al., 2009), while experiential approaches emphasised tracking and an advanced level of empathic responding (Paivio & Pascual-Leone, 2010), which was also indicated in the present study. Empathic responding was viewed as an intervention in itself which was used throughout EFT and EFTT (Paivio & Pascual-Leone, 2010), taking into account conscious and unconscious processes. Greenberg et al. (2001) summarised,

“Empathic therapists assist clients to symbolise their experience in words, and track their emotional responses, so that clients can deepen their experience and reflexively examine their feelings, values and goals. Therapists need to help clients access as much internal information as possible. To this end they need to attend to what is not said, or what is at the periphery of awareness as well as what is said and is in focal awareness” (p383).

The findings of the present study aligned with the sensitive, tracking and making sense of client experiences, with deep emotional empathy while relating in a genuine manner.

Empathic exploration not only increased client understanding but also assisted them to extend their level of awareness. The therapists explored the clients’ experiences with them, slowly and gently, noticing and bringing attention to areas that were brushed over or unclearly differentiated, and tentatively redirected to the clients. The clients’ narratives were expanded in the moment, as the therapists tentatively put forward an elaborated experience (Elliot et al., 2005; Greenberg et al., 2001; Paivio & Pascual-Leone, 2010). Elliot et al. (2005) gave some examples, in response to a client reportedly feeling ‘flat’, the therapist responded,

“Uh-huh, sort of dead inside, but also a bit like, what’s the use, nobody cares” (p122).

Sometimes the awareness was guided to client internal experiences, with the therapist asking tentatively,

“What is happening inside right now?” (p122).

Empathic attunement and responsiveness were thought to be complex and done well, required complex micro skills and an advanced empathic method that continued to be refined after years of counselling practice (Elliot et al., 2005), which aligned with the psychologists’ humbleness in the present study, and the complexity of detail in the findings.

3.3.1 Individualised empathy

Psychologists reported adjusting their empathy attuning and responding to their clients’ personality, gender, emotionality, and level of arousal of the individual to create a safe and productive alliance. They were able to personalise their compassion. Tom (P) said,

“Being compassionate and caring, in his language” (Appendix L, p295)

Irene (P) differentiated her empathic approach with her clients,

“With Catriona (C) I could be quite robust, whereas with Ken (C) I couldn’t be robust. I had to be very gentle and tentative with him” (Appendix L, p89)

Sam (P) described his individualised approach with Michael (C). He had a more cognitive focus with him,

“For him that is really hard to be emotionally present, to deep emotions in the room. That is quite hard for him, so I haven’t done so much of that. I have gone much more slowly and carefully with him. Cognitive understanding yes, and certainly I would share something that I might be feeling. I noticed this or I am feeling that, but not to stay in the emotional process for so long. That’s just you know a bit intolerable for Michael (C), although more than it used to be” (Appendix L, p288)

With a socially anxious client Georgie’s (P) voice became quieter and more gentle than usual to attune to her. She avoided prolonged eye contact and therapeutic exercises that may have worsened her client’s sense of exposure. Georgie (P) explained,

“I matched her sensitivity and I matched her pace, and I matched her gentleness, because she speaks very quietly, very quietly. It was like I had to turn my enthusiasm dial down. To match that and I think she really appreciated that because as a highly sensitive person she is often around people who are much louder and so I think that really gave her a sense of being understood in a more intimate sort of a way, because I really met her in that more sensitive environment” (Appendix L, p123)

One further example was in the therapist’s withholding of sharing her full understanding of the client, with a client who experienced deep shame, as a strategy to minimise the client’s sense of exposure. Liz (P) described the balance between warmth, distance and genuineness as walking a tightrope, in meeting the needs of the individual client,

“With some people who develop that style as a result of complex trauma, it would be equally alarming to her if someone felt too engulfing or warm, or too much. So I had to get the balance right between not being too cool and being smothering and perhaps coming across as lacking in genuineness, because that is what her radar is up for” (Appendix L, p125)

Tina (C) described appreciating the adaptation of Georgie’s (P) empathy through body positioning and voice during the session,

“It is deep empathy and that she demonstrated it in her non-verbal skills, it wasn’t just using those basic, oh that sounds difficult, in her tone.....In her voice. She would often sit forward like this when I was in a really difficult place....Modulate her voice and speak really quietly. I think it was those things, not knowing that she may have experienced it, it was she was right there with me” (Appendix K, p140)

Recognition of the need to individualise empathy with the different clients’ presentations has been acknowledged by various researchers (Elliot, et al., 2011; Kennedy-Moore & Watson, 2001; Greenberg et al., 2001). Finding the most beneficial distance between clients and therapists that was most comfortable for the clients, and attuning to individual needs while taking into account clients’ boundaries (Elliot et al.) have been found in research studies. Clients were known to have differing comfort zones and it was the therapists’ responsibility to attune to the individuals and to adapt accordingly (Elliot et al.; Holmes, 2014; Paivio & Pascual-Leone, 2010). For sensitive clients, some empathic actions may be too “intrusive” (Greenberg et al., 2001, p383), aligning with the example in the present study of Tina (C) who felt more comfortable without eye contact, because it was thought she would feel less exposed. For a hostile client, empathy may be experienced as too “directive” (Greenberg et al., 2001, p383), which was similar to Tom’s (P) comment. He commented about attuning to Jake (C) through directness and firmness while deeply caring and accepting him for who he was. He said,

“I took a no shit attitude with him. It was obvious from the get go to dispense of writing notes. It was obvious from the get go to just look him in the eye.... I hear what you are saying but there is another side to you. And just call him on things. He responded really well to that” (Appendix L, p294)

Irene (P) sometimes withheld part of her cognitive understanding of her clients to minimise a sense of exposure,

“Their body language. It often happens without conscious connection happening I think, but I do read that, I can read quite well I think without it being articulated. So certainly with Charlotte (C) and with Todd (C) I can then and often with both of them I have to be careful that I am not showing them too much how well I can read them” (Appendix L, p95)

Some clients found empathy too unfamiliar (Kennedy-Moore & Watson, 2001). Furthermore, clients have also been found to have negative experiences with empathy.

For some survivors of childhood trauma the perpetrator of the abuse was initially kind and understanding, hence clients may have a fearful response to caring therapists initially, highlighting the importance of responding to clients' nuances and bringing forward the clients' experiences for discussion. Empathy could also elicit distrust and anger (Elliot et al., 2005). Therefore, most skilled and empathic therapists were thought to adapt their level of empathy to the individual clients (Elliot, et al., 2011), aligning with the findings of the current study.

Some clients were thought to be easier to empathise with than others (Barrett-Lennard, 1981; Elliot, et al., 2011) and to have differing clients' abilities for developing a therapeutic alliance, as being affected by early parental or caregiver experiences. Clients who were more open to sharing inner experiences were found to be easier to empathise with than those who do not (Barrett-Lennard; Elliot, et al.). Also, when therapists and clients were more similar they scored higher on a perceived empathy scale (Duan & Hill, 1996). Some clients exhibited self-hatred with an absence of self-soothing behaviours which created increased difficulties in establishing the alliance. Therapists were guided to be actively affirmative with these clients (Schechter & Goldblatt, 2011). Psychologists in the current study managed to individualise therapy and work with each clients' presentation and personality.

Attachment Theory elaborated on variations in therapists' delivery of empathy with clients. A different approach was necessary for avoidant types who classically presented with high levels of self-reliance, tending to withdraw and distance themselves, when they felt uncomfortable with relational closeness. They could be more critical or even hostile in presentation, undermining the therapeutic process itself. Therapists were encouraged to actively engage with these clients, connecting with them beneath the surface, defensive stance, and empathising with the vulnerability that was hidden beneath (Chu, 2011; Courtois & Ford, 2013; Elliot et al., 2005; Paivio & Pascual-Leone, 2010). Power struggles were avoided and an attitude of curiosity was advised with a solid therapist presence and attunement to non-verbal information (Courtois & Ford). Too much soft, sensitive empathy was contraindicated with these clients. Detachment was reframed as self-protection. Examples such as Jessica (C) emerged in the findings of the present study who appreciated the firm, fair approach from Louise (P) who could see beneath her angry exterior. She said,

“She saw past a lot of defence mechanisms I had up. She saw the good parts of me, that I think I kept hidden” (Appendix K, p242)

Therapists’ emotional empathy was found to be adapted to soothe and reduce hyperarousal in clients, or to heighten and evoke emotion when clients were hypoaroused in the literature (Elliot et al., 2005; Paivio & Laurent, 2001; Paivio & Pascual-Leone, 2010). Empathy acted to create enough safety so as to enable clients to have experiential access to their trauma memories (Paivio & Pascual-Leone). Interventions were focused around increasing awareness of emotional experiences through labelling, accessing emotions, and making sense of emotions, which created a safe alliance from which to allow reprocessing of traumatic memories. Those with over control problems, were guided to learn to be present with emotional experiences. Therapists then assisted clients to manage their emotions that were interfering with the accessing of trauma memories to enable reprocessing to proceed (Elliot et al.; Paivio & Pascual-Leone). Findings from the present study aligned with these findings. Jenna (P) explained her emotional and cognitive approach with Brad (C),

“Helping him to develop a new framework of emotional patterns and to feel his emotions, rather than sitting back in cognitive, “This is what I have inherited”. This is what’s going on inside you, so turning him internally was a very big struggle and again helping him to be vulnerable, and when he is vulnerable to uphold his dignity and space, to take his time. Wherever he was at he was ok” (Appendix L, p276)

Andrew (P) articulated his empathic management of Henrietta’s (C) emotions,

“So I think the sense I got was that she was looking to see if that could be held for her. So to see if the more vulnerable parts could be held and how that would be related to, and ultimately for her experience to be made sense of. So to bring up a lot of vulnerability and if that wasn’t held and contained in a sense that it didn’t lead anywhere, make meaning of it within the context of the relationship, in a sense of meeting that vulnerability, um, that furthered the deepening of the work and her ability to sit in her own distress and emotionality”

Georgie (P) described a consciousness around the pace of therapy, giving her clients space and not deepening the clients’ emotional experiencing too intensely. She said,

“A lot of trust with her was allowing her to express and not rush in, in terms of when she was feeling really, really sad” (Appendix L, p217)

Survivors of childhood trauma in the current study did not make negative responses about their current psychologists’ empathy, suggesting that the experienced psychologists were able to attune to their individual clients and to give them the level and type of empathy that they needed. Many clients commented on the space between therapists and clients, which is elaborated in more detail in Chapter 6 on Boundaries. The above research fits with the findings of the current study generally, emphasising the importance of therapists’ responsiveness to adapt empathy required for each individual client.

3.4 Empathy through Non-Verbal and Paralinguistic Behaviour

Non-verbal behaviours and tone of voice were found to be emphasised as important for both clients and psychologists in the findings of the current study. Clients were found to be attentive to the psychologists’ non-verbal behaviours, emotional experiencing, and voice. They noticed their therapists’ facial expressions.

For example, Kate (C) commented on empathic messages received through her psychologist’s eyes during vulnerable moments, also reinforcing the powerful positive effect of the psychologists’ empathic voice,

“You see the look in his eyes, you know. I’d be mid filth and he’s like, oh Kate (C), that’s awful and it was just like oh, who says that?” (Said compassionately) (Appendix K, p40)

Kristen (C) said,

“I can see in her eyes that she is understanding, that she is not going anywhere” (Appendix K, p281)

The psychologists’ eyes not only conveyed understanding, therapists’ presence and absence of therapists’ avoidance, but also conveyed a sense of security that combatted fears of abandonment. This highlighted the inability of the psychologists to be able to mask their feelings.

Numerous clients made comments related to the therapists’ tone of voice, both positively and negatively depending on their experience. The psychologists interviewed were observed by the interviewer to have regulated, calm voices. Adriana (P)

commented on the profound impact of the clients' responsiveness to her voice in helping her to emotionally regulate when hyperaroused. She said,

"She would straight away respond to my voice" (Appendix L, p9)

Belinda (C) said,

"She was soft. Her tones (voice) were soft" (Appendix K, p9)

Alistair (C) was soothed by Sam's (P) voice and manner,

"That was useful. I think he is quite calm in his manner. His voice is calming" (Appendix K, p71)

Adriana's (P) voice helped Belinda (C) to soothe,

"Yeah and she was able to bring me back here and make me feel calm and safe. And it was by that grounding technique.... just hearing her voice. There was no, come on, Belinda (C) don't be so ridiculous! Type of stuff....Yeah, "no you're being silly now!" (Said firmly and critically)" (Appendix K, p11)

Deep caring was conveyed through Felicity's (P) gentle voice. Bess (C) said,

"She will talk softly and she speaks in that motherly voice again" (said softly)

Psychologists adapted their voices to their clients, which was noticed and appreciated by many clients. The calm, gentle, warm, regulated voices of the psychologists were reported by clients to help them to emotionally regulate and to feel safe. In contrast, clients' trust was detrimentally and significantly affected by a cold, authoritarian voice, which left the clients feeling inferior, judged and at times fearful. Belinda (C) described her bodily fear response being triggered by a critical tone. She said,

"If I detect anything in a tone (voice), my system just goes off" (Appendix K, p19)

Tina (C) said,

"When you are in a therapeutic relationship with someone and you are feeling very open and unravelled all the time, those quick responses can feel very abrupt" (Appendix K, p139)

Kate (C) explains appreciating a gentle voice with an absence of pressuring. She said,

“He’s not pushy or um kind of being I know more than you...He’s not grumpy about the way he puts that across either...He’s again very gentle. He says, what do you think about this Kate (C)? And I like that” (Appendix K, p44)

Peter (C) described his noticing of judgment that can come across in tone of voice,

“I was more concerned that she would judge me and think (said assertively) or that’s not right Peter (C). Or that’s a bit strange” (judgmental tone of voice) (Appendix K, p22)

In contrast, Cas (C) described equality in her therapist’s voice. She said,

“And she was gentle, not coming across like I am the client and like oh yes, you have got this problem sort of thing (superiority in her voice)” (Appendix K, p262)

A firmer voice was used to take a more directive stance in situations in which clients were stuck or repeating old patterns of retraumatising. Alistair (C) stated,

“There was an occasion about two years ago when I was in a bit of a bad space and Sam (P) stepped in and said actually used those words as the psychologists, “I am going to have to step in here”, we need to pull you up on what you doing, because what you are telling me is probably not helping, it’s making things worse. I need you to do this, this and this. It was work related stuff. I needed to change things....He kind of raised his voice, took control of the session, stopped what we were talking about” (Appendix K, p80)

These findings highlighted the sensitivity of survivors of childhood trauma to therapist’s tone of voice. In between sessions the tone of voice in phone conversations or text or email was noticed by clients and either supported the genuine empathic stance if it was warm and caring, or disrupted client trust if there was a hint of therapist’s impatience or a business like manner. The importance of maintaining an empathic stance for negotiating expectations, payment, appointments, and across all encounters with the clients was highlighted as being critical to preserve the clients’ trust in their therapists. This was elaborated further in Chapter 5 on Boundaries.

The importance of a gentle and kind therapists’ tone of voice was described and conveyed by Rogers in Person Centred Therapy (Elliot et al., 2004) and was mentioned in some therapeutic modalities (e.g. EFT, EFTT). Attachment Theory and neuroscience experts also brought attention to the therapists’ voice having the capacity for a soothing effect, similar to that of a parental figure to a young child. The calm, regulated voice

assisted emotional regulation, both to enhance pleasure, and to soothe distress (Quillman, 2012; Schore, 2012; Siegel, 2012). This was also recognised by trauma specialists (e.g. Elliot, et al., 2005; Kinsler et al., 2009; Paivio & Pascual-Leone, 2010; Siegel). Sometimes it was mentioned in case examples bracketed next to therapists' words, "in a soft soothing voice" (Fosha, Paivio, Gleiser, Ford, 2009, p293), and at other times rarely mentioned (Courtois & Ford, 2013; Mooren & Stofsel, 2015). Perhaps this lack of attention was because there were so many issues to address and to consider when working with survivors of childhood trauma that non-verbal behaviours were overshadowed, however the findings of the present study suggested the voice quality and non-verbal behaviours were an important under emphasised area that has both positive and negative effects on the alliance.

Clients disliked therapists' communication behaviours such as excessive advice giving, interrupting or talking too much. For example, Daisy (C) appreciated the slow pace and silence, without being given immediate solutions,

"Well, she listens a lot, Felicity (P). She's a good listener. Maybe I have been to psychologists before that talk more. And give you more solutions and things like that...Um, but the talking was um, the silence from her was actually quite worked for me...Sometimes it's a bit frustrating, it's like oh just tell me what to do" (said assertively and jokingly) (Appendix K, p58)

Hannah (C) also disliked advice giving and being handed instructions or strategies. She said,

"You are the one experiencing it, so in some part you are the expert. It was nice to hear. Not to learn from you, but to listen. Rather than you need to do this and you need to that and the other. Which I have had before. This is what you need to do" (Appendix K, p258)

Daisy (C) clarified the deleterious interruptive effects of the therapist not allowing her the space to talk. She said,

"When some of them jump in to say something, you kind of keep talking and um, and if someone does jump in and start talking, I'll easily let them...It isn't a good relationship for me to have with a psychologist....No, she (Felicity (P)) kind of just listens and, but you feel like she is listening, she is definitely listening, it is not like she is off in her own little world. I look at her eyes sometimes to see if she is looking at me" (Appendix K, p58)

Felicity (P) reinforced how important listening was without jumping too quickly to provision of strategies with survivors of complex trauma. She said,

“Yeah, I think the kind of listening, that I would kind of think about it is, listening for themes...Not just the content. But for what might be the meaning behind these behaviours. So very active listening, kind of taking it all in, um, and not going into a series of strategies. It would have been easy for me, except I don’t work this way, it would have been easy for a CBT to say, “Ok, acting out behaviour! Let’s put in a whole series of strategies”... So we have not done one strategy around this behaviour. Well I think he would have been set up again to be the naughty boy. Because he does that to himself” (Appendix L, p236)

However, Felicity (P) elaborated that sometimes she needed to manage the sharing and listening between herself and Dennis (C). She proceeded to say,

“I think what I worked out was he could take up the whole space just with talking. And for me just to listen isn’t enough. He will take up the whole space, so I realised I had to interrupt him at times. And to hone in on one issue. As opposed to skimming across the surface of many issues” (Appendix L, p241)

Penny (C) found instructive therapy to be unhelpful during her most vulnerable moments,

“I had had a lot of issues for a long time, and CBT, I just looked at it and I was laughing on the inside, thinking you know, this is ok, and I can behave like this for a short period of time. And then something happens and then I am triggered. And I just I don’t think about it, it’s just something that I do. I automatically go into this...I melt down. I don’t have control over it, so all the CBT in the world is not going to fix the problem. ..It’s a quick fix. It’s a bandaid that lasts for a period of time....Until you are triggered again and then it falls apart”

The therapist behaviour of advice giving has been found to be negatively correlated to perceived empathy in research studies (Barkham & Shapiro, 1986; Elliot, Elliot, Filipovich, Harrigan, 1982) and cautioned by trauma specialists as unproductive and potentially detrimental to the alliance with survivors of childhood trauma (e.g. Courtois & Ford, 2013; Paivio & Pascual-Leone, 2010). These findings aligned with the current study. If therapists were too directive, the clients might lose a sense of being in control, a necessary requirement for clients’ empowerment and safety which was agreed upon generally by trauma specialists (Courtois & Ford, 2013; Kinsler et al., 2009;

Paivio & Pascual-Leone, 2010). This issue is discussed in more detail in Chapter 5 on Power and Control.

Hayes and colleagues (2003) highlighted how therapists can fall into the trap of being too verbal, intellectual and potentially persuasive during interventions, eliciting a sense of the therapist being right. This was considered counterproductive within a context which emphasised mutuality and equality and aligned with the findings of the present study. Therapists inferring the client was wrong, or over intellectualising was thought to risk increasing the clients engaging in pleasing behaviours in therapy, which obstructed the experiential learning (Hayes, Strosahl & Wilson, 2003). Alternatively, being too silent as therapist can be unnerving for the clients and reinforced self-critical thoughts (Schechter & Goldblatt, 2011) and has the potential to elicit negative transference interpretations in the survivor of childhood trauma, such as the therapist being disinterested, hostile or uncaring (Chu, 2011; Siegel, 2012). Clients in the current study commented on appreciating an appropriate level of silence to enable them to have the space to gather their thoughts and not be interrupted by their therapists. Being attuned to the individual clients was found to be important.

Clients in the present study also noticed therapists' body language in sessions. They sensed when the physical distance between their psychologists and themselves was too close or too far. The appropriate closeness was reassuring and they felt safer when the psychologists were perceived as being comfortable with them, through non-verbal behaviours. Kate (C) commented,

“His body language was always very open. He always had that focus with you. About this distance, maybe two or three feet....Yeah, so he didn't invade me.....He was very good. Close enough, but not too far. Not too close” (Appendix K, p40)

Tina (C) described the body language of Felicity's (P) presence as reassuring regardless of her understanding of the situation,

“Like physically with her body language and with her voice, it really conveys, well I don't really care if you get it or not because it really feels like you do. It doesn't matter whether I know if you have experienced it or not, you are conveying that you do” (Appendix K, p140)

Henrietta (C) was reassured by Arthur's (P) regulated voice and body language. She said,

“He was just holding me, putting an arm around me and getting me to slow down and stop. He did it in a couple of words in a very gentle way. And he wasn’t panicked. I didn’t feel he was worried about me” (Appendix K, p162)

Catrina (C) noticed that Irene’s (P) body language remained open to her during intense expression,

“She is a very calm person, but I mean I remember in the early days of seeing her, there were times, and I am not proud of it now, but I would just lose the plot...And I have to say I could have matched the language with anybody, having worked in the field I did. Living in remote areas, which is a different world. And Irene (P) used to be so calm, didn’t flinch” (Appendix K, p89)

Eleanor (C) said, with fondness,

“I think she very subtly monitors my breathing” (Appendix K, p195)

Liz’s (P) reading of facial expressions and body language elicited a sense that Liz (P) had a solid knowing of Antoinette (C). Antoinette (C) said,

“She’ll see it first. Well that’s how she knows me so well. I’ll walk into a session and she’ll take one look at my face, and she’ll say, you’re not doing well are you” (Appendix K, p121)

Clients noticed subtle nuances in their therapists. Their therapists’ body language combatted client fears of abandonment through non-verbal presence and a lack of reactivity.

Several clients commented on therapists’ note taking affecting the perceived quality of empathy, quality of listening and therapists’ intention and presence. Having the therapists’ full attention was important. Daisy (C) pointed out,

“She doesn’t take notes either. I think she remembers it. I’ve thought, yeah, that’s a bit different, she doesn’t take notes..... maybe it is good, because she just looks at me and is very engaged the whole time” (Appendix K, p67)

Peter (C) said,

“Then another psychologist, I saw a couple before I saw a lady called Eliza, but the next one I went to, the whole time I spoke to him, he was just ah ha, and writing it all down, so I am thinking, if you are writing it all down, you are actually not listening to it. The

happy medium with Felicity (P), is that every now and again, she'll write something down, but most of the session is she was talking as we are now" (Appendix K, p24)

Therapists and medical professionals were perceived negatively if they were too held back in their body language and demeanour. Clients felt that when professionals were too formally dressed in suits or leaning back too much in their chairs, it often elicited a sense of authority and power which left the clients feeling unsafe and untrusting of their professional. For example, when asked if Louise (P) looked professional, Jessica (C) said,

"Yeah, but not threatening, like in a suit or anything. She was, she was a person. That was a big thing as well. She was just a person. She was just another human" (Appendix K, p248)

Tina (C) described her experience with Georgie (P). She said,

"She was right there with me, in it with me and sometimes physically close and I think that is actually a stark difference between other psychologists who have just, I am going to sit here (leaning back) this whole session and be attentive to you and caring. But she went a level above in her displayed empathy" (Appendix K, p140)

Edward (C) disliked that a previous practitioner's demeanour which was one of superiority. He said,

"Oh well the one that I came across had this air of overbearing principles, like at school. Treated like a child" (Appendix K, p306)

Belinda (C) found an abrupt, direct practitioner disrupted her trust and found his body elicited fear and suspicion in her. She said,

"From the moment he walked in the door, he was really upright and he asked me a few questions, and he didn't go into what was ...just tell me what you are here for" (said abruptly) (Appendix K, p18)

Alistair (C) noticed his previous therapist's ill ease,

"She always looked nervous in the sessions. Which was quite off putting" (Appendix K, p79)

Distant, superior or nervous body language had the effect of negating therapists' empathy and interrupting clients' trust. Body language and paralinguistic³ information were gathered by the clients and used to confirm or question therapists' genuineness and level of care. Clients' noticed if their therapist was preoccupied, distracted, or seemed disinterested through subtle changes in therapist's posture, facial expression, and tone of voice. This drastically altered clients' trust in their therapists, often leading to dropout. Non-verbal behaviour and consistency of empathic communication between appointments were found to have an impact on emotional empathy that in turn deepened or disrupted clients' trust in their therapists.

Non-verbal behaviours have been respected by researchers and practitioners to be important in the counselling encounter for many years (Egan, 2002) with a number of studies particularly in the 1980's and 1990's (Dowell & Berman, 2013; Egan, 2002). Basic counselling has often involved skills training in non-verbal therapists' behaviours (Hill & Knox, 2012).

Aligning with the present study, research studies have found non-linguistic behaviour and paralinguistic behaviour to affect empathy (Duan & Hill, 1996). Increased eye-contact, without staring, has been correlated with increased empathy and genuineness (Darrow & Johnson, 2009; Fretz, Corn, Tuemmler, & Bellet, 1979; Myers, 2000). Furthermore, Dowell & Berman (2013) explored client perception of empathy across two therapists, the therapeutic alliance and treatment credibility. Clients were students mocking counselling through role play. High levels of eye contact and therapists' leaning forward were found to increase perceived empathy, alliance and treatment credibility, giving support for the importance of non-verbal behaviours of therapists (Dowell & Berman) and aligning with the present study's findings.

A few qualitative studies have supported the importance of the positive influence of factors such as body language, eye contact, positively expressed emotion by the therapists, and warmth (Bachelor, 1995; Bedi et al., 2005b, 2006; Mohr & Woodhouse, 2001). More specifically, eye contact and body lean have been found to affect clients' ratings of therapists positively (Hall et al., 1995). Conversely, detrimental effects of perceived counsellors' disinterest, too much directness, and insufficient attention have been found to impact on the alliance negatively (Bedi, Cook & Domene,

³ Para linguistics can be defined as "the properties of voices, separate from the words being spoken that convey meanings" (Baden, 2012, p 263)

2012). The findings of the present study supported Bedi's assertion that non-verbal behaviours were an under researched area of the alliance.

Eye contact, leaning forward and voice quality have been found to be correlated more specifically with empathy (Watson, 2002) as well as a soft and tentative voice (Watson, 2016), which were supported in the current study. Furthermore, a high pitched voice and large variation in voice tone have been found to be correlated with reduced empathy (Watson, 2016). Getting the voice tone and quality attuned to the individual clients emerged as important in the findings of the present study. Some psychologists used firmer voices while others became softer and more sensitive to attune to their individual client.

Psychologists noticed and made sense of clients' body language and tone of voice. They gathered information on clients' status and progress, and were attuned to their clients' emotional experiences, which guided intervention. For example, Adriana (P) said,

"I think its tracking really closely, you know, really watching what's going on for her you know body language, emotionally, pick very quickly when she was leaving the room, when her distress levels were getting too high" (Appendix L, p8)

Andrew (P) described endeavouring to understand his clients' nonverbal behaviour. He said,

"I guess the confusion comes from that the energy that I am witnessing in front of me is not only what's going on. So there's a sense of trying to work out um, sometimes it's about holding onto, ok this person is angry, but underneath that there's some fear or some shame or something else. Um, and keeping those at different levels, at other times presenting is so strong. It's kind of distracting. It's like you are occupied by managing this energy that doesn't give you a context for what's happening. Because it's reactive it doesn't tell me what that person's needs are. It's more that their needs are met. So, I don't understand is it some sort of attachment need. Is it some sort of sense of shame or is it they need to set their boundaries or something like that" (Appendix L, p141)

Jenna (P) explained being attuned to the internal processes of Brad (C). She said,

"This is what's going on inside you, so turning him internally was a very big struggle and again helping him to be vulnerable, and when he is vulnerable to uphold his dignity and space, to take his time" (Appendix L, p276)

Furthermore, Georgie (P) mentioned identification of the most intense area of the clients through observing non-verbal behaviour. She said,

“So my intuition picks up where the most acute pain is in someone. So it’s a target as to where my intervention or my invitation to bring their awareness to, is the pain. So it’s like the most hot issue or the most intense issue” (Appendix L, p157)

Sam (P) spoke about noticing dissociation in his clients through observation. He said,

“He has a fairly narrow window of tolerance. He will dissociate in the room. The way that I’ll know that is that he will say to me, what did you say? He’s gone.....So I have had to track him more closely” (Appendix L, p288)

Miriam (P) noticed positive changes in her clients through non-verbal information. She said,

“The next session she would say oh I have had some moments of feeling so good. You know and you could almost see the theory you know in living colour.....Processing. You could see it next session...Her face shows it. Yes. She is in an amazing place now compared to what she was” (Appendix L, p8)

A strategy of noticing clients’ body language and saying it back to the client to increase their awareness was used by some psychologists. Cathy (P) said,

“I noticed that you were teary or something like that. And she might say it in a really gruff way and I would say I am confused about that process or.....You know if I feel she has moved further away from me or fluttered off or something like that” (Appendix L, p216)

Elliot and colleagues (2005) urged therapists to attend to clients’ voice quality and non-verbal behaviours and to bring clients’ attention to discrepancies between non-verbal behaviour and words, aligning with the finding of the present study. For example clients may have reported feeling fine about an issue while at the same time trembling, moving and fidgeting or showing redness in the face (Elliot et al.). Clients sometimes withheld verbal disclosures, however it was difficult to hide from the body language for example through the eyes (Quillman, 2012). Furthermore, helping the clients to get in touch with their non-verbal behaviour assisted them to use it as a cue to attend to their emotions in the future (Elliot et al.). Some researchers have highlighted non-verbal

behaviour as particularly important for trauma clients, and reiterated attention to verbal and non-verbal factors when relating to clients, due to the likelihood of messages being misconstrued negatively (Chu, 2011; Schechter & Goldblatt, 2011). As indicated in the present study this would need to be done empathically with a level of sensitivity adapted to the individual client so as to avoid excessive feelings of exposure.

Current neuroscience brings attention to and also supports the importance of non-verbal behaviours in the area of sensitive attunement of the clients through embodiment of non-verbal and verbal behaviour in order to respond attentively and to facilitate a secure attachment (Siegel, 2012). The right brain has been found to be responsible for non-verbal messages, voice, body language and affect regulation in the mother and child, and therapist and client (Schore, 2007, as cited in Quillman, 2012). Clients were found to be more responsive to *how* we say messages in contrast to the content of what was being said. In other words the tone of voice and body language of the therapists had a powerful influence on the clients through responding to subtle facial expression, tone, leaning forwards or backwards, consciously or unconsciously through the right brain (Schore, 2012; Siegel, 2012). For example, when asking how someone was going, the facial expression and tone of voice can elicit richer and more elaborate information than a simple response such as good thanks (Siegel, 2012). Furthermore, Quillman (2012) noted that,

“It is as much, or more the sound of the voice as it is the words spoken that succeed or fails to touch the lost, terrified, ashamed, and often pre verbal child still curled in the patient’s body”(p8)

Attending to non-verbal information and vocal quality were found to yield important information about the client and also have a powerful ability to assist in a sense of trust, care and security.

3.5 Instilling Responsibility, Challenging and Managing Avoidance

Although genuineness, deep caring and emotional empathy were considered highly influential in the therapeutic alliance in developing trust and maintaining engagement through evocative trauma work, the clients and psychologists in the present study also placed significant emphasis on the therapists challenging the clients, and in managing avoidance of painful material and feelings, in a firm and empathic manner.

With a strong alliance Andrew (P) explained to his clients transparently and directly about the potential work that needed to be done to elicit change. For example, he said,

“I find if you have got a good working alliance, you can put it on the table a bit more and say you know this is my sense of what’s happening and you keep going around in this pattern here, and until you address this or that, or until work through this or that, it seems that you are going to be stuck” (Appendix L, p144)

Related to managing alcoholism, Sam (P) instilled responsibility through gentle guidance without being instructive or authoritarian,

“One of the things that I have tried to do is to circle back to the therapeutic relationship. My approach to this stuff is to try and help him to come to the point of making his own decision on that. Rather than saying to him, you know that you are not allowed to drink.... How do you think you are managing? What are your goals?” (said firmly and empathically) (Appendix L, p287)

In response to a depressed client, Irene (P) gave the message to Evie (C) of her choice in taking action to change her situation. She said,

“You have to do some things. I am getting the feeling that you would like me to be like your mother and to come around and to get you out of bed and dress you, and feed you and to do all those things, and she did say well it’s only natural to feel that way. I said I know it is Evie (C) but the truth is there’s a lot here, a lot of care, but that I am not your Mum. You have to find that in yourself. And that was huge for her” (Appendix L, p81)

Adriana (P) spoke about Belinda’s (C) positive changes and taking of responsibility,

“She has certainly had some setbacks and fairly recently from memory....but she doesn’t hit the depths that she used to and she comes out of them much faster. She is sleeping well. Joyful about life and can see a future and she said to me the other day “I have pulled down the walls and I have started to build boundaries. A big contrast to where she started off which was around life and death” (Appendix L, p13)

Psychologists gently and confidently guided their clients back to overcome avoidance, in collaboration with their clients and without shaming them or dominating. Clients knew that they had to be ready to confront painful parts of self and to make changes in their behaviours, and were prepared to do this under their therapist’s

guidance, at the right time. Psychologists' firmness and directness were balanced with warmth and deep caring. Some clients appreciated the clear directness of the therapist, whereas others preferred more gentle tactfulness. No clients reported negatively on therapists holding the clients responsible in managing avoidance, when it was done respectfully. However, as outlined in Chapter 6 on Power and Control, effective therapists maximised control in clients, particularly related to accessing trauma material, and managed alliance issues or ruptures if they occurred (See Chapter 7 on Repair work). Managing avoidance during therapy was supported in clients' subjective experience in research by Curtis et al. (2004) whose clients expressed through questionnaires that their therapists managing the clients' avoidance was one of the most helpful factors in therapy.

Experiencing empathy and listening alone were considered to be limited by some clients who experienced this during previous counselling experiences. They needed more active and evocative therapy. For example, Daisy (C) said about a previous therapy experience,

"It was great, but it probably didn't get to the real reasons why I might have been angry" (Appendix K, p63)

For Jake (C) listening alone was too passive. About a previous therapist, he said,

"They just sat there listening...not enough interaction I guess" (Appendix K, p354)

For Catriona (C) being heard without feedback from the therapist, meant that she practised her well-worn path of avoidance. She wanted increased directiveness from her therapist.

"I needed someone who wasn't going to let me do all the naughty things I could do, to get out of what needed to be done. And in her lovely way, she did that" (Appendix K, p101)

Alistair (C) described the pace of challenge being manageable and with clear purpose. He said,

"I found that difficult sometimes, but I guess there was also a part of me that was also looking for that too. It wasn't just about being comfortable, it was about being challenged....Yeah, the way he did was positive, it wasn't constant, it wasn't happening all the time....But that was about challenge, making it a bit uncomfortable with a purpose" (Appendix K, p69)

Kate (C) reiterated Tom's (P) approach to address her sense of being stuck, in a gentle voice,

"You are going about it in a one track mind and you think this is it. There can't possibly be other views on things, but he says what about this and what about that?" (Appendix K, p44)

It was important that the clients took responsibility for their own healing and had a persistence to remain in the process. Peter (C) wanted Felicity (P) to help by holding him responsible. He said,

"Whereas with Felicity (P), the relationship has gotten to a point, and I was completely honest with Felicity (P) from the start, and I said to her here's the thing, I will hide from things if I think they are going to be adverse on me...From the start, that this is what I do. I have done it for yours, it doesn't work, um don't let me off the hook" (Appendix K, p22)

Bess (C) knew she had to take responsibility,

"I didn't go in there expecting her to fix me...I needed someone to help me to fix me...And I have done a lot of work...I knew it was going to be hard" (Appendix K, p166)

Xavier (C) explained,

"And I don't take it personally what she says. I just say well, even though sometimes I walk out of here and I have been challenged, you know because I have had to really look into myself and not to chuck stuff onto other people and I think that's a really hard one" (Appendix K, p294)

Belinda (C) took a leap of faith,

"I had to put a lot of trust and faith in her" (Appendix K, p10)

Jake (C) realised that he needed to take action to move forward,

"Yeah, well the last visit he said he said well if you are not willing to change then I feel obsolete...Yeah well he can't do any more if I am not willing to change..... I know the ball is in my court" (Appendix K, p357)

Laura (C) knew that the more she put in, the more she would benefit from the therapy. She said,

"So I felt as though I needed to share as much of what I felt as I could, in order for her to understand and for us to then go from there to helping me" (Appendix K, p142)

These findings in the present study of the clients' contribution to the counselling process was supported by researchers (Hatcher & Barrends, 2006; Schechter & Goldblatt, 2011; Wampold, 2001), including finding differences amongst individuals in their abilities to remain present to uncomfortable feelings (Hatcher & Barrends). Clients in the present study had to be willing to endure the experiential discomfort inevitable in trauma therapy. Differences amongst clients' tolerance to painful material emerged in the present study, as found in the following examples. Jessica (C) noted that she came regardless of her own resistance,

"There have definitely been times when I didn't want to come, because I knew it would be confronting and hard, and I knew I had stuffed up and I didn't want to face that....But I don't feel like any of that was her. I think she was always been pretty good" (Appendix K, p244)

In contrast, Irene (P) described Hugh's (C) avoidance patterns,

"I thought it might have been aggression. Like it was almost impossible for me to speak. When he arrived, time was pretty pressured and in the last couple of minutes he would throw all this stuff and I would go oh God. Why are you telling me this now?" (Appendix L, p88)

Cas (C) appreciated the gentle guided empathy and realised that she had to take a massive leap of faith in confronting her fears. She said,

"I was able to face some memories for myself that I hadn't gone to for 25 years. Not that I was able to go into details with Jenna (P), but the courage I had to face. It was big for me and awful. Awful enough but also freeing. It's freeing in the end, awful going through it. Like you are a wreck for a month but in the end freeing. So it's almost like you have got to be open to go through the pain of it. You have got to be open enough with what Jenna (P) is doing. She is gentle, encouraging. I don't know how she does it, but it's gently, encouraging you to let you face the pain" (Appendix K, p268)

Belinda (C) described the huge courage that was required to participate in the therapy process. She said,

"And um I wanted to talk. I wanted to talk. I wanted to let her know. I wanted her to help me. And ah. It was about courage. I had to find the courage to talk...Some days I left here without saying much at all...And I would go home and I would be exhausted, totally exhausted...And I would sleep. I was that tired from coming here. I would sleep for a few

hours, then I would be up...I wanted to talk. I had all these things I wanted to say....I had all these things I wanted to ask (teary)” (Appendix K, p9)

The differences in clients’ comments regarding remaining in the difficult therapeutic sessions were not surprising given the diversity amongst clients in their trauma histories, personalities and life circumstances.

Belinda (C) described a recognition that she had to reach out and take the lifeline that Adriana (P) had thrown. She said,

“You got home and you thought well I have to get courage, something has to happen, and I have to keep seeing Adriana (P) and I have to keep going on? She was like a lifeline. And ah it’s like you reach out for the lifeline but you’ve got to actually grab” (Appendix K, p10)

The balance between empathy and instilling client responsibility emerged as a complicated balance with these survivors of childhood abuse. Finding it difficult to remain experientially present to their experiences, survivors of childhood trauma tended to interrupt their feelings through avoidance strategies that sometimes remained ingrained for years. This limited clients’ freedom as they avoided similar environments and not infrequently they became socially isolated and emotionally numb (Elliot et al., 2005). Given that clients develop sophisticated avoidance strategies, delivering the correct level of directiveness at an appropriate time, pace and attuned to their individual clients required skill, judgment, deep caring and interpersonal presence from the therapists.

Psychologists were balancing an empathic holding while instilling responsibility in clients to remain in the therapy process even though difficult and evocative, with an absence of rescuing the clients. Trust in the client and the process was required. Adriana (P) stated,

“She has found her own solutions her own life and that’s how she has not taken her own life. And she does. It’s remarkable what she puts up with... Yes, I do have a philosophical position of everybody has got their answers.....Well I think with a client like Belinda (C) who has suffered and continues to suffer, it’s tempting to get over involved, to want to protect you know do more, and of course at the end of the day, it’s about her doing more, not about me doing more” (Appendix L, p10)

Jenna (P) reinforced the importance of not rescuing clients also. She said,

“There’s a lot going on isn’t there at the end of the day. You are working on all cylinders...Which at any moment can be exhilarating and at any moment be devastating as well....To experience such awful places that humans can go to, particularly at the hands of other human beings....In that hopelessness and helplessness, and feeling that there is no escape. So keeping that light at the end of the tunnel that there is a way of exiting, not escape, but you can’t take that person there until they are ready to exit themselves. You have got to go through the emotion to come out the other side” (Appendix L, p226)

Tom (P) also explained his strategy to not rescue his client,

“Yeah, I wasn’t there to rescue here. I was there to show her that I am there. I didn’t want to go into rescuer mode, because if I go into rescuer mode I would have become frustrated with her and then somehow hurt her or disengaged from her in one way or the other. She was trying to create and to prove a point that none wants to engage with her. She was trying to prove that in the room”

Davis and Frawley (1994) described four roles that trauma clients can enact within the therapeutic encounter that required active therapist management beyond empathic responses. These included; being a victim, being an abuser, being a passive bystander, and having a wish to be rescued. Therapists, according to Chu (2011), needed to be actively involved in the enactment, however required a level of conscious awareness in their responses to these roles in order to facilitate a corrective relational experience.

In an abused or victim role, the clients presented as “helpless and devastated, angry and manipulative, appeasing or caretaking, or demanding and entitled” (Chu, 2011, p168; Elliot et al., 2005). The therapists could be drawn into tendencies to rescue, retaliate, withdraw or show passivity, none of which were considered therapeutically productive. Examples of the problems with therapists rescuing and being too passive were described by psychologists and clients above in the findings of the present study.

Similar therapists’ experiences could be elicited through a client abuser role, acting out either a mean invasiveness, distancing and withdrawal, or seduction. The therapists may also be left feeling violated or over functioning in the alliance. These situations left unattended may have resulted in an alliance rupture, hence required the therapists to actively instil responsibility in the clients, through responses that elicited development of collaborative understanding (Chu, 2011; Hill & Knox, 2009). The

therapists needed to have clear boundaries and to set limits, as well as to manage their own feelings (e.g. Anger) (Geller & Greenberg, 2012; Kellog & Young, 2006; Young, Klosko & Weishaar, 2003). This could be stressful for the therapists as at the same time, their clients could feel highly defensive and easily offended, interpreting any form of anger, including the therapist's, as abuse (Chu). If the therapist avoided the confrontation, the anger may be acted out by the therapist in unproductive ways such as distancing, or forgetfulness (Chu; Geller & Greenberg; Kellog & Young; Young et al.). Alternatively, some therapists experienced the anger as anxiety and worried excessively for their clients (Chu). For the clients to learn and be involved in a corrective relational experience, a delicate dance was required by the therapists. The clients benefited from a confrontation which was delivered empathically and collaboratively (Chu; Elliot et al., 2005; Hill & Knox; Paivio & Pascual-Leone, 2010) as found in the earlier examples in the present study. A shared responsibility and modelling opportunity occurred whereby the therapists initiated a confrontation about the relationship, while the clients were simultaneously learning to take responsibility. These suggestions were supported in the findings of the present study and are discussed further in Chapter 7 on Repair work.

As found in the present study, rescuing of clients was considered unhelpful by trauma specialists (Courtois & Ford, 2013; Kinsler, Courtois & Frankel, 2009) who guided clinicians to assist the clients to confront their problems, develop awareness around issues of safety, and in contrast to giving the clients the solution, collaboratively assisted the clients to make decisions and to take positive action (Courtois & Ford). Confronting the clients can be seen as validating. It gave the clients a message that you saw beyond the here and now and into the future, for example "let's talk about suicide" (Schechter & Goldblatt, 2011, p104). Clients in the present study appreciated the confrontation even though they found it difficult.

Clients in the present study did not like what they perceived as aggressive challenging by therapists, or being questioned for what they were saying. It was important for clients to be heard, accepted, normalised and believed, and challenged in sensitive ways. Some clients found therapist's approaches to be impersonal and aggressive. Roz's (C) sensitivity to therapists' aggression was evident in the following comment,

"And challenging me in very gentle ways (Miriam (P)). Not challenging me an aggress, there's a kind of therapy that's quite aggressive. It works for some people, alpha types.

Where the therapist will challenge you but in a slightly aggressive way....Great way to get me to come out of my shell! I just go middle finger raised” (Appendix K, p371)

Henrietta (C) felt safe without feeling challenged by Andrew (P), although appreciated the increasing insights that she was gaining through the therapy. She said,

“And he doesn’t kind of challenge me, or he doesn’t, I don’t feel I have to defend myself or explain myself” (Appendix K, p156)

Valerie (C) described limits to instructive methods that she found limited due to their inefficacy during the post vulnerable moments. She said,

“And I have done that in the past, knowing this is what I have to do to get by the world. This is how I have to behave, if I say this, if I do that, if I dress the right way, I if I talk in this way, if I have positive things, this is the outcome, but that doesn’t work when I go into the whirlpool, when I am triggered” (Appendix K, p239)

What mattered to the clients was how the therapists redirected them tactfully, gently, and kindly back to the trauma. A balance was described between a sensitivity to the clients’ feelings and assisting the clients to remain present to emotionally painful material. For some clients, psychologists were more direct, without pushing them too hard, and always with an attitude of acceptance and openness to the client, while instilling client control.

Psychologists gave clients choices of different paths, delivering thoughts and ideas to the clients in varied ways, attuning to the individuals. Georgie (P) commented on the importance of,

“Not frightening people away. And also reassuring them that there are possibilities of being able to get through this stuff” (Appendix L, p116)

In Cognitive Behavioural Therapy, clients were seen as “requiring confrontation and breaking through clients’ avoidance behaviours” (Mooren & Stofsel, 2015, p26). This more direct approach seemed to be delivered less empathically. More aligned with the findings of the present study, Paivio and Laurent (2001) encouraged empathic responses rather than ‘questions, challenges, or interpretations’ (Paivio & Laurent, 2001, p218). This was thought to reduce the risk of the sensitive trauma clients’ feelings of judgment or fear evaluation, which were easily elicited. However, Paivio and Pascual-Leone (2010) also brought attention to the risk of the clients interpreting a topic

as “taboo” if the therapists avoided it. Also, if the therapists were too protective, the clients’ avoidance could be exacerbated inadvertently by reinforcing negative behaviours (Paivio & Pascual-Leone). Clinicians were encouraged to set firm and direct limits when working with difficult narcissistic behaviours that disrespected the therapist (Geller & Greenberg, 2012; Kellog & Young, 2006; Young et al., 2003). Hence, confrontation with empathy was required which assisted clients to take responsibility and was most psychotherapeutically productive (Elliot et al., 2005; Paivio & Pascual-Leone; Young et al.).

In Schema Therapy, process rather than content was the focus when the clients attacked or devalued the therapists. The therapists were required to remain as an onlooker rather than participants of the clients’ game. The clients devaluing the therapists was thought to be an attempt to avoid painful emotion (Young et al., 2003), hence the therapists understood the motives beneath the overt behaviour. Therapists were recommended to assertively but kindly convey to the clients the unpleasant way that they were communicating to them. The therapists directly gave feedback to their clients and worked collaboratively with them, without being coerced, manipulated or bullied, and used empathic direction and assertion with tactful, firm words (Kellog & Young, 2006; Young et al.). An exploration of entitled behaviour was used to help the clients to understand and become aware of their motives, and the impact on others and themselves. A high level of therapists’ emotional regulation was required to negotiate this complex dance between empathy and instilling of responsibility, with a management of their own triggers and bracketing of reactivity in themselves (Kellog & Young; Young et al.). Examples of psychologists managing their own reactions and instilling responsibility while remaining empathic were found in the current study also in the examples above. Navigating the management of avoidance or confrontational behaviour was implemented with deliberation and firmness, which was made more or less sensitive depending on the client.

The balance between empathy and challenge was also evident through Attachment Theory. The most effective parents have been found to have a combination of warmth and nurturance (frequently the mother) and energetic believing and empowerment (often the father) (Grossmann, Grossman, & Kindler, 2005; Slade, Grienenberger, Bernbach, et al., 2005). Furthermore, optimal parenting for children involved not only parental sensitivity, but also in the adult figure a sense of being in

control and mastery. This aligned with the sensitive and challenging therapists (Grossmann, et al.). Holmes (2014, p152) summarised the qualities of an effective therapeutic encounter as “both soothing and empowering”. He said, therapists,

“Need to not just be empathic but also communicate mastery – a sense that she knows what she is doing, is in control of therapy and its boundaries without being controlling” (p152)

In addition children needed tasks that were neither too easy nor too hard to function optimally (Grossmann, et al., 2005; Holmes, 2014). This aligned with Freud’s wisdom from 1914 of engaging with clients’ “emergent thoughts about neither too deep nor too superficial” manner (Holmes, 2014, p152). The open communication required in a secure relationship also aligned with Freud’s sense of the clients feeling free to say whatever they wanted (Holmes). He applied this notion to therapy encouraging clinicians to be nurturing and also empowering. An appropriate level of difficulty for the individual clients was orchestrated by the therapists, without power differential and with adequate empathy. Challenge with insufficient empathy risked eliciting feelings of inferiority in the clients. It needed to be in consultation with the clients, while tracking and checking in to reassure the clients (Elliot et al., 2005; Paivio & Pascual-Leone, 2010).

According to researchers, therapists brought their own attachment styles into therapy, both secure and insecure types. Avoidant therapists have been found to have a greater tendency to deactivate during attachment need (Diamond, Stovall-Mc Clouch, Clarkin, & Levy, 2003) and anxious ambivalent therapists more commonly hyperactivate (Holmes, 2014). Therapists need to adapt their attachment stance for the presenting clients, initially matching the style and later in a more challenging, growth enhancing way (Dolan, Arnkoff & Glass, 1993; Mallinckrodt, Porter, & Kivlinghan, 2005). For example, therapists may initially be more intellectual with avoidant clients, until they became increasingly able to express emotions in therapy (Mallinckrodt, et al., 2005). Anxious clients may initially be given more boundary flexibility, then tightened and challenged once alliance and security was established (Holmes). Challenge and confrontation were thought to be essential in assisting the clients to develop new perceptions of selves and others through new experiences which were different from the past (Bernier & Dozier, 2002) but also required gentleness and persistence (Courtois & Ford, 2013). Therapists needed to be aware of their own fluctuations in attachment

style, noticing tendencies to be closer or more distanced (Courtois & Ford, 2013; Holmes, 2014). Psychologists in the present study described noticing their own self-awareness and taking action within the therapeutic relationship to address problems. They were highly attuned to themselves as well as their clients and the interaction, as later described in Chapter 5 on Boundaries. In addition, in the present study, Tom (P) monitored his own bodily responses and described careful self-awareness with clients' best interests established to maximise their taking of responsibility. He stated,

“Sometimes I would get frustrated and feel really bored. I wouldn't say, “I am bored of you”. And sometimes I find it hard not to yawn or grit my teeth, and I would say, “Well I find it really hard to concentrate now or connect with you. My mind is wandering. I feel tired, heavy”. That does two things for me, one it helps them, two it helps me assert myself, so I don't start to get overwhelmed by them....I know that I get exhausted if I go into rescue mode. So if I go into over responsibility, go into overdrive, then I can't help my client” (Appendix L, p44)

A more recent advancement of Schema Therapy, namely Emotional Schema Therapy has integrated increased attention to therapists' emotions. Leahy (2015) advised a caring and non-critical attitude towards clients and gave examples of how personal and interpersonal schemas can emerge for the therapists in the therapeutic encounter, interfering negatively with the alliance. For example, therapists perceiving particular emotions negatively (e.g. anger) may have negative cognitions that influence how they address or avoid the anger in sessions (Geller & Greenberg, 2012; Kellog & Young, 2006; Leahy, 2015; Young, et al., 2003). Furthermore, therapists who struggle with intense emotional experiences may have engaged in their own avoidance patterns by rescuing the client, thus inadvertently reinforcing client experiential avoidance (Leahy, 2015). If therapists are not aware of their own tendencies or of how to manage their own personal behaviours and defences in sessions, client care has the potential to be compromised negatively, through the alliance (Geller & Greenberg; Kellog & Young; Young, et al.). Gelso and Hayes (2012, p95) stated that, “Our understanding of others is limited to the extent to which we understand ourselves”. Within this framework the therapists' awareness of their own emotions were highlighted as important, aligning with more recent Attachment Theory and fitting more closely with the research findings of the present study. Numerous clients in the findings of the present study noticed and articulated changes in their therapists' distancing and

avoidance behaviours, and were affected both positively and negatively by their emotional presence or distancing. This is discussed in further detail in Chapter 5 on Boundaries.

Treatment for trauma survivors was thought to require emotional access to and transformation of traumatic memories (Cloitre, Bryant, & Schnyder, 2015; Paivio & Pascual-Leone, 2010; Rothschild, 2000). Avoidance of these memories and related emotions were thought to cause interruption to processing of memories. Complex trauma treatment often involved developing a narrative of experiences, and imaginal exposure methods to access trauma for transformation with resultant recovery (Paivio & Laurent, 2001; Paivio & Pascual-Leone). Exposure based treatments have research based outcomes (Foa, Rothbaum, Riggs, & Murdock, 1991; Paivio & Nieuwenhuis, 2001; Wilson, Becker, & Tinker, 1995), however, dropout rates were found to be high and not all clients may be suited to this approach (Scott & Stradling, 1997; Paivio & Laurent). Nonetheless, an evocative confrontation was thought to be required in order to assist some avoidant clients to access the memories for reprocessing (Paivio & Pascual-Leone).

EFTT facilitated the reprocessing of traumatic memories through specific therapeutic procedures, namely imaginal confrontation (IC) or empathic exploration (EE) which were designed to access and process unresolved trauma, which has been previously been avoided. The techniques were evocative and required a level of tolerance for experiential discomfort as found in exposure techniques generally. Hence, it was essential to establish safety through empathy, validation, and development of a secure attachment first (Paivio & Pascual-Leone, 2010). This assisted insecurely attached clients to confront emotionally painful experiences rather than to avoid them (Holmes, 2014; Paivio & Laurent, 2001; Young et al., 2003). This approach was contraindicated for clients who had high levels of arousal due to the risk of being hyperaroused and overwhelmed. The procedure was controlled, delivered with high levels of empathy and collaboration, and although the client was encouraged gently but firmly to persist, the clients always made the final choice to discontinue if they wanted to (Paivio & Pascual-Leone).

Elliot et al., (2005, p301) summarised,

“Helping clients to feel safe enough to reveal and thereby explore their deep sense of vulnerability may be the key change process in the post trauma difficulties”

This changed depending on the individual clients who presented with their unique yet predictable array of problems, and on the therapists’ ability to establish a secure enough alliance with their clients (Elliot et al., 2005). In the present study the level of directiveness with clients in confronting trauma material varied, as discussed further in Chapter 6 on Power and Control. Perhaps some psychologists in the present study used the interventions to assist access to avoided areas, whereas others created an environment in which they emerged in the sessions spontaneously. Some clients may have needed the more directive approach, whereas others may not have. Either way deep, consistent empathy, with client consultation and control, were consistently found to assist the alliance across researchers, clinicians and in the findings of the present study.

3.6 Summary of Findings related to Empathy

The findings of the current research underscored an advanced level of emotional and cognitive empathy adapted for the individual that extended beyond basic counselling skills. Clients were attentive to their therapists through monitoring of non-verbal messages and knew if their therapists were avoidant, uncomfortable, bored, impatient or distant, which affected them in a way that reinforced negative self perceptions such as; feeling unacceptable, judged and unimportant. Not surprisingly, safety and trust were affected negatively when this occurred. In contrast, the humanness and depth of caring experienced by their psychologists was profound and found to be deeply important to them. The way that this was conveyed varied amongst psychologists with common themes of; deep emotional connection, genuine caring and humanness, bodily felt sensing, connecting with the vulnerable child, comprehensive understanding, tracking, listening actively, body language, tone of voice, and intuitive knowing, all with consistency and professionalism.

Clients felt relief and support through feeling deeply heard and understood by their psychologists. The sharing of insights and delivering of knowledge assisted clients’ understanding and instilled a sense of confidence in their therapists and the process. This enabled the clients to feel safe, to trust and to proceed with therapy. Clients also appreciated therapists’ evocative challenging. Extending the clients and

instilling responsibility was indicated as positive even though this cohort tended to be sensitive to feeling judged and evaluated. The findings highlighted the need not to over protect survivors of childhood trauma clients, rather to balance deep empathy with managing avoidant behavior proactively, firmly and sensitively.

CHAPTER 4 DEEP ACCEPTANCE

This chapter presents examples and summaries of the research findings related to deep acceptance of the clients by their therapists, which contributed towards trust and strong alliance. The discussion has incorporated comparisons and similarities in theories and findings from previous research and literature in the areas of acceptance and validation, acceptance through the use of humour and metaphor; acceptance through therapist presence and the interference of acceptance that can occur through diagnostic labelling.

4.0 Acceptance to the Core

Alongside advanced empathy, clients also expressed the importance of the need for a profound sense of acceptance of not only their thoughts, feelings and behaviours on an overt level, but a deep acceptance of the whole person, past and present, verbal and non-verbal, conscious and unconscious, physical, emotional and spiritual. Of the 30 clients interviewed in the current study, there was diversity in appearances, ethnic origins, sexual orientations, and socio-economic backgrounds. All of the clients experienced being accepted deeply and fully by their psychologists, indicating an ability of the psychologists to be able to relate and be open to a broad array of individuals.

Daisy's (C) experience was,

“That’s a big thing with Felicity (P), that I never get any judgment from her. Sometimes I say some shocking things or I admit stuff, that I might not be that proud about, but I never get any sort of judgment from her. It’s pretty special...Well, it’s like she 100% supports me, it often feels like she is really on my side, or really interested in looking after me, and, like she is really interested in my mental health...And she kind of likes me...Yeah, there’s a sense that she kind of trusts me like she thinks I am alright as well. But, she illuminated a lot of stuff for me that a lot of other psychologists hadn’t illuminated” (Appendix K, p65)

Kim (C) immigrated to Australia from a developing country. She said,

“When I grew up I feel so stupid and worthless and just a waste of space. She didn’t make me feel like a waste of space.....She tried to encourage me that there’s a life. I just need to learn to find it..... I have been able to have someone labelling with how I

felt....And not making me feel stupid....Yeah (tears). I think that may have helped me to trust her” (Appendix K, p12)

Robyn (C) wanted therapists to be open minded and accepting of diversity,

“Yeah I could never relate to someone who was very straight. That’s just not how I am. I need someone who is open to alternative ideas and sees things in greys rather than rigid black and white.....Is flexible in their own ideas.....It’s almost the idea of learning through the therapist, that they are open to your ideas. Then you do open more, because they are open” (Appendix K, p370)

Clients were vigilant to noticing subtle signs of judgment through therapists’ words and non-verbal behaviours. They listened and responded to their own intuition and sensing. Lin (C) who spent most of her life abroad said,

“And that’s why I trusted her. She never grumpy with me or make me nervous” (Appendix K, p362)

Fran (C) determined an absence of judgment related to her sexuality. She said the following,

“I think I liked her straight away. Um, I felt a sense of ease with her and I mean my partner and I are a female couple, we are a same sex couple, so. Neither of us felt any sort of weirdness from her, or judgment” (Appendix K, p59)

Mark (C) described noticing Tom’s (P) acceptance and non-judgment of him through Tom’s responses when he recounted his trauma narrative. He said,

“Around sort of sexual abuse. It is something that it has taken a long time to share with him, um, over time, and I think that for me it was kind of the development of that relationship over time has allowed me to do that....But also his response in the moment was very professional, and empathetic and very affirming...So I think that’s probably one of the things during those difficult times as well, is that in those moments,.... and he has responded in a way that has been supportive, but also therapeutic” (Appendix K, p81)

A number of clients in the current study initially presented to their psychologists with intimidating and angry exteriors. Psychologists were able to see beneath the surface of their defensive stance. For example, Jessica (C) described that Louise (P) could get under her aggression, to access her primary emotions of sadness, shame and hurt. This resulted in a deepening of Jessica’s trust in Louise (P). Jessica (C) said,

“I think what happened was that in the very first session, um, she said to me that, it was sort of her idea that, underneath all my layers of anger and destructiveness was just a core of sadness and she said that was what I needed to work with, not the layers of anger. And when she said that I went whoa. No one has ever thought of that before. Everyone has just thought of ways to calm me down and not be so destructive.....And that’s when I went ok, I am going to give her a go. And that was when I learned how to trust her and her insight. I think it was a chance for me to be accepted by someone” (Appendix K, p243)

This had a profound impact on Jessica (C) who had been to numerous other counsellors. It enabled her to trust and to accept herself more fully.

This genuine and pervasive sense of acceptance by the psychologists helped clients to shed shame, to feel safe and to deepen trust in their therapists and themselves. Psychologists were open to and curious to explore all the different aspects of client selves.

Valerie (C) appreciated Jenna’s (P) acceptance. She explained,

“And very much in the beginning of therapy it was a chance to be accepted, which was big in those days. Yeah, I think it was that first one. There are other moments that come to mind. It was her job to peel back some of the onion layers, the way we see ourselves in the world to get to a truer state or calmer state” (Appendix K, p244)

Psychologists in the present study displayed an openness and acceptance of each individual client aligning with the client comments. They were able to genuinely and deeply connect with the diversity of clients and their behaviours through exploration and interest, and without judgment. Deep acceptance created a sense of safety that enabled clients to be more open and to share shameful material. For example, Sam (P) said,

“Like if he has done something really bad, if he doesn’t have any money. Or if he is having trouble with his sexuality, wanting to be a man. Or he’s gone out and used drugs and kissed a girl. He has told me things which are very shameful for him. I have hopefully not reshamed him” (Appendix L, p291)

Furthermore, Jenna (P) summarised,

“I was going out of my way to connect with him, to accept him where he was at, so he didn’t have to put a mask or anything on for me.....genuine acceptance” (Appendix L, p252)

Tom (P) said in relation to Alistair (C),

“So he told me about his sexual abuse, and then I knew I must be on the right track. But just the general way that I relate to clients, so allowing him to see what my reaction is to him at any point, giving him honest feedback” (Appendix L, p63)

Jenna (P) commented about Edward (C),

“I put so much of myself out there as a seeker and a pursuer..... upholding him and his boundaries and that I really understood him, and labelling his experience of what it was, because his critic could undermine and say it was nothing (said warmly and softly) ... With him, when I realised what his parents had done and the impact on him, it enabled him to have empathy for himself and to attach with himself” (Appendix L, p257)

Therapists’ openness, found in the present study, was supported by researchers (Greenberg, 2007; Moloney & Andrew, 2016; Paivio & Pascual-Leone, 2010; Schechter & Goldblatt, 2011). Openness has been found to be a therapist factor that predicted improved alliance across different psychotherapeutic orientations (Gilbert & Leahy, 2007; Nissen-Lie, Monsen, & Ronnestad, 2010) and has been found to be positively associated with strong alliance in reviews of alliance studies (e.g., Ackerman & Hilsenroth, 2003). It was thought that therapists’ openness would increase the clients’ ability to be open to their own experience (Constantino, Castonguay, Zack, & De George, 2010; Rogers, 1967; 2007, 1980; Razzaque, Okoro, & Wood, 2015).

Openness and non-judgmental acceptance were key characteristics of mindfulness practice, however there were few studies found exploring the impact that mindfulness had on the therapeutic relationship (Razzaque et al., 2015). Razzaque’s et al. study examined the relationship between clinicians’ mindfulness and perceived therapeutic alliance. The cross-sectional correlational design involved 76 mental health professionals who completed questionnaires. Openness to experience and non-judgmental acceptance were found to be significant predictors of strong alliance, empirically supporting the importance of these two factors. They also found that therapists’ practice of mindfulness accounted for more than 30% of variance in the alliance, giving support to their importance (Razzaque et al., 2015).

Psychologists in the present study were non-judgmentally flexible and accommodating of clients, while also instilling responsibility. Jenna (P) was accepting of Penny's (C) delay in responding to her, which elicited in Valerie (C) a sense of trust. Jenna (P) said,

“Because even say if I had not got back to her early enough or something, she might not pick up the phone for a week or so, or she may not turn up to a session, so I am waiting here for her, and so I still give her that unconditional love or the therapeutic alliance would have broken down. And she actually said to me today in our session, I don't know how it got to this place. She said other therapists never stuck by me. Because she has never been able to break through. She said for the first time today she has felt compassion for herself” (Appendix L, p192)

Further details related to psychologists' acceptance and flexible, firm and empathic management of client behaviour and boundaries were presented in Chapter 3 on Empathy; and Chapter 5 on Boundaries. Miriam's (P) deep sense of acceptance and non-judgment extended to Josie's (C) family of origin. Miriam (P) said,

“And again accepting, she will say oh I haven't been able to say no and it's a family member and I'll say that's ok. You are putting it in place. You are putting it in place. It's all happening. It's gonna be this low. And whether that violence is verbal and we label the behaviour. We don't vilify the person. We go that's ok they're, you don't have to look after them anymore, but we are not going to blame them either. So that she can still love them and care for them. But we are separating out, but the behaviour is not ok” (Appendix L, p267)

Miriam (P) discriminated between the undesirable, abusive behaviours from past and present experiences, with the individual family members. Miriam's (P) acceptance of Josie's (C) family was thought to assist Josie (C) in being able to have positive feelings towards her mother, while also holding her accountable for unacceptable behaviours, and facilitating self-protective changes in Josie's (C) behaviour. She also accepted that Josie (C) was making changes at her own pace. This contrasted with approaches that take a rigid view of violence, in which a perpetrator and a victim are identified, and the perpetrator is blamed. While not condoning the abusive behaviour, it also does not demean the individual exhibiting the behaviour. It aligned with the Emotion Focused Therapy for Couples model that reframed aggressive attacks through an attachment framework, in which the intrusive behaviour was often an attempt to

reach the significant other or to gain a sense of control. The process facilitated understanding of the motivation behind the behaviour and acceptance of the whole person. It also encouraged responsibility for the destructive behaviour in a sensitive and empathic, yet firm approach (Johnson, 2004; Kallos-Lilly & Fitzgerald, 2015).

Clients in the current study also reported negative experiences related to non-acceptance with previous practitioners. They were vigilant in noticing therapists' judgment beginning with the first phone call from the professional or secretary, picking up on subtle signs of impatience or disapproval. Perceived judgment and emotional interruption or avoidance were disliked immensely, compromising their sense of safety and disrupting trust in the therapeutic alliance.

Catriona (C) said in relation to her previous therapists who invalidated her through her inability to acknowledge and remain present with her feelings,

"I found that one person I had gone to see in Tasmania had done exactly that, and I think just tried to, in hind sight now, had tried to minimise my feeling about what had happened rather than listening... That didn't help....It sort of put you back" (Appendix K, p87)

Laura (C) also experienced an assessment process with a therapist which contrasted the deep acceptance experienced with Liz (P). She described,

"I think the first one was like a screening thing, so it wasn't really a session. It was just like a screening thing to work out what to do with me. It was odd" (Appendix K, p151)

The assessment process left her feeling like she was a problem to be sorted out in contrast to the deep and genuine acceptance and humanness conveyed in her interactions with Liz (P). Clients were sensitive to a variety of feelings of pathologising, rejection and hurt during moments of non-acceptance by practitioners. Eleanor (C) said in response to her therapist's tone of voice and approach with her,

"I felt like she just jumped at me. It was like I was being reprimanded. There's nothing wrong with being on the pension (said abruptly)..... I felt like she pigeon holed me as a certain type of person" (Appendix K, p196)

Peter (C) described withholding disclosure when he felt that he would be judged and not accepted, in relation to a previous therapist,

"I was also seeing a psychologist over that side of town as well, and it got a point where I was more concerned about what the psychologist would think of me, than the need to

actually engage with major issues. Well I don't want to talk about it, because I don't want her thinking I am strange, or bad, or messed up....Or anything, so I just wouldn't talk about things" (Appendix K, p22)

Both clients and psychologists commented on the importance of the client being deeply accepted in a holistic and profound way, including and extending beyond thoughts and behaviours, incorporating all aspects of self regardless of client undesirability or perceived extremeness. Clients sensed acutely and had a vigilant radar noticing hints of judgment or non-acceptance from previous practitioners. They knew that practitioners were uncomfortable with them through reading non-verbal signals and subtle paralinguistic nuances, which negatively impacted on trust. In response clients withheld aspects of self and disclosure when this happened.

The findings of the current study aligned with Rogerian principles as mentioned in the previous Chapter 1 on Empathy. Of specific relevance to acceptance, Roger's notion of unconditional positive regard referred to maintaining a positive attitude held towards the client regardless of what the client was saying, feeling, thinking or doing, while refraining from making one's own judgments overt (Bohart, 1991; Kohut & Rogers, 1985; Rogers, 1967, 2007). The therapists needed to be able to care and feel positively towards their clients regardless of the feelings or content that emerged, for example not feeling repulsed by the client themselves (Rogers, 1967, 2007). This was likened to how effective parents related to their children in Attachment Theory. They may dislike the behaviour or content of what their child was saying, however the love towards the child was maintained (Bohart, 1991). According to Rogers, the liking and caring of the client must be deep and genuine (Bohart, 1991; Rogers, 1967; 2007). Roger's (1967; 2007) described an acceptance of the whole client that was depicted in the above examples. He said,

"The extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing" (p243).

Although complex trauma was not operationalised during the introduction of Person Centred Therapy, the prizing and accepting of the whole client depicted by Rogers was thought to help the client to accept themselves, and was particularly beneficial for scared, shamed and proud aspects of the self (Kohut & Rogers, 1985), which were frequently experienced in survivors of childhood trauma (Paivio & Pascual-

Leone, 2010; van der Kolk, 1996). The deep and genuine acceptance of the client in congruence with Roger's assertions above, was thought to facilitate an alliance that was safe and trustworthy. Although this concept was identified in the early 1950's by Rogers, it may have been overshadowed by the subsequent introduction of scientific methods into the field of psychology that shifted in focus to objective, observable factors (Kohut & Rogers, 1985).

Acceptance was emphasised in Self Psychology through a focus on validation of the client, extending early psychoanalytic theory beyond interpretations (Schechter & Goldblatt, 2011). Reassuring the whole client and their worldview through validation was thought to assist the clients to be heard and accepted. It was not a blind acceptance of the other, rather an active process of holding the clients' view and noticing one's own judgments, with the therapists' consciousness about when to hold back and when to speak up. This empathic understanding and acceptance of the clients through validation was thought to contribute to self-acceptance (Elliot et al., 2005; Paivio & Pascual-Leone, 2010; Schechter & Goldblatt, 2011).

Acceptance models have been supported by empirical research generally (Hayes, Strosahl & Wilson, 2003; Harned, Korslund, Foa, & Linehan, 2012; Kleim, Kroger, & Kosfelder, 2010; Bedics, Atkins, Harned, & Linehan, 2015) and acceptance has been seen as a fundamental precursor of client change (Greenberg, 2007; Linehan, 1993; Schechter & Goldblatt, 2011). Acceptance and Commitment Therapy (ACT) and mindfulness emphasised a non-judgmental stance while encouraging the client to adopt an attitude of acceptance of their experiences of thoughts, feelings and bodily sensations (Hayes, Strosahl & Wilson, 2003; Kabat-Zinn, 2003; Hayes, Luoma, Bond, et al., 2006). Acceptance was contrasted with the use of control strategies that clients use, which were seen as problematic. Over control of emotions was thought to lead to increasing anxiety, and was therefore challenged as unhelpful. This was normalised with clients as part of human beings common attempt to gain control, which was thought to prevent shaming the client and was demonstrated experientially through exercises rather than intellectual explanations (Hayes, et al., 2003). If clinicians were more accepting of their clients' issues, then this would enable the clients to be more accepting of themselves (Hayes et al., 2006).

This approach was similar to the findings of the present study in that an accepting, non-judgmental and open attitude was conveyed through the exploration of

clients' feelings and thoughts. However, the psychologists in the current study strongly validated and empathised with their clients' experiences and feelings, acknowledging and feeling within their own bodies, how deeply painful the experiences were. The findings of the current study also differed to acceptance models (Hayes, et al., 2003; Harned, et al., 2012; Kleim et al., 2010; Bedics, Atkins et al., 2015) in that the unconscious, non-verbal and spiritual aspects of the interactions between the psychologists and clients emerged as important, while also linking past and present client experiences, in a holistic acceptance of the client.

Paivio and Pascual-Leone (2010) in EFTT elaborated on descriptions of how therapists can embody acceptance in therapy. Their writing had a stronger focus on the emotional empathy that accompanied a deeply accepting attitude of the clients, their experiences and internal aspects of selves that may be perceived as revolting or ugly. Empathy assisted the clients to remain experientially present, integrated with acceptance and validation (Paivio & Pascual-Leone, 2010), aligning with the findings of the current study. Through acceptance, the clients were able to face more of their own experiences through a reduction of anxiety and an increase in their ability to tolerate their intrapersonal experiences (Elliot et al., 2005; Greenberg, 2007; Hayes et al., 2003).

4.1 Acceptance Conveyed through Validation

Within the findings of the present study, psychologists were found to accept clients and their emotional experiences while validating them within a context of their past and present experiences. Meaning was attributed to undesirable behaviours (e.g. related to sexuality, relationship dynamics or substance abuse) within a context, which helped to normalise it. There was an absence of bias or judgment about the clients or their behaviours, rather a reassurance and acceptance.

Mark (C) had the impact of sexual abuse normalised which helped him to shed shame. He said,

“Yeah and today he kind of drew on some analogies with other people, normalised it in the context of sexual abuse, so that's helped” (Appendix K, p81)

Laura (C) liked that Liz (P) put her childhood abuse into a context. She said,

“She sort of understood...I guess the thing that I felt was that she was able to normalise a lot of my feelings, which was really important because you know, when you have had that background” (Appendix K, p145)

Dennis (C) appreciated being understood by Felicity (P) as demonstrated through her ability to join threads across sessions, and to weave together past and present experiences, eliciting a deep sense of acceptance. Dennis (C) said,

“So that she has a real solid understanding of the personal effect that all those issues have had, but also the understanding that all of those issues have had around me, that have had an influence on my mental state. Which I am not saying that I have any particular issues, but I have had behavioural issues and I have had, you know I am constantly in the scale in a minor sense, and I might turn up and say, I have had another crisis this week or whatever, ...I have had a shocking week. She will really get to the heart of things and she will draw on elements that we have discussed and soWell of course you are going to feel like that because this happened and that actually means I am being understood” (Appendix K, p285)

Acceptance of Dennis (C) and understanding his shameful behaviours with a focus on the underlying motivations and patterns, assisted development of trust, which resulted in an increased ability to be open in sessions with Felicity (P), and the bringing forward of issues. Dennis (C) confirms,

“I have been incredibly raw and honest with her, like nobody else in my life, and the fact that I feel comfortable enough to do that has certainly helped. But at no time at all, have I felt, oh, I have surprised her with that one. She has never.....I have never said anything that hurts or done anything or come up with a thought or an idea that she has been shocked or surprised” (Appendix K, p285)

Alistair (C) described incomplete acceptance and absence of validation when his therapists only examined either the past or present without the integration of both. He said,

“I was dealing with anxiety at the time and I felt that she was looking at issues from my past, which I could see the relevance of, but there was a lack of awareness of what was going on for me...In the moment, yeah. And the other one was like the opposite. The other one was focused on the present....Sympathising and letting me talk through that, but not making any connections to the past” (Appendix K, p74)

Alistair (C) appreciated Tom's (P) ability to marry past and present experiences to makes sense of what was going on.

Many clients appreciated therapists validating their experiences both past trauma and present difficulties, acknowledging the negative impacts and emphasising the positive resilience of the clients. Validation of the whole person, with their unique personality and specialness instilled a deep sense of acceptance.

Psychologists in the current study assisted clients to make sense of the behaviour rather than judging the behaviour, which enabled clients to soften their self-critical judgments, develop self-compassion, to take control and make decisions around behaviour change.

Cathy (P) normalised Tina's (C) intense emotional states. She said,

"If she is distressed, to say no wonder you are distressed" (said very compassionately and calmly)" (Appendix L, p119)

Sam (P) reframed Ronan's (C) behaviour into underlying attachment yearnings and attempts to gain control,

"Well it's complex and trying to understand the client sort of what I call character style. It's empathically trying to sort of feel what that would be like for me and to try and reach into the client and let him know that what's happened is not so inhuman or dreadful. It sounds very human to me, like I might offer him a reframe around that. It sounds like you have been very lonely..... I am always interested in when someone is suicidal, what is this about? With him it's I want to quieten my mind. So he doesn't point to his leg or his heart, he points to his head. He want to quieten his head, so some of the reframes when he got really drunk or did this and that, I imagine that you were trying to quieten that head" (Appendix L, p291)

Psychologists understanding got beneath the symptoms and behaviours, and compassionately unpacked client experiences. This high level of acceptance and validation helped Ronan (C) to deal with his shameful feelings and to make positive changes.

Adriana (P) commented,

"It's hard to put words around. Like she had some really skewed ideas about herself that she had grown up with that were still being reflected back. You know she thought she was

mad, crazy. And she is a smart woman. She has got an amazingly compassionate view of the world really given what she has been through, and so she had been devalidated the whole way long. She thought she had it all wrong. And so she'd say things to me and I'd say things like, "Yeah, that makes a lot of sense. Yes, I can see where you are coming from..... Normalising what her experiences were which somehow buffered that sense of madness" (Appendix L, p13)

Adriana (P) had a genuine, deep acceptance of Eleanor (C), and by normalising her experiences, she buffered her sense of madness. Rather than negating Eleanor's (C) experiences she made sense of them within the context which gave her relief. Adriana (P) added, that she counteracted negative childhood experiences by,

"Not imposing opinions on her, you know as they had been imposed" (Appendix L, p13)

In some psychotherapeutic models (e.g. DBT, EFT, EFTT) acceptance and validation were emphasised heavily, which contrasted and balanced a focus that was heavily imbedded in interpretations such as psychoanalysis (Schechter & Goldblatt, 2011). Accompanied by cognitive understanding but distinct from empathy, validation was seen as a "type of reassurance or a confirmation of reality in context" (Paivio & Pascual-Leone, 2010, p105). It offered responses that normalised the clients' experiences. For example the therapist might say to the client in a gentle, warm voice, "A lot of survivors of childhood trauma experience that", or "It makes sense that you felt that way". This assisted clients to feel non-judged and accepted by their therapists (Paivio & Pascual-Leone, 2010) and was found in similar examples above, in the findings of the current research.

A non-judgmental acceptance of the clients and validation of clients' emotional experiences counteracted childhood experiences of invalidation and unmet emotional needs, and was deemed particularly useful for clients who exhibited symptoms of complex trauma. It was thought to assist in a sense of acceptance and understanding in the individuals' subjective experiences, in contrast to frequently experienced judgments and pathologising (Elliot et al., 2005; Linehan, 1993; Schechter & Goldblatt, 2011). The emotional experiences were normalised within the context in which they occurred both past and present. Validation had the potential to relieve distress and profound loneliness, and assisted in emotional regulation and in softening self-blame. All of these factors were thought to assist the therapeutic alliance and clients' engagement that has

also been found in other treatment (e.g. Greenberg, 2007; Linehan, 1993; Paivio & Pascual-Leone, 2010; Schechter & Goldblatt, 2011).

4.2 Acceptance through Humour and Metaphor

Sometimes psychologists found creative ways to connect with their clients through the use of humour and metaphor, which assisted clients to have hope and to feel deeply accepted. Reva (C) appreciated her psychologist's ease with her dark side. She said,

“He uses my sense of humour and serial killer nature, that I want to go out and kill....he uses it to help me” (Appendix K, p43)

She elaborated that Dann (P) would weave Reva's (C) death related fantasies into interventions. He suggested that while she sat in the bus ride home, that she pretended in her imagination to shoot people. The impact that this playful task had on Reva's (C) sense of safety with Dann (P) was profound.

“And so he has this sense of humour. This dry, funny sense of humour that he uses to help me....So I love that about him..... He plays with it. He plays with me you know. It's hilarious at the funniest times. And I go really Dann (P)? Like he's this straight, upstanding, lovely sort of bloke, but man he's got the wickedest sense of humour, you know” (Appendix K, p43)

Dann (P) was able to connect effectively with Reva (C) through humour. Reva (C), had experienced significant difficulties with trusting men, and yet was able to laugh and feel deeply accepted by Dann (P). Furthermore, the messages Dann (P) reinforced were the opposite of fear or rejection of Reva (C), which she frequently experienced in her relationships, and by society.

Another example of acceptance through humour and metaphor was given by Damian (C) in relation to Kellie (P),

“As I say she comes out with these things, which at the time are bemusing, well actually they are clever because it seems like this environment I grew up in when I never felt able to express myself, but also it also kind of neatly describes a very complex situation. So she describes my ex as a gold plated narcissist....Which is just, wow. When I heard that I just burst out laughing, because you know...You've got it....Absolutely. It was just perfect. If ever there was such a person, then she is it, so it is really helpful. It sort of

creates an environment where we can explore those really, some of the quite bitter experiences and you know, I feel confident....Yeah, you know her thing about my mother reaching out from the outside room, pulling my strings, is absolutely spot on, in a subtle kind of way” (Appendix K, p107)

There was a deep sense of non-judgment about Damian (C) and his family, in a playful way. Kellie (P) was attuned to the relevant individuals and the metaphors and humour confirmed her understanding and acceptance of the whole situation. Kellie (P) confirmed,

“And I tend to work a lot with metaphors or visual sort of things. And that doesn’t work for everyone. For a lot of people, yeah. And then we have a kind of language. I remember once I called his Dad the colonel one time. The fondness of Dad, so even though Dad was a bit of an arsehole, you called him colonel and it wasn’t a put down..... And I suppose it’s like almost fond teasing to get something more out of them. And that’s the boy sort of thing. It’s almost like if he was a ... you might ruffle his feathers” (Appendix L, p95)

Eloise (P) also spoke in metaphor and humour. She said,

“After seeing her for this length of time I really admire Maryanne (C). I reckon if ever I got into trouble, she would have the bikie gang there.....She is a lioness, I mean with her children (said with admiration and strong emotion). In terms of me listening....I admire her. I think she saw that emotionally it really resonated with me, and that I had some sense of her pain. Because she has a horrible story, horrible story” (Appendix L, p174)

The fondness that Eloise (P) displayed of Maryanne (C) amongst her tough exterior, elicited a strong sense of acceptance. Her use of metaphor and humour deepened this expression of acceptance.

Another example was with Karin (P), who also expressed fondness, acceptance and admiration of Catriona (C)’s resilience,

“And I said there are some things that you can do. You’ve got the constitution of a mallee bull, you know the fact that she is alive, you know and that’s a standing, you can do some more things to just chill and live some more of your life, you know” (Appendix L, p78)

Irene (P) used an overall metaphor for depression related to animals,

“And she is pretty theoretical Kate (C), she is not a waffler. I thought this might be solid enough for her and I guess it was a bit like my idea of depression in a way. Depression is a response to the animal of things that are distressing it and a logical response that tends

to work is that we neglect our animal health and that's the signs we see, you know, can't get out of bed, not feeding, our doggy noses are dry. And we have to re wet our noses" (Appendix L, p82)

Connie (P) gave an example of metaphor use also. She said,

"I think my role over the last number of years has been a very consistent and reliable holder of hope and nothing shakes that, because she often loses hope. So sometimes I felt that the dose of hope I could give in a session might not be enough or sufficient to get her through the fortnight, so I would double the dosage by writing her a letter that would talk to her about all the strengths I saw in her, the resilience, things I had noticed in the session or just about her, um, what I saw emerging as her as a person, um, what I saw and what I heard from her about how her life might be different... And I probably used a lot of corny metaphors too, but it seemed appropriate at the time. She seemed to like them, like at the moment there is churning waters and lots of jagged rocks but I can see a still calm lake and I can imagine you sitting there, you know at peace and this is what I see for you and this is what I see that you are fighting for and I want to let you know that I can see the path, and I'll be there with you on the path" (Appendix L, p100)

A positive focus on Antoinette's (C) strengths and interests through metaphor, elicited a strong sense of Connie's (P) acceptance and hope for her. This aligned with Greenberg's (2007, p56) "unconditional confidence in the inner core of possibility in the client".

Karin (P) conveyed her deep acceptance of Tracy (C) including admiration for her resilience. She said,

"She had really significant developmental trauma. Really significant. But her tenacity was extraordinary and her internal strength amazing.... I really enjoyed working with her. It was wonderful and there was humour in amongst the pain, which is always interesting how that comes in. But yeah, she, she has got this red hair, so she is this fiery little lady, you know" (Appendix L, p191)

Louise (P) highlighted the non-verbal, spiritual aspects of the alliance and her deep attitude of acceptance of Jessica (C) holistically, as well as using humour. She remarked,

"So it is implicit. I think too with these kinds of clients who are highly sensitised. I think there is really a lot that is implicit about why they feel safe and how they feel safe in here...Even the bits that they can articulate, in any relationship there is so much that

isn't, that is energetic, sensing. Why this person gravitates. Humour has been important with Jessica (C). And I think we all like humour. You know appropriate kind of humour, but um. I think affirmation is very important. Like being genuine and authentic. Not laying it on too thickly...Sort of in a good kind of dosage....And the validation of how I see her as a person...And the relationship over the past 7 years and over the last few years, you know she can tolerate well now, me kind of challenging her, so yeah and appreciates that I think. Doesn't feel that it is a criticism...And that sense of knowing that I do have her interests at heart. Something about an attitude" (Appendix L, p207)

Jenna (P) with Brad (C) used metaphor to assist with a sense of holding and reassuring with deep acceptance and caring,

"I use a lot of symbolism and a lot of words with guys because I can't necessarily use a lot of touch or hold them.....Or whatever to put their identity back together. He must have given me the cue for the symbol, but you know using pictures of sewing a seed, or the seed has just sprouted, you have to look after your little sapling, or he would say, "I pulled out a lot of weeds then".. We got that bitter root out, or that twisted root....Lots of stuff, like that that I can hold him in ways" (Appendix L, p277)

The deleterious effects of inappropriate metaphors left clients feeling that their therapists were not attuned or accepted. For example, Peter (C) described,

"I've seen a couple of psychologists over the years and there was one, and a couple of shockers. I mean the first psychologist I ever saw, when Ted said I needed to see a psychologist, every analogy he had was a cricket analogy.....So it was like do you need to play that one straight Peter (C)? So he would use cricket whenever I talked about issues you know..... I never have been (into cricket).... You know, Id talk about things, and I am sure that some of the ideas he had and the processes he went through were good, everything he said was you know, you need to step back for that one, and you need to bowl a bit higher. And I am we're not in a cricket ground here mate" ...So he lost me. I only saw him three times, and it didn't change and I thought I don't need this" (Appendix K, p24)

Metaphors and humour were used to express and demonstrate overtly the deep sense of knowing and acceptance of the clients to their core, by their therapists. Psychologists were able to draw on clients' strengths of character and connect with them in a manner that captured the essence of who they were.

Humour was rarely found to be mentioned among either alliance or trauma literature. It was however found occasionally and briefly to be linked with hope and the accessing of positive resources (Kezelman & Stravropoulos, 2012; Mosak, 2005), and as a potential means of eliciting positive affect and connectedness (Paivio & Pascual-Leone, 2010). Laughter and playful humour were found to be a possible strategy to assist clients to shift out of stuck places, through offering a different perspective on a situation. In this way the clients were given the opportunity to expand their problem-solving and to move away from routine patterns (Kottler, 2010; Linley & Joseph, 2004).

Humour was found to be emphasised most heavily psychotherapeutically in Positive Psychology that explored human strengths and flourishing. Its associations with optimism, hope and happiness in individuals were deemed essential in well-being (Hefferon & Boniwell, 2011; Linley & Joseph, 2004). Recently, appropriate use of humour was found to contribute to good alliance when working therapeutically with war veterans in a study by Laska, Smith, Wislocki, Minami, and Wampold (2013). Supervisors of the therapists who counselled these clients, rated their therapists according to findings from their supervision sessions and archived client notes. The supervisors were interviewed about what therapists' characteristics were found to be present in the more effective therapy. Humour was one of the factors that was identified as being associated with good alliance, highlighting the potential benefits of humour within the counselling setting, and aligning with the findings of the current study.

Healthy humour was differentiated as assisting anxiety reduction, in contrast to humour used as a defence mechanism to avoid or hide from painful feelings (Brennan, 2014; DSM-IV, p752). In addition, if humour was delivered inappropriately it was found in general literature to have the potential to leave individuals feeling embarrassed, attacked, offended, or inferior. When used with "sarcasm, ridicule, irony, satire, vulgarity, and jealousy" it was found to be problematic. Clearly, psychotherapeutically, there was a need to apply humour in a manner that was acceptable, and attuned to the individual client (Kottler, 2010; Sathyanarayana, 2007, p222). Of the examples described in the current study, the psychologists were not found to demean, offend or embarrass their clients, rather the humour seemed to be capturing aspects of their character or significant others, was spoken with fondness and acceptance of the client, and without criticism or judgment (e.g., lioness, meerkat, the colonel). It demonstrated

an active attunement to the clients and their situation, and was delivered in a manner that was accepted and appreciated by the clients.

Metaphors were also rarely present in alliance or complex trauma literature. Carl Jung used symbolism in his language as a means for the therapists to communicate with the unconscious and to assist in meaning making (Jung, 1961). In the literature, metaphor was found to be a means to increase clients' understanding (Carmichael, 2000; Hendrix, 1992; Martin, Cummings & Hallberg, 1992) and to intuitively connect with clients (Carmichael, 2000). It was a way of capturing clients' emotional experiences when describing feared events (Elliot, Slatick & Urman, 2001). Metaphors were a means of putting non-verbal experiences into words (Kövecses, 2010) and to increase the vividness of memories and remembering (Carmichael, 2000; Elliot et al., 2004; Martin et al., 1992). Empirical findings suggested that individuals differed in their alignment of metaphors (Fetterman, Bair & Werth, et al., 2015), highlighting the importance of attuning to individual clients, which was supported in the findings of the current study.

More specifically, metaphors have been shown in studies to assist in emotional understanding (Fetterman, Bair & Werth, et al., 2015), and were specifically mentioned as an intervention that can be used during empathic evocative reflections. The use of metaphor was intended to access and deepen clients' emotional experiencing, as well as to assist the clients' narrative telling and meaning making. Metaphors were also used to increase clients' experiencing of vulnerability through reflecting back clients' deep experiential pain. For example, "It feels like a knife has gone through your chest" (Elliot et al., 2005). In contrast, metaphors were used to create distance from clients' feelings for survivors of disasters when they were overwhelmed by emotional experiences and helped to normalise the emotional responses, as enabling expression of what happened without giving a detailed narrative (Carmichael, 2000). The metaphors that emerged in the present study were related to understanding clients' self-identity and understanding of their relationships that elicited a sense of deep acceptance by their psychologists. Metaphors were frequently playful and linked with humour. This aligned somewhat with Kövecse's (2010) use of metaphors that characterised positive feelings through metaphor, including the concepts of satisfaction, pleasure and harmony (Kövecses, 2010, p113), however the current study entailed more depth of knowing and accepting the clients physically, emotionally and spiritually. The findings of the current study

highlighted that both the appropriate use of humour and metaphor were effective means of demonstrating deep acceptance, fondness, optimism and fun with survivors of childhood trauma which was emphasised minimally in both trauma and alliance research and theory.

4.3 Acceptance through Therapist Presence with Clients

4.3.1 Therapists' presence in intense emotional states and narrative

Survivors of childhood trauma clients were found to have sensitive radars for detecting therapists' experiences and knew through their own sensing and awareness when their therapists were avoiding, non- accepting or judgmental through subtle nuances, which were perceived negatively. This highlighted the importance of therapists' presence and profound acceptance of the clients throughout therapy, in the findings of the present study.

For example, Belinda (C) summarised that it was with relief that Adriana (P) was able to manage her own emotions. Belinda (C) said,

"I didn't feel she wanted me to calm down for her own sake" (Appendix K, p11)

Another example was Jessica (C), who also felt reassured that Louise (P) could handle what she brought to therapy. She remarked,

"I knew that whilst Louise (P) may be distressed at my extreme level of suffering or saddened in my dire state in the moment, I kind of knew that she wouldn't judge me and be disappointed" (Appendix K, p245)

This assisted Jessica (C) to feel safe that Louise (P) could handle her and her content, and to progress with therapy. Catriona (C) had a similar experience. She noted,

"It was like an unconditional, I am here, it doesn't matter what you tell me, I am here" (Appendix K, p92)

One further example was said by Henrietta (C) about Andrew (P),

"I think he has got quite a neutral way of being. He doesn't ever look worried or concerned about me. He sort of trusts me. And um, he just feels really calm and centred and solid. Because he is neutral and calm and solid, I can be what I need to be in the session" (Appendix K, p155)

Before Hannah (C) disclosed her story she wanted to know that Cathy (P) could handle the content of abuse, which reassured her that she would remain present and not abandon her. She said,

“Whereas for her, she has had training in it and horrific stories and she is ok with horrific stories. I am pretty sure she said, if I am not ok, then I will invite somebody else in. Yeah, so she was ok with it and I think that was reassuring too, that she could get external advice if she couldn’t handle the situation. She never did. Um, if it’s something I can’t handle I am not going to leave you alone with it. I am going to get somebody else to assist” (Appendix K, p258)

Clients sometimes wanted to protect their psychologists from “contamination” of content, making their own judgments as to whether the therapist was able to manage with the heaviness of the disclosure or not. They made their own assessment before proceeding with the deeper disclosures. Kristen (C) said,

“She has compassion but she is not panicked or freaking out” (Appendix K, p281)

Kristen (C) also felt safe with Jenna (P) knowing that she could handle her, which differed to numerous previous therapists. When reflected back by the interviewer that, “This meant that Jenna (P) wasn’t going to leave her”, she replied,

“And that is huge for me...She won’t just leave me hanging” (Appendix K, p282)

Laura (C) was watching Liz’s (P) response, searching for signs that indicated feelings of disgust in her,

“She was happy for me to talk about it and get it outShe showed empathy towards me but not a sense of repulsiveness” (Appendix K, p146)

Clients watched therapists vigilantly and noticed signs of discomfort, withdrawal and alternatively ease, warmth and openness in their psychologists. They were attuned to their psychologists’ body language, tone of voice, and topic changing, noticing and sensing therapists’ avoidance of uncomfortable feelings or content of narrative. When detected, this resulted in clients withholding information and fearing their therapists’ abandonment. Knowing that the therapist could remain present to clients’ experiences enabled clients to feel a sense of security, and this frequently counteracted childhood experiences from primary attachment figures. A non-fearful,

regulated therapist instilled confidence in their clients and the sense that the therapist could handle and accept them, and would not leave them.

In the research, working with complex trauma was recognised by trauma specialists as navigating “tumultuous and challenging relationships that test the client and therapist alike” (Kinsler, Courtois, & Frankel, 2009, p83). Therapists needed to be able to work with difficult and intense relationship challenges, including distrust, emotional dysregulation, and neediness (Chu, 2011; Kinsler, Courtois, & Frankel, 2009), as well as stories that involved horrific abuse, cruelty and deeply hurt or emotionally injured individuals. Unpleasant and painful feelings were recognised as frequently emerging in the therapists when working with these clients (Kinsler, Courtois and Frankel, 2009; Geller & Greenberg, 2012) that created difficulty for the therapists to maintain therapeutic presence, and sometimes elicited tendencies to avoid their clients. Survivors of childhood abuse were vigilant to therapists’ withdrawal, and their attentiveness and attunement. Therapists’ presence was needed to manage this in order to maintain clients’ safety and to prevent feelings of abandonment in sessions (Schechter & Goldblatt, 2011). Clients were attuned to therapists’ presence through their words, facial expressions and bodily movements (Erskine, 2015), as supported in the findings of the current study.

In the current study, clients described negative experiences related to therapists who were unable to remain present to their emotional experiences. When clients detected bored, impatient or judgmental therapists, it elicited feelings of unacceptability, judgment and unimportance in the clients.

Alistair (C) noticed during one of his previous therapy experiences that his therapist was ill at ease, which transferred to Alistair (C). He explained,

“She always looked nervous in the sessions. Which was quite off putting...I’m here to see the professional and you are the professional. So yeah, that wasn’t very reassuring”
(Appendix K, p79)

Another example was with Daisy (C) who noticed when Felicity (P) was distracted in one of her sessions,

“I had a few sessions with her that I felt that she was pretty flat, that she was distracted”
(Appendix K, p56)

With Felicity (P), Daisy (C) was able to resolve this alliance problem through open dialogue as described in Chapter 7 Repair work. However, it also highlighted that therapists can and do have moments of lapse in their presence on occasions. When their therapists were honest and admitted their mistakes, the clients were forgiving and accepted that sometimes they would lose their attention. Henrietta (C) explained,

“There was one time when we were doing a process and I felt that I had lost him, you know, for seconds, I felt like his attention was gone and yeah we talked about that yesterday. So yeah, most of the time he is there and present, but I felt just in those few seconds, that, he might have still been present but it felt like he’d gone. And yeah, I was able to say it. And he remembers, it was a few sessions back, and he didn’t say whether he was thinking about what he was going to have for dinner tonight. As we do. But just the fact that he was aware of that, and how important it is for me that he remains present with me, as much as is physically and emotionally possible” (Appendix K, p160)

Laura (C) compared her experience with Liz (P) to that of her family members who were not able to remain present with her emotions. She said,

“Sometimes when you go to talk to family or friends, they don’t really want to talk about it. It’s just a bit too uncomfortable... and that reaction often makes you feel like there’s something to be ashamed of. Because it’s not about the fact they don’t want you to get upset, it’s about the fact that they really don’t want to... feel uncomfortable themselves, and when you get that reaction you feel bad as well, because you feel well this happened to me and you find that repulsive and that makes you feel bad, whereas you know when you talk to a psychologist, when it is a good one like Liz (P), it’s a sense of “No, you would feel that because of that, and that’s perfectly normal for somebody that’s been through this” (Appendix K, p145)

Laura (C) was attuned to her psychologist’s ability to remain with her content and emotional experiences, and to normalise them within a context, which assisted her to relieve maladaptive shame and disgust related to her sense of self. The opposite occurred with her family members when they were unable to be present to her experiences.

In alignment, Tom (P) was conscious of not reinforcing shameful feelings in clients and was aware that he was being watched vigilantly for signs of judgment by his clients. He said,

“So that it is, I let them know at any point what is going on for me, so that they feel in hearing that, because it is not in a punitive way, it’s in a curiosity way, they get a sense that they can say it how it is, I am not wanting to run even though he saying those things....There so much shame in the moment or relieving in the moment. That requires a lot of psychoeducation, a lot of checking in with me. When they have told me something, I know they are scanning me, looking for reactions. I know they are looking for negative feedback to say, see here’s another person who can’t handle me or who rejects me, you know” (Appendix L, p67)

Henrietta (C) explained the presence she felt with Andrew (P) which contrasted with a previous therapist who was unable to remain present to her difficult emotions. She said,

“And I think with Andrew (P) not expressing that sympathy I feel that he is more solid for me. There is not any wavering. He’s just a bit more, he doesn’t show too much, or express much of himself, yeah, which, whereas Ava (previous therapist) I think was, how do I describe it? She (Ava) was a bit more sympathetic and would show overt compassion for me...Through words and the way she looked as well, whereas Andrew (P) was a bit more, you know he is still really warm and really present, but there is something about his expressions and what he says that keeps him solid... I just knew at times when I was emotional, she’d tell me, she interrupted my crying and wanted me to be strong, so I kind of felt angry about being interrupted” (Appendix K, p157)

Clients noticed when their therapists were not present, and found that having vulnerable emotional experiences interrupted was difficult and undesirable. In contrast, when therapists in the present study were noticed to be emotionally present and able to handle clients’ intense emotional experiences and content, the clients felt acceptable and safe, with a freedom to disclose and to progress with their therapy (Erskine, 2015). Troy (C), who initially presented with an angry, intimidating exterior, said in relation to Georgie (P),

“And she didn’t kind of rise up when someone was angry. She kind of remained regulated” (Appendix K, p319)

Valerie (C) described favourably Jenna’s (P) emotional regulation and presence that helped her to remain present to her own feelings and instilled a sense of safety. This differed to her previous experiences with therapists,

“She (Jenna (P)) wanted to go a bit deeper, and it happened over a period of time, and she would try and make me sit in the emotion .. She really let me go through it... And she would say, just stay there. Stay there. And we would work through it until I came out the other side and I had never experienced that before....She was there while I was experiencing it, and letting me know, that I was safe , that I was going to come through it, that it was ok for me to feel whatever it was that I felt. I didn't have to pretend that I wasn't feeling it... I might go home and feel like that. It might take a couple of days. But she allowed me to feel those things here and it was kind of like I had never done that before, not with another person” (Appendix K, p234)

Andrew (P) also explained his ability to remain present for clients while they experienced deep emotional processing. He said in a clear and confident, yet tentative way,

“I guess doing all the kind of holding and empathic stance to that persons' experience in that moment. And I think it comes from just your presence as a therapist in a sense that, you are not freaking out. You're not having to think. You feel comfortable in that emotional whirlpool as it's happening, helping that person to navigate that space for themselves. And they feel that sense of being accompanied by you and that you're beside them, with them in that experience” (Appendix L, p139)

A number of clients appreciated their psychologists' ability to handle their anger, and that they weren't avoidant or afraid of it, which allowed the clients to express themselves freely in sessions. Clients noticed if their psychologists were distancing physically or emotionally in the moment. Regulated psychologists helped their clients to feel safe to express themselves fully. Clients adapted themselves depending on what they perceived their psychologists were open to and able to cope with. As well as a sense of relief at not having to keep a “lid on” their anger, clients described also a sense of acceptance of unlikable aspects of self. For example, Hannah (C) said,

“And allowing me to be who I was, just in the session. Sometimes really extremely angry and other times a sobbing mess. And she allowed that. She allowed me to sit in the moment and she didn't try and pull stuff out of me” (Appendix K, p253)

Psychologists practised therapeutic presence with the interviewer through the research process. They did not avoid clients' emotional experiences or content, were not disgusted in the clients themselves, or overwhelmed by their content. They were deeply accepting of their clients in the moment. The psychologists interviewed largely

perceived the emotionally intense work as “challenging” and “stimulating” and preferred the deeper more intense therapy. Louise (P) said that she built a resilience over years of experience and was less affected by unpleasant content or a “bad session” now. Several psychologists felt doing their own therapy assisted their ability to remain with their clients during intense experiential states.

Andrew (P) described his own sense of aliveness when present with clients’ intense primary emotions. He said,

“I think that that’s important that you don’t get afraid of the bigness of their feelings....It pulls me in, the experiencing and the emotion that comes up...Feels really important to stay with and I see other people tend to be, tend to at that point tend to intervene, in a way that doesn’t allow the emotions...So um, I feel like I have a personal interest let’s say in that space, that allows me to be more comfortable or certainly have an interest in that kind of experiencing... That’s my sense of it. It might bring up other things, but for me it brings up an interest and a desire to go in there. It’s almost like I get activated and go oh, now something important is happening. Let’s stay with that and see what we can hold in that space and what happens when we do hold that space for this person” (Appendix L, p140)

The findings of the present study revealed that to deeply accept our clients we need to remain fully experientially present with them. Aligning with this notion, Rogers highlighted the need for the therapists to be able to stay present with their clients. Therapists were cautioned to be aware of their own fear avoidance behaviours, and losing focus through wandering of their minds (Rogers, 1967; 2007) which would compromise therapists’ presence. The genuine caring and prizing relationship between therapists and clients in which each were present to one another was considered fundamental to humanistic therapies (Elliot et al., 2005; Rogers, 1967, 2007). The therapists needed to be able to be fully engaged in the therapeutic experiences of their clients, able to tolerate high levels of discomfort, and to maintain emotional engagement and hope in the recovery of the adult survivor of childhood abuse. This emotional engagement was also highlighted in trauma literature (Courtois & Ford, 2009; Paivio & Pascual-Leone, 2010; Schechter & Goldblatt, 2011), which was thought to contribute and strengthen the therapeutic alliance (Schechter & Goldblatt, 2011). Research has shown that therapists who can handle painful material were considered favourably by their clients. In addition therapists who were more present with heightened and negative

feelings have been found to be perceived by clients to have greater empathy (Peabody & Gelso, 1982).

Therapists' presence has been thought to be similar to that of a mother to her baby, with the capacity to heighten pleasurable states and to alleviate distressed states through soothing as mentioned in Attachment Theory and supported by neuroscience studies (Bowlby, 1988; Schore, 2003, 2012). This was mentioned across therapeutic approaches to varying degrees. For example CBT emphasised maintaining a presence with the clients' stories while providing a structure, encouragement, comfort, recognition and assisting the clients to emotionally regulate. Therapeutic presence was used to increase clients' awareness of painful and positive aspects of the clients' narrative (Courtois & Ford, 2009).

Therapeutic presence has been aligned with the development and continuation of the alliance (Geller & Greenberg, 2002; Rogers, 1980). Aligning with the findings of the current study, empathy was thought to increase therapeutic presence which enabled the clients to feel deeply heard and understood (Bohart & Greenberg, 1997; Erskine, 2015). Furthermore, the importance of therapeutic presence during clients' vulnerable emotional states has been emphasised in the trauma research as important (Elliot et al., 2005; Paivio & Pascual-Leone, 2010; Schechter & Goldblatt, 2011). Therapists were guided to be open, facilitative and accepting of the clients' vulnerable feelings and experiential states, allowing the client to deepen their experiencing as far as they wished to go (Elliot et al.; Erskine, 2015; Geller, Greenberg & Watson, 2010). Therapists held the clients through empathic presence while providing validation, understanding and reassurance to the clients, often engaging with a warm, gentle, slow voice. A deep sense of acceptance was then conveyed to the clients in their highly vulnerable states (Elliot et al., 2005). The therapists' caring needed to be genuine, the empathy deep (Elliot et al.; Paivio & Pascual-Leone; Schechter & Goldblatt), and the therapists needed to remain in a vulnerable state with their clients until a shift occurred in the client, which elicited a more hopeful position. Trust was required by the therapists in the clients' innate tendency for psychological growth. This aligned with a belief that through the therapists' presence without avoiding their own feelings, rescuing the clients or interrupting their emotional vulnerability, the clients would process primary emotions and make a shift forward towards a positive direction (Elliot et al.; Paivio & Pascual-Leone). After all, as Paivio and Pascual-Leone (2012, p62) highlighted,

“Leading clients into feeling bad in order to feel good is certainly counterintuitive and can be an obstacle for clients and therapists alike”

These findings paralleled the findings of the present study.

Schechter and Goldblatt (2011) cautioned that therapists can consciously or unconsciously move away from clients exhibiting intense emotions such as hatred, loneliness, and shame, through the therapists' own avoidance of intense affect. This can leave their clients alone with their inner painful experiences. Therapists can fear losing control and subsequently withdraw in contrast to remaining present with their clients (Maroda, 2002). An overemphasis on symptoms can sometimes result. Alternatively, therapists who denied clients' experiences by attempting to shift them from their feelings, by telling them they don't need to feel that way, were all thought to interfere with the alliance and the therapeutic process (Maroda; Schechter & Goldblatt). The therapists needed to be able to be fully engaged in the therapeutic experiences of their clients, be able to tolerate high levels of discomfort, and to maintain emotional engagement and hope in client recovery. This was thought to contribute and strengthen the alliance and to prevent dropout (Geller & Greenberg, 2012; Paivio & Pascual-Leone, 2010; Schechter & Goldblatt).

Therapists in the present study worked with a broad array of client presentations, and they managed to remain present to their clients, most of the time. Some clients have been found to be harder to remain present with than others (Geller & Greenberg, 2012). Some therapists in the literature were found to be triggered by clients' anger and consciously or unconsciously moved away. Issues such as death, manipulative behaviour and narcissistic self-importance were found at times to be also difficult issues for the therapists (Geller & Greenberg; Kellog & Young, 2006; Young et al., 2003). Remaining connected to self, rather than merging, while maintaining deep empathy was required. This had a complexity that required therapists' insight and awareness of their own experiences and tendencies to manage in the sessions (Erskine, 2015; Geller & Greenberg). Therapists were also required to be able to remain present through uncertainty in the psychotherapeutic process, going at a slow pace without rushing the clients through interventions, filling in silences and avoiding difficult topics (Geller & Greenberg, 2012). A high level of self-awareness in the therapist was indicated as a requirement. In alliance research, therapists' insight has been found to assist towards improved alliance (Constantino et al., 2010; Errazuriz et al., 2015). Overall, the area of

therapeutic presence with survivors of childhood trauma was found to be complex, but was necessary and beneficial, as reflected by clients and psychologists in the current study.

4.3.2 Psychologists allowed themselves to be affected by their clients

Psychologists were affected by their clients' experiences and were transparent in the impact that clients had on them. This influenced the relationship positively. For example, Eloise (P) said,

"I think she saw that emotionally it really resonated with me, and that I had some sense of her pain" (Appendix L, p174)

This affirmed to the client the psychologist's depth of feeling and care towards her. Psychologists spoke of a willingness to be affected by their clients through remaining present and not avoiding.

"I am not pulling away... And I can sit there with you" (without getting caught in hopelessness) (Appendix L, p208)

Psychologists remained curious about their clients even during moments of high intensity. For example Sam (P) stated,

"I am always interested in when someone is suicidal, what is this about? With him it's I want to quieten my mind. So he doesn't point to his leg or his heart, he points to his head. He wants to quieten his head, so some of the reframes when he got really drunk or did this and that, I imagine that you were trying to quieten that head" (Appendix L, p291)

Psychologists described the importance of being fully emotionally and cognitively present with their clients and being able to handle clients' negative emotions, defensiveness and unpleasant abuse content. Psychologists demonstrated a willingness and capacity to remain present with intense shame, neediness, suicidation, and issues related to sexuality in order to be able to meet the needs of their clients. Sometimes the psychologists questioned their own capabilities, however they maintained a strong commitment to be present to the client in the moment. This following comment demonstrated the space that Cathy (P) was willing to make within herself to accommodate her clients, and to remain client focused,

"Some of the stuff already in my mind is just disgusting or just abhorrent and then you kind of in those moments I wonder if I can handle that stuff too, but knowing in my mind

that I would. If she wanted to, because it's about going as far as she wants to. In sharing what she wants to and not if she doesn't" (Appendix L, p221)

Deep emotional and cognitive empathy were apparent in this comment, alongside a profound sense of acceptance.

The notion of therapists' presence can be found in the concept of mindfulness. Mindfulness practice has been thought to increase our capacity to be able to be present with our own and our clients' uncomfortable feelings and to be less avoidant. If therapists affect tolerance is improved then this allows them to be able to be increasingly present with thoughts, images or bodily experiences rather than to avoid them during sessions (Hayes, Strosahl, & Wilson, 2003; Geller & Greenberg, 2012). This is thought to help therapists to avoid less and to increase their ability to regulate their own emotions (Wyman, 2011) and to remain experientially present with their clients.

Furthermore therapeutic presence was found helpful to clients by researchers. The undesirable aspects of self that emerged in clients within mindful therapeutic presence were thought to allow access and ultimately integration of hidden parts of self (Siegel, 2014). Furthermore, the attitude of acceptance and non-judgment of thoughts, feelings and emotions was thought to generate compassion towards self and other (Paivio & Pascual-Leone, 2010; Siegel, 2014).

Geller and Greenberg (2002) conducted qualitative research involving interviewing of seven expert therapists from various psychotherapeutic orientations in the area of therapeutic presence specifically. Extending Roger's (1980) definitions of presence that emerged in his writing, Geller and Greenberg (2002) developed a model and definition of therapeutic presence. Their definition included, a

"State of being open and receiving the client's experience in a gentle, non-judgmental and compassionate way, rather than observing or looking at or even into the client" (p85)

Additionally they needed to be,

"Willing to be impacted or moved by the client's experience, while still being grounded and responsive to the client's needs and experiences" (p85).

This stance aligned with the comments made by psychologists in the present study.

Physical, emotional, psychological and spiritual aspects of therapeutic presence have been found in recent qualitative research studies (Erskine, 2015; Geller & Greenberg, 2012). Geller and Greenberg emphasised the varying degrees of therapeutic presence that may be practised by therapists, including five different levels. First, the physical presence, that of the environment, the therapist and client's initial superficial dialogue, and awareness of self in the therapy room. Second, the psychological presence through the therapist listening attentively to the clients' stories with interest and curiosity. Third, an emotional presence which incorporated Rogerian conditions of unconditional positive regard, empathy and understanding, while being responsive to the clients with consideration for an appropriate intervention. Fourth, a transpersonal presence which incorporated being physically, psychologically, emotionally and spiritually present with the client. The therapist's body was considered a 'vessel for healing' (Geller & Greenberg, 2012, p140). This deeper level of presence was described as 'palpable', and used therapists' intuition, wisdom and knowledge. Geller and Greenberg described the therapist who,

"Feels in contact with a larger sense of spirituality as well as high levels of vitality and an enhanced sensory and perceptual experience in direct relationship with the client" (p140).

This deep and intuitive connection was thought to be accompanied by alive energy levels with heightened sensation and perception by the therapist. The fifth and final level involved an interplay amongst the different levels, responding to the client while remaining connected in self (Chu, 2011; Elliot, Bohart, Watson, & Greenberg, 2011; Erskine, 2015; Geller & Greenberg, 2012), and ultimately reaching a flow in this deep transcendental experience (Geller & Greenberg). As Geller and Greenberg pointed out, the intuitive self and transcendental core were noted by Rogers (1980) which also aligned with the above framework. The findings of the current study has shown examples of all five of these layers of connection as important when working with survivors of childhood trauma.

For example, psychologists in the current study expressed their own resonances and deepen emotional knowing that emerged in the presence of their clients. Their own experiences reportedly helped them to empathise with the clients' vulnerability and pain

which also enabled a deep, non-judgmental acceptance of the whole client. Louise (P) reflected,

“That deep place of such profound abandonment goes to the core” (Appendix L, p208)

Although she did not disclose her experiences she believed empathy and acceptance based on personal experience was conveyed to the client non-verbally. Another example of this was from Felicity (P), who said,

“Actually knowing from the inside you know (what the client is going through). You trust the process you know. And also understand the anxieties that come up, holidays, cancelled sessions because of sick kids. You have an inside understanding of what anxieties that brings up, you know feelings of panic from the inside, feeling shame about different things. You understand that” (Appendix L, p30)

Hannah (C) recalled that Cathy (P) shared her feelings of disgust while hearing Hannah’s (C) narrative. Although feeling intense bodily feelings, Cathy’s (P) face was expressionless, which meant that Hannah (C) did not worry about her managing her feelings and could remain focused on herself. Hannah (C) explained,

“A couple of times she would say how she felt about a situation. I really spoke about the sexual abuse. She is one of two people. And she actually said about what she felt about it. That makes me feel sick. And it was ok for her to do that....It didn’t justify it. It was she heard it. Ok then. My reaction from other people in my life, she understood that. They would throw it back at me. Whereas she didn’t. It was horrific. And it was nice to have that reaction...So yeah, it was nice. And at the end of the day, she is human. And it’s nice to have that human interaction” (Appendix K, p257)

Miriam (P) described her embodied positive feelings towards Natalie (C) when she made a decision to take positive action in her life and to return to her country of birth. She said,

“I nearly jumped out of my skin, when she told me that. I tried not to get too excited....I probably would have said something like, you are amazing and she....I nearly jumped for joy. I was like really this could happen as a result of this process! Like I get amazed by all my clients all the time and I say how fantastic you are. Because they’re the ones who are doing it. They’re the brave ones doing it” (Appendix K, p268)

Andrew (P) described deep physical, emotional and spiritual connection with Henrietta (C) through connecting in the moment in each other’s breath. He said,

“Other times it’s just more, even though more subtle resonances, you know, when she breathes, you breathe, you know. You take a deep breath and they know that you are there. And you might say, just take it, just slow it down, in a sense of it’s not about stepping back from the emotion and then kind of starting to say a problem... let’s just stay here. This is really important. Just slow down your breathing so you can be with this a bit more. And therefore reinforcing the quality of the connection to the intra psychic process” (Appendix L, p139)

This notion of embodied therapists’ responses also aligned with Erskine (2015, p45) who found alongside sensitive and compassionate empathy, that therapists’ presence involved an attunement to “a kinaesthetic and emotional sensing of others, knowing their rhythm, affect and experience by metaphorically being in their skin”. Yalom (1980, p26) also encouraged the therapist to let the client “influence” and to “change” you, contrasting the traditional psychoanalytic stance of neutrality and distance.

Although there was such complexity and difficulty in remaining fully physically, psychologically, emotionally and spiritually present, this may be where the real healing occurs, with the deepest level of acceptance (Erskine, 2015; Geller & Greenberg, 2012). It was this level of depth of therapeutic presence that was identified through the current study as being useful for survivors of childhood trauma, as indicated through clients’ and psychologists’ examples. In confirmation of the clients’ and psychologists’ narratives, a profound depth of acceptance was also experienced through bodily felt experience by the interviewer during and after most of the interviews.

4.3.2 Vicarious traumatisation

Being open, deeply empathic and connected holistically with clients has been thought to leave therapists vulnerable to countertransference and vicarious traumatisation (Gelso & Hayes, 2012; Kottler, 2010; Pearlman & Caringi, 2009). Vicarious traumatisation refers to the negative effects that therapists can take on during the empathic process when working intimately with survivors of childhood trauma (Pearlman & Caringi, 2009). These effects include symptoms that are similar to trauma clients themselves such as; symptoms of PTSD (numbness, hyperarousal and avoidance), relationship difficulties such as boundary issues and re-enacting, dissociation, depersonalisation, loss of meaning and isolation (Arvey & Uhlemann, 1996; Schauben & Frazier, 1995). As a result sometimes therapists were found in the

literature to be avoidant in hearing about the abuse themselves due to a fear of vicarious traumatisation (Walker, 1994).

Insight and self-awareness were thought to help the therapists to deal with countertransference, although insight itself comes with uncomfortable feelings and can be avoided by some therapists (Gelso & Hayes, 2012). The psychologists in the findings of the current study were found to be humble, unassuming, deeply present and open to their clients, however they also had clear boundaries related to self and other. They were open to the notion of the clients bringing forward negative alliance material if it emerged through the interviewing process, indicating an openness to introspect about themselves and to reflect on their relationships. As discussed later in Chapter 7 on Repair work, they heard the client concerns when an alliance issue presented whilst also owning their own contribution to the problem, highlighting an openness to explore problematic areas within sessions.

Although feeling deeply into the clients' pain was considered a necessity with this work by numerous researchers (Elliot et al., 2005; Erskine, 2015; Geller & Greenberg, 2012, 2002; Paivio & Pascual-Leone, 2010; Seale, 2015), to be fully present emotionally, to hear the narrative and to feel the pain of the clients can also leave therapists vulnerable (Pearlman & Caringi, 2009). Differentiating empathy with taking on personal distress for the clients' experiences was thought by some researchers to affect the level of vicarious traumatisation by the therapists, with increased risk being attributed to taking on personal distress. A neuroscience study by Lamm, Batson, and Decety (2007) found different neural responses when participants experienced pain themselves in contrast to being present to someone else's pain, giving support for the differing responses of empathy and taking on personal distress. Therapists were encouraged by some practitioners to process their own trauma histories to minimise the effects of triggering and vicarious traumatisation by clients (Courtois & Ford, 2013) and to have clear boundaries between self and client (Kottler, 2010). Self-care, including therapists' own psychological health, and self-awareness were also thought to assist with management of vicarious traumatisation (Geller & Greenberg, 2012; Pearlman & Caringi, 2009).

Contradicting the above literature and the findings of the current research study, some trauma researchers advised therapists to maintain emotional distance from clients' content, and to avoid too much identification with the narrative, to minimise vicarious

traumatisation (Mooren & Stofsel, 2015). This aligned with Geller and Greenberg's (2012) suggestion for the need to separate self and other whilst engaging with the clients, however they differed in the guidance to avoid and maintain distance with the clients. Self-awareness assisted in monitoring therapists' reactions and responses and processing the therapists' own experiences were deemed important (Geller & Greenberg). Therapists withdrawing from the clients' content or presence, are likely to be noticed and the vigilant survivor of childhood trauma clients may misinterpret the therapists' unspoken messages with negative perceptions of self or abandonment. This may then negatively impact the therapeutic relationship, as found in trauma literature (Paivio & Pascual-Leone, 2010; van der Kolk et al., 2005). Clients in the current study were aware of their therapists' presence or lack of, as described in the examples above. One further example was the avoidance of the topic of death noticed by Charlotte (C) with her therapist,

“I get the impression, I constantly think about death.....I get the impression that Kellie (P) doesn't want to go there, sometimes.....yeah a sense. Um. The conversation often gets diverted... Yeah. So that's the only negative” (Appendix K, p193)

Feelings of negative self perceptions or abandonment did not emerge by Charlotte (C) in this instance that may have been as a result of an otherwise strong alliance.

4.4 Pathologising and Perceived Judgment

Clients and psychologists in the present study described mixed experiences in relation to diagnostic labelling, however many clients did not appreciate being categorised or diagnosed. Many clients experienced being pathologised by mental health professionals, which elicited a sense of being judged and labelled, while scratching at surface symptoms rather than resolving the underlying trauma. For example Daisy (C) explained,

“She wasn't put any labels on me or that sort of thing.....and part of that in there was that she really believed that my childhood was really traumatic and she said that to me” (Appendix K, p66)

In relation to the mental health system, Catriona (C) articulated,

“They label people and put them in pigeon holes. They like to medicate people, instead of actually dealing with what the problems actually are” (Appendix K, p94)

Jessica (C) resented being labelled with depression, and felt judged and misunderstood when she became angry in sessions. She said,

“Yeah, in Louise’s (P) room, I was a human that was suffering. I wasn’t an angry teenager with depression, or a troubled teenager that needed to be put back in their place. You know it was none of those things. I was a human that was suffering...It is so different...I mean I had never gone in for the labelling of an illness, so being able to say something like that and not being labelled, and being respected. Being told, “You do have depression. You do!” (By previous practitioners). It was things like that” (Appendix K, p250)

Jessica (C) elaborated that her softer sides were not seen or recognised by previous therapists. As a result she felt unaccepted and judged by those professionals who were focused on her overt symptoms. In contrast, Louise (P) was open to explore what was beneath the anger, and to understand her unique experiences. Jessica (C) described a positive experience of being deeply accepted by her. In relation to Louise (P), she went on to say,

“She saw past a lot of defence mechanisms I had up. She saw the good parts of me, that I think I kept hidden” (Appendix K, p242)

Jessica’s (C) sense of acceptance and focus on strengths empowered her and gave her hope, which contrasted the labelling of diagnostic categories.

Many clients appreciated being given the message of having a normal response to a traumatic situation in contrast to being given the message of pathology and dysfunction that often occurred with diagnostic labels. Eleanor (C) said,

“I always thought there was something wrong with me, but Adriana (P) has made me realise there is nothing wrong with me, but there is something wrong with what I experienced in childhood” (Appendix K, p198)

Another example was with Dennis (C), who explained,

“I have never felt unusual or that I have a particular set of problems that are different to anybody else. It’s like, oh yeah. This is people like you....So there is that depth of understanding and has helped me to feel so comfortable talking about these things...., That I am not unique and I don’t want to be. Not with my bag of tricks. There is some

comfort in other people have these issues. And that she had dealt with” (Appendix K, p291)

Diagnostic labels sometimes interfered with the human to human interaction, separating the clients into a problematic box, which contrasted therapists’ tendencies to normalise experiences within a context with minimal emphasis on diagnoses generally. Tina (C) felt that her sensitive nature had been pathologised in the past and that her therapy became based on fixing this part of her personality, which she did not find useful. She explained,

“I am a particularly sensitive person, which makes life great and hard at the same time and Kellie (P) really validated that and treated it as important...She saw that as a huge underlying factor that contributed to what I was presenting with, whereas with other people I have had that really as in, not only is this a quality that you have, it is a negative quality that we need to fix somehow...So that was a huge, really important in seeing Kellie (P)....Yeah, it was that too sensitive, so therefore it is an issue, that’s the way you are.... I think now I am talking to you about it, with Kellie (P) she really stuck to that complete acceptance and non-judgment” (Appendix K, p35)

Kellie (C) was accepting and empathic towards Tina (C) helping her to understand herself, rather than pathologising or fixing her. This resulted in Tina (C) feeling validated and accepted.

Psychologists explained broad psychosocial understandings of their clients rather than simplifying them into diagnostic categories. Tom (P) conceptualised Kate’s (C) issues in this way,

“So she came in quite fragile with me, she was suicidal. She had significant, major bouts of depression. Um. She was extremely anxious, very jumpy and very defensive. And seemed to be just holding up, and was getting progressively worse. So she was functioning, employment finished, she started getting into financial difficulties and it just started to unravel a bit” (Appendix L, p33)

Andrew (P) explained seeing beneath clients’ reactive anger, rather than pathologising it. He said,

“So there’s a sense of trying to work out um, sometimes it’s about holding onto, ok this person is angry, but underneath that there’s some fear or some shame or something else” (Appendix L, p141)

A high level of acceptance and respect was held for the clients, with a broad openness to understand their unique individuality. Diagnoses were used as a guide, however they did not define the individual. Another example related to Jake (C). Tom (P) said,

“There is a really strong sense of loneliness from him and that loneliness serves as a very good protection for him. So that he is not going to be hurt. Because his assumption I think is that he will always be hurt, because he is always easy prey even though he comes across as very stern....For some a very scary man. I had sent him to a colleague of mine. A clinical psychologist.... she over the phone decided not to see him. She didn't feel safe with him...I have never felt that, but I can imagine how he comes across. His neediness comes across as quite aggressive. If he needs something he is already firing canons to the person which is borderline presentation. But he doesn't have that element of suicidality or the self-harm, so that's where I lean more towards the complex PTSD diagnosis” (Appendix L, p297)

When psychologists used diagnostic labels for the purpose of shared understanding, they were tentative rather than definite, and highly respectful of the client. They used the labels to guide interventions, however were not restricted by them. For example, Liz (P) said,

“It depends who it is. I guess I conceptualise most of my complex trauma clients um, as having complex PTSD, and within under that umbrella, there will be some like Antoinette (C) who will have certain symptoms or impacts and not others, and then there will be others that are still under that umbrella that will have some additional things going on which mean that they might meet diagnostic criteria for like Borderline Personality Disorder. So that, their capacity to regulate is much more compromised and the intensity of their and frequency of their need and abandonment fears and their transference responses is much more challenging” (Appendix L, p105)

Moloney and Andrew (2016) reinforced the use of diagnoses for the purpose of understanding however, cautioned against being rigidly held to a certain intervention as a result of a diagnostic category. They emphasised flexibility within and between interventions to meet the need of the clients, in contrast to rigid adherence. Flexibility within interventions has been supported by other researchers (Elliot et al., 2005; Paivio & Pascual-Leone, 2010) however, government based organisations generally enforce specific interventions to be used for particular diagnostic categories (Moloney &

Andrew, 2016; Norcross & Lambert, 2011; Wampold, 2001). This medicalised approach was not supported in the findings of the current study when working with survivors of childhood trauma.

Psychologists maintained connection to the humanness of clients in contrast to simplifying clients to diagnostic categories. Georgie (P) commented about Xavier (C),

“I think it has been pretty significant the whole way through actually. And also when he was in the psych ward, there was talk of some borderline qualities that he has and he acknowledges that. I attributed it more to post traumatic stress, and I think there is a bit of that there. I think the borderline is a bit spot on um, but that is becoming less and less. It’s like the work that we have done has moderated those mood swings that attention seeking stuff, so we know have got the personality of Xavier (C), not the pathology of Xavier (C)” (Appendix L, p250)

Tom (P) described periods of depression to Kate (C) that suggested a temporary state of mood rather than being labelled with a mental disorder which can often be held onto as a permanent part of identity, genetics and illness. He said,

“Well I’d give her a lot of psychoeducation about feelings, I’d give her a lot of information about the rollercoaster ride of therapy, and I’d be showing her and telling her to see that depression, bouts of depression are actually getting shorter. So she’d bouts of depression and instead of staying down there, she would bounce up a lot quicker....And that started to be true to her. She started to see that that was the case” (Appendix L, p36)

Miriam (P) also explained how clients can become limited and stuck as a result of identifying themselves within diagnostic labels,

“It’s not the first time I have heard, you know whether it’s borderline, or bipolar or schizophrenia that people are locked in and that’s who they are. And I am hearing time and time again how in the research, how the labels, well the behaviours are just not happening anymore. Well because they are actually healing and they are creating different lives for themselves and they are not in the same context, and so they don’t need that role anymore” (Appendix L, p313)

Tom (P) reinforced strengths in Kate (C) and avoided being held back by labels being representative of who she was. He said,

“One thing, with Kate (C) I would just give her hope about where we were going, so she understands why we are doing this or that, so that we are not just doing them for the sake of doing them. Outside of the therapy room. I didn’t get sucked into her depression. At times I would say to her I don’t feel sad right now, even when she is crying her eyes out at me” (Appendix L, p43)

These findings extended beyond the clients being stigmatised and judged (Elliot et al., 2004; Leahy, 2015; Yalom, 1980) and holding onto the diagnostic labels as part of their identity, and thus becoming entrenched in dysfunctional roles. This was found to interfere with psychological growth. Building on clients’ strengths generally was supported by researchers as mentioned previously as most strongly emphasised in Positive Psychology (Hefferon & Boniwell, 2011; Linley & Joseph, 2004) and seemed to combat the stigmatisation around diagnostic labels.

Georgie (P) was firm and empathic about Xavier (C). She managed rather than judged challenging behaviours that emerged in the alliance,

“He is not deliberately coercive or manipulative, which of course a lot of borderline clients can be. And so we have had to tease out the intentionality of the relationship, so we keep it clear. And if he does do something deliberate I’ll call him on it” (Appendix L, p262)

Miriam (P) also endeavoured to understand “borderline behaviours”, saying,

“You know with psychiatrist and a lot of healthcare workers. Oh, it’s BPD. Oh, there’s things you do with BPD. I am thinking well, maybe. No one develops that from nothing. Why don’t we find out what happened and their behaviours are all going to make sense actually. Often they are really adequate roles in the face of traumatic experience” (Appendix L, p315)

Psychologists reported on the limitations and restrictions that diagnoses can impose, and the importance of engaging with the human being. For example, Miriam (P) said,

“That we are going to say, well ok maybe we don’t need DSM IV. Let’s burn the books. Get a big pile of them. It’s not going to happen in my lifetime, but there are enough people who realise that this keeps people limited and more and more, I reckon people are going to the psychologists who don’t limit them. Who really see them as a whole person....Not judging them? Not trying to put everything back on the client as if this is

their session. And it's like hang on they are in the room with a living, breathing person who has brought their own. There has to be an interacting element" (Appendix L, p315)

Psychologists also described depathologising already diagnosed clients. For example, Miriam (P) explained how she disentangled the client from the label, persistently and subtly over time. She said, in relation to Robyn (C),

"Like she came to me with a diagnosis. Herself of Bipolar. Um, I kind of thought I am not sure if this is accurate, but, so you know. I just carefully listened to her I think. Some reflection that I think she was a caring mother. So what I could see in terms of it's a different sort of reflection than I think she has had in the past. Like I think she has been labelled and written off very quickly" (Appendix L, p310)

Diagnostic categories were used to meet requirements for various government funding or to access to services, however the psychologists in the current study consciously depathologised their clients and explained their intentions to minimise a sense of dysfunction. For example, Miriam (P) said,

"The way of dealing with the labels is really not to mention them.....But if they need something or a service, you know I can pull out the DSM... I will use those labels but I will let them know that this is happening. That this is the language and the framework that I have to use because it's the one that is accepted. It doesn't mean I have to believe in it. You know when people come in with a label, it just takes so long for them to work outside of that. But they almost grow into the box, rather than, and I'll say ok let's put the box over there and let's not talk about that and they will bring it, some for a couple of years will keep bringing it and I will be like let's put that over there and let's keep talking about what you have been doing this week. One day the Valerie (C) will drop and they will realise, oh I haven't been relating to a label or actually I am doing things quite well, and I seem to have helped the relationships here. So maybe I am not so sick as I thought I was, or that people told me I was" (Appendix L, p315)

Occasionally diagnostic categories helped clients to understand what was happening in themselves, which they reported as a feeling of relief. Also at times psychologist's classification of abusive behaviour by others, for example "bullying", left the client feeling supported and validated. For example, Natalie (C) said,

"And then it just comes with Miriam (P). Before I trust my friend and I tell my friend everything and now they laughing at me. They say it's only my opinion. They say even at

work the people I feeling like myself, the people they don't like me. They don't understand me, like they bullying me" (Appendix K, p368)

Kate (C) described managing her depression,

"I'd work really hard. Hit rock bottom, then worked really hard to swing everything around...Used to have big bouts of depression. Just awful you know, just so hard. I am lucky I've got, including Tom (P), I am lucky I have really good people around me, so...People don't realise that going for a walk is really good for depression" (Appendix K, p51)

Daisy (C) appreciated a diagnoses. She found it reassuring,

"Well no one had ever said that to me before, sort of identified it (depression) and even though it was hard to hear at the time, you know, oh really, but it was still actually quite nice um, because I was feeling crap every day, and also I knew I was having suicidal thoughts, so it was actually nice to have someone go, this is what, and she actually made the appointment with the doctor too" (Appendix K, p64)

Diagnoses had the potential to help and hinder clients in the findings of the present study. They were used to guide therapists in their psychotherapeutic interventions, however when managed poorly were found to inhibit the therapeutic process and clients' growth.

Rogers (1967; 2007) emphasised understanding of the whole client and their situation in contrast to simplifying to diagnostic labelling aligning with the findings of the current study. Broadly capturing the human experience was supported by many researchers in contrast to reducing clients to symptomatology (Courtois & Ford, 2013; Elliot et al., 2004; Leahy, 2015; Moloney & Andrew, 2016; Paivio & Pascual-Leone, 2010; Yalom, 1980).

Aligning with the findings of the current study, trauma specialists emphasised a non-judgmental, open and accepting stance towards complex trauma clients. They endeavored to understand clients' behaviour within a context of surviving in childhood environments in which the child developed coping skills and means of self-protection, when parents or caregivers were unavailable or neglectful of the child's needs (Kinsler, Courtois & Frankel, 2009; Linehan, 1993; Paivio & Pascual-Leone, 2010). Acceptance of client feelings and thoughts was also thought to enable clients' presence to their experiences rather than shame based avoidance, dissociation, or blocking from

awareness (Elliot et al., 2005; Kinsler, et al.; Paivio & Pascual-Leone) that facilitated trauma work. Through accepting and validating the clients' experiences therapists were guided to avoid blaming or labelling of clients for their manipulative behaviours and symptoms (Kinsler, et al.; Linehan; Paivio & Pascual-Leone). These findings aligned with the findings of the present study.

Some researchers cautioned against pathologising clients, which had the potential to be stigmatising and to be perceived judgmentally by others (Elliot et al., 2004; Leahy, 2015; Yalom, 1980) and in the instance of Borderline Personality Disorder (BPD), interfered with "empathy, prizing, and presence" (Elliot et al., 2005, p303). Elliot and his colleagues (2005, p303) preferred to use the term 'borderline processes', instead of BPD as it referred to a natural human response that all individuals can experience aspects of, at some stage in their lives, hence depathologising the clients and normalising their experiences. These findings aligned with the present study.

Some trauma specialists differed in their emphasis of diagnostic labelling during assessment. Whereas the approaches described above depathologised the clients and described labels tentatively, others researchers strongly encouraged the use of clinical diagnoses, considering them essential (e.g., Mooren & Stofsel, 2015). Some trauma specialists urged clinicians to develop an extensive assessment and accurate diagnoses in trauma management, with a list of criteria that was suggested to be addressed in the assessment process, using formal methods, and in a structured interview format (e.g., Mooren & Stofsel, 2015; Weathers et al., 2009). For these same researchers, the structured interview was considered the "gold standard in the diagnosis of mental disorders", enabling accurate diagnosis and treatment plan (Weathers, Keane, & Foa, 2009, p36). This approach contrasted the findings of the current study that highlighted the importance of being with the clients in a human to human encounter, attuning carefully to their words, emotions and non-verbal behaviour, and becoming emotionally present with the clients. The exploration to find clinical diagnoses was a cognitive process, which taken to an extreme had the potential to interfere with the therapists' emotional empathy, and to minimise the client to a list of behaviours. This contrasted with engaging in the present moment and getting to know the human being, with openness and deep acceptance, while holding the diagnostic label lightly and tentatively.

Research has shown evidence to adopt caution around the use of diagnostic labelling. For example, Lebowitz and Ahn's (2014) study examined the effect of biological categorisation on clinicians' empathy, finding evidence towards the use of diagnoses being linked with reducing the clinicians' empathy. A mix of doctors and allied health professionals working in mental health read vignettes of client cases, half of which were described with biological underpinnings and the other half with psychosocial explanations. The clinicians were asked to score empathy related adjectives to the vignettes. Clinicians demonstrated reduced empathy towards clients with biological explanations than with psychosocial ones, aligning with the findings of the current study. One suggestion for this finding was due to the dehumanising that can occur through biological approaches that can lead to problems with being seen as fixed and potentially unable to change. (Haslam, 2006; Yalom, 1980). It created arguably a larger gap between people with mental health issues and the rest of the population through the dehumanising of those with issues (Haque & Waytz, 2012; Lebowitz & Ahn, 2014). Yalom (1980) encouraged diagnoses with more severe pathology such as with Schizophrenia, Bipolar Disorders and Major Affective Disorders. In the current study psychologists worked with clients who were diagnosed with severe pathology and used these labels to guide treatment, however they maintained an openness to their clients and their possibilities for change.

In Leahy's (2015) operationalisation of Emotional Schema Therapy, she encouraged therapists to put themselves in their clients' shoes and to avoid pathologising and being critical in attitude towards them, because of the negative effect this may have. Emotional Schema Therapy used diagnostic categories to guide treatment, however also recognised individual differences in thoughts and emotions. Aligning with this practice Kudler (2009) within the psychodynamic field recently questioned whether psychodynamic principles may be more useful with PTSD than medical model categorisation, due to the deeper understanding and humanness required. These broader means of understanding aligned with the findings of the current research, in which the psychologists avoided labelling their clients as it risked reducing clients' experiences to a set of symptoms with a rigid focus on diagnostic categories. Yalom (1980) in addition cautioned against the potential narrowing of therapists' vision when diagnosing, which may have resulted in aspects of the clients being overlooked, as described by Jessica (C), above.

A number of researchers emphasised being attuned to emotional states and to the needs of the clients, while responding attentively through the therapists' presence (Elliot et al., 2005; Erskine, 2015; Paivio & Pascual-Leone, 2010). Erskine (2015, p46) suggested responding to sadness through compassion, anger through "attentiveness, seriousness and responsibility, with possible acts of correction" and offering security and protection to a frightened client while sharing the pleasure of happiness and joy. He also highlighted the importance of attuning and responding attentively to clients' needs, which varied from one client to the next. Some required validation and affirmation, while others needed confirmation of self through the relationship. Some clients needed to express love, while others needed to have an impact on others (Erskine). In this sense, he cautioned against pathologising clients and encouraged therapists to understand the underlying needs of the clients (Elliot et al.; Erskine; Paivio & Pascual-Leone). For example, if a client gave a gift, it may be because they needed to express love in the relationship rather than violating a boundary or trying to manipulate the therapist. A more trusting stance was taken of the clients' motives and needs, as well as an openness, compassion and acceptance of the clients, similarly to Geller and Greenberg (2002, 2012). This stance aligned with the findings of the current study.

The research or literature in the area of clinical diagnosing was not found to explain how to manage the dance of labelling mental disorder categories, which on the one hand had the potential to be problematic while on the other hand was a requirement for working within the healthcare system. Furthermore, clients frequently presented to counselling with diagnostic labels that were already imprinted, having been referred from general practitioners who practise within a diagnostic medical model. This needed to be managed carefully, to maintain connection to clients' identity and to empower them rather than reinforce dysfunctional roles.

4.5 Summary of Findings Related to Acceptance

Survivors of childhood trauma clients were found to be vigilant and aware of therapists' perceptions of them and whether they were open and accepting of them or not. Judgment or an avoidance pattern in therapists was perceived negatively indicating messages to the clients of unacceptability and reinforcing childhood trauma

experiences. The importance of therapists' unconditional acceptance of the clients with an ability to remain present to all aspects of them was highlighted as paramount.

Furthermore, clients made their own judgments around whether their therapists were able to handle intense emotions and content, and either withheld disclosure or were trusting enough to express themselves. This enabled the clients to connect more fully with themselves, as they did not have to worry about the wellbeing of the psychologists. Knowing that their therapists could handle whatever arose between them, enabled clients to disclose more freely and to greater depth.

Clients experienced deep acceptance, openness and presence from their therapists in relation to their traumatic experiences, emotional responses, shameful behaviours, sexuality, swearing, drug use, religion, physical appearance and personality. The therapists were able to be present and listen to all aspects of the clients, from a prickly, defensive façade to the deep, core sense of self that may feel flawed, shameful, damaged, or disgusting. They were able to explore a diversity of clients' aspects of selves and difficult experiences, knowing that it was assisting their clients. They described handling diverse and intense clients' emotional experiences in sessions with openness and warmth, managing their own fear or impatience, and in doing so connected deeply with their clients physically, emotionally, psychologically and spiritually, sometimes using humour and metaphors. Their depth of empathy and profound acceptance of their clients' experiences remained consistent across a diversity of clients and pathologies.

Psychologists in the present study generally focused on broadly understanding their clients in contrast to pathologising them, although they sometimes used clinical diagnostic labels during interviewing to categorise and share understanding. They described how traumatic childhood experiences resulted in clients finding various ways to cope with their situations, which often became pathologised by significant others. Some therapists used the diagnosis of borderline behaviours to show the depth of trauma and possibilities for recovery and shared a respectful attitude towards these clients. The psychologists were non-judgmental and tentative in their description of diagnostic labels, which clients appreciated.

Pathologising of clients by previous health professionals in general frequently left clients feeling like there was something wrong with them and that they were being judged. This reinforced childhood schemas of dysfunction and a sense of being flawed.

This also impacted on the alliance negatively. The clients' priority was to be heard and cared for, rather than being labelled.

CHAPTER 5 BOUNDARIES

This chapter has been divided into three areas. Firstly, broad boundaries; the importance of therapist consistency, availability and routine, firm and flexible boundaries, issues related to boundaries that were too rigid, and adapting boundaries for individual clients have been outlined; secondly, the boundary between therapists and clients will be explained; thirdly, therapists' self-disclosure that includes helpful and hindering factors, and the way in which the psychologists made decisions in this complex area. Examples are given highlighting themes, with comparing and contrasting of theories and research applicable in these areas.

5.0 Consistency and Availability of the Therapists

Providing a consistent, routine time, place and therapeutic method for the clients, was facilitated by psychologists that assisted clients to feel secure. Boundaries were described by both clients and psychologists as important, balancing firmness and flexibility, with the potential for the alliance to be affected both negatively and positively, depending on *how* and under what circumstances they were implemented.

Clients appreciated consistency in their psychologists. For example, Josie (C) appreciated Miriam's (P) predictable presence. She said,

"For all the good that she has done to me. She hasn't changed in any way. She is still that same person. That was very important" (Appendix K, p335)

Clients also wanted to know that their therapists were consistently available to see them for sessions. Brad (C) explained his experience related to his psychologist,

"The only issue was the lack of appointments rather than anything else. Her availability and not being able to see her as often. Her appointment times and my work. That has been an ongoing frustration I suppose" (Appendix K, p342)

In contrast, Josh (C) said,

She was willing to put a structure in place. She was willing to see you twice a week.....I seen her a couple of times before Christmas and then a couple of days she said look, I am in between holidays. I am only seeing one or two other clients, Troy. If you want you can come and catch up in that time, and I said yeah, alright" (Appendix K, p322)

In the above example, Connie (P) gave Josh (C) regular sessions and choice to maintain some routine during extended periods of leave. She and other psychologists wanted to be available for their clients, knowing that that consistency was important to them. Clients expressed finding long periods of therapists' absence during extended leave breaks to be difficult.

It helped clients to have forewarning and an explanation during periods when therapists were going to be unavailable. For example, Al (C) said,

“There were some times that Tom (P) wasn't available, one related to his child, and another when he had some holidays and things....., for me I kind of noticed in those weeks that it felt like I should be coming. So it was more the absence that I noticed in terms of, I thought a bit like the support was missing that I had been used to....., and what helped there was probably that he pre-empted me about those times, that it wasn't a surprise, that he gave me notice of these incidences. Um, so there was lots of warnings around it, so that was helpful” (Appendix K, p81)

A number of clients in the present study also expressed wanting to be able to keep coming for therapy on an ongoing basis for as long as they needed to. When therapy was ended suddenly it was difficult for clients. One example of this was from Tracy (C),

“I have known people who have gone to therapy and been very dependent on their therapist and almost cracked up because their therapist had to stop, or had left and it has been really traumatising for them that the relationship has ended. And I didn't want that..... but I think I would want that from any therapist, that they weren't going to up and leave. That would be pretty bad” (Appendix K, p224)

Both being able to come for as many sessions as the clients wanted, as well as not being cut short in therapy by the therapists leaving was found important by clients in the present study. It was especially difficult for clients when the therapy ended suddenly. This contradicted treatment plans that enabled approved access for a limited number of sessions defined by government organisations, within a required timeframe. The findings also highlighted the importance of therapists' longevity in their role, especially when working with survivors of childhood trauma. This work may be less suited to therapists who enjoy a variety of positions and changeable work environments.

Sometimes the clients were worried that the therapists would not be able to handle the content and as a result feared the ending of the therapy. Other clients had had previous experiences of being moved involuntarily to a different therapist because the current one was described as not being suitable for the client. Therapists may have been making decisions based on the Australian Psychological Society Code of Ethics following advice to work within your area of expertise, however when the therapists ended the therapy in a decisive, boundaried manner, without involving the clients in decision-making, it was found to reinforce the clients' sense of being too difficult for the therapist. It re-enacted childhood parental deficiencies and childhood negative self-perceptions of the clients. These findings highlighted the importance of screening prior to developing an alliance with the clients and of therapists seeking support through supervision or professional development to deepen understanding related to the clients rather than handing them over to another therapist too readily. Consultation with the clients through the process was also indicated as beneficial.

When an open discussion was held about the clients' perceptions of self being too difficult, the psychologists were able to reassure the clients and reinforce that they had their own supports in place, and that they could handle the clients' content, and inadvertently the clients themselves. This had a positive impact of deepened trust. For example, Kate (C) feared Damian's (P) abandonment of her, prior to discussing the matter openly in a session in which she was reassured of his presence. She said,

“And that let me have a whole new level of trust and getting rid of mine. Getting rid of my dirt and filth.....he'll stay engaged as well. He won't just shut down on me in my trip”
(Appendix K, p39)

Knowing that the Damian (P) was not going to leave instilled hope and confidence in the Kate (C), assisting a sense of security in the relationship that Damian (P) would be there for the entire journey. Clients also wanted to have the option to be able to return for further sessions in the future if they wanted to, when therapy had discontinued. This gave a sense of comfort and support in contrast to being cut off, again highlighting the need for therapist longevity of practice working with survivors of childhood trauma.

Both psychologists and clients indicated having a structured format to the sessions as important. Being professional in presentation with a routine time, place and

pattern of events was thought to elicit implicit boundaries according to some psychologists. These factors were seen as important to maintaining safety and consistency across sessions.

Psychologists' comments in the present study paralleled clients concerns. They recognised the importance of being available and consistent to their clients, and to being able to give their clients a more positive experience than in childhood. For example, Georgie (P) described using consistent language across sessions so that the clients knew what to expect. She said,

“I keep very regular times with trauma clients and, and I don't go over time. Because again this is about safety and boundaries, because sometimes clients can go on and on, and I am very clear when I go in. I use the same language every time, so there is a sense of safety, oh yeah, we are doing....” (Appendix L, p118)

Georgie (P) further explained the importance of consistency and routine for her clients,

“So a trauma client is going to be very mistrustful, they are not going to have a secure attachment, and yet that is what you are trying to foster. Pure attachment that is based on routine, regularity, security, consistency, all of those things which were all absent, and so it's even more important” (Appendix L, p119)

Psychologists believed the structured, consistent haven facilitated secure attachment and provided a corrective experience for the clients. Aligning with the findings of the present study, the importance of therapists' availability, reliability, and consistency has been strongly emphasised in Attachment Theory, as being essential for the development of a secure bond between therapists and clients (Holmes, 2014; Tronick, 1998) and supported across researchers (Briere & Lanktree, 2012, Elliot et al., 2005; Paivio & Pascual-Leone, 2010, Siegel, 2012). Therapists' responsiveness was likened to the responsiveness of a parent to their child, which assisted the child to soothe, emotionally regulate and trust. However, when absent or deficient the lack of parental responsiveness elicited either hyperarousal or emotional disengagement (Bowlby, 1988). Similar to the findings of the present study, trauma clients, who frequently present with insecure attachment, have been found to be highly sensitive to therapists' presence and can experience high levels of attachment distress as a result of therapists' absence, unavailability and unresponsiveness. A compassionate and non-

judgmental stance has been encouraged to reassure clients during periods of therapists' absence by experts (Bowlby, 1988; Elliot; Paivio & Pascual-Leone). Having a safe, consistent and reliable therapeutic space with a soothing and reassuring therapist has been found to assist clients to develop the ability to emotionally regulate and to assist secure attachment (Elliot et al.; Holmes; Paivio & Laurent, 2001).

In the findings of the current study, the responsiveness and availability of the therapists frequently involved having contact with the clients outside of the therapy hour. Clients appreciated being able to make occasional contact in between sessions when they needed more support, especially during periods of high vulnerability. Psychologists shared a willingness to make contact on occasions outside of sessions, and reinforced the need to respond to the clients' messages within a reasonable timeframe.

For example, one client Bess (C) said,

“Another thing about Georgie (P), I am not going to call her the psychologist, I’ll call her Georgie (P), is that when that door closes, it’s not over. When I have a problem, I can ring her. Anytime of the day, and she will always respond. Might not be straight away, but she is there and she’ll be sending me positive texts, telling me I am ok, I always get a response” (Appendix K, p166)

Bess was reassured by Georgie's (P) responsiveness and willingness to make brief contact when she was feeling overwhelmed. Valerie (C) had a similar experience with Jenna (P),

“Ok, but I could ring her, but she might not be able to talk to me that minute, or I could leave a message and she would always get back to me. And so even if she couldn’t speak to me in that moment, she would always contact me and she would say, look I am here with my family, bla bla bla, just letting you know I am here for you. Can we talk in an hour or two? Or can I ring you at a certain time tomorrow and I just knew she would” (Appendix K, p235)

Therapists reliably responding and being available within a reasonable timeframe was important for many of the clients interviewed in the current study. The clients appreciated having a sense that the therapists were there for them, if they needed it. It assisted them to emotionally regulate knowing that the therapist would make contact with them at a given time. A brief phone call, text, or email often gave the

clients a strong sense of comfort and reassurance in between sessions during difficult periods of time. It also helped clients to feel more deeply cared for, special and validated, deepening perceived, genuine empathy and assisting to reconstruct negative perceptions of self. For example Kate (C) said,

“In between therapy, I like that he (Tom (P)) says reach out to me if you need me.....I can email him, I can ring him up. If I need someone to talk to he’s there.....And he has become so important to me. Because he is very human about the whole thing Just you know he’s not just there for the money, he isn’t over it (the job) and just shutdown”
(Appendix K, p37)

For Kate (C) and other survivors of childhood trauma, the flexibility in being available outside the therapy hour assisted them to trust, because it reinforced the genuineness of their therapists’ intentions. This negated fears frequently experienced by survivors of childhood trauma, of being unworthy and unlovable, and hence was found to have a powerful positive therapeutic benefit. Behaviour involving flexible boundaries such as extending a session by a further 10 minutes at the end of a difficult session, and being concerned for the client once the session had ended had the same effect.

Boundaries in general were emphasised in trauma guidelines with firm and flexible boundaries commonly recommended when working with adult survivors of childhood trauma (Courtois & Ford, 2013; Dalenberg, 2000; Elliot et al., 2004; Kinsler, Courtois & Frankel, 2009; Paivio & Pascual-Leone, 2010). Generally, a harm minimisation approach was taken in this area. Boundaries were emphasised as important to protect clients and therapists, rather than the potential therapeutic benefits of extended boundaries, found in the present study. There was variation found in the approaches taken towards the meaning of firmness in boundaries and in the level of flexibility advised across trauma specialists.

Some trauma experts have warned therapists of the potential for endless demanding behaviour from survivors of childhood trauma without strict boundaries, particularly if they have a diagnosis of Borderline Personality Disorder. Concerns such as; unhealthy dependency patterns resulting in clients contacting the therapists during work and after hours, with repeated suicide calls have been highlighted. There was a strong protective focus on therapists who were advised to take care of themselves or risk reacting negatively towards their clients as a result of their own burnout (Courtois

& Ford, 2013; Kinsler, Courtois & Frankel, 2009). A firm and strict approach was thought to teach the clients boundaries. This extended to areas of fee payment (Kinsler, Courtois & Frankel), avoiding contact with the clients outside session times (Fisher, 2001; Kinsler, Courtois & Frankel), affection, personal disclosure (Kezelman & Stravropoulos, 2012; Kinsler, Courtois & Frankel), and strict adherence to session times (Fisher, 2001). This stricter approach to boundaries to manage the potentially out of control clients was not supported in the findings of the current research.

Contrary to the notion that clients will take advantage of the therapists and become increasingly demanding and without boundaries, on the whole the clients interviewed in the present study, were found to acknowledge and respect the psychologists' time and capacity. This occurred for example, when psychologists made themselves contactable during difficult times outside of sessions. Some clients also appreciated more directness on the odd occasion, when it was needed. However, most clients were found not to violate the extended boundaries, and were conscious of not intruding too much on the therapists' time. The occasional extension of the boundary had profound positive effects on clients' trust in the therapists' intentions. For example, Bess (C) said,

"It was almost like you were a baby and you couldn't move. We'd go into another room and it was funny. She had a cancellation and so she was able to sit there, stroke me and just get me back to the real world so to speak. It didn't happen too often. But I can remember, she didn't just say, well Bess (C), your time is over, get up, get out (said firmly). She would take me to another room. She would give me something to eat, give me something to drink to get me back. You know and to me, she cares" (Appendix K, p172)

The approach taken by the psychologists was more generally optimistic than that taken by some of the researchers and viewed clients as fellow human beings with struggles, in contrast to being defensive and taking a highly therapist and client protective stance. The psychologists in the current study were protective of their clients' wellbeing and were aware of the importance of their own self-care however, conveyed a more positive attitude of trust towards their clients. If issues with boundaries arose, on the odd occasion, they used honest and empathic dialogue.

These differing findings may be partly explained by the in-depth nature of the current qualitative study that allowed for greater scope in individual descriptions by clients and experienced psychologists, compared to broad recommended guidelines that

were designed by practitioners, and were written for novice therapists, as well as more experienced ones. Fisher's (2001) guidelines applied to dissociative disorders, rather than specifically to complex trauma clients. Not all survivors of childhood trauma experience dissociation, however it has been considered common to have at least some degree of dissociative symptoms amongst the survivors of childhood trauma cohort (Fisher). There may also have been cultural differences due to gun laws in America, as some of the examples given involved clients arriving with weapons (e.g. Courtois & Ford, 2013) that has been arguably less of a threat in Australia to date.

The increased flexibility described within a structured approach found in the current study was supported by some authors, including an openness to client contact outside of sessions occasionally, use of affection with some clients, and therapists' above and beyond behaviours during specific, targeted events (Erskine, 2015; Holmes, 2014; Schechter & Goldblatt, 2011). More specifically, Schechter and Goldblatt (2011) acknowledged that clients may need contact outside the therapeutic hour in the form of phone calls, emails, text messages, and that this outside session contact can have internal meaning for the clients and strengthen the alliance, aligning with the findings of the current study. Greater compassion, flexibility and respect were encouraged towards the clients with increased emphasis on the positive experiences that may emerge through boundary stretching (Schechter & Goldblatt).

Furthermore, according to Attachment Theory and aligning with the current study, responding empathically to clients' distress during vulnerability has been found to facilitate a secure bond (Holmes, 2014; Siegel, 2012). By therapists responding to their clients' reaching out to them for help outside of sessions empathically, it was found that clients' trust in their therapists was enhanced. Given how easily survivors of childhood trauma survivors can misconstrue therapists' intentions (Holmes, 2014; Paivio & Pascual-Leone, 2010) not responding or being unavailable outside the therapy hour has the potential to elicit negative feelings about the therapists in the clients, potentially reinforcing childhood schemas of significant attachment figures being unreliable or not caring. Insecure attachment systems may be reinforced if the therapists were found to be unreliable, inconsistent and unresponsive (Holmes). As described in the examples, this notion was supported by clients' comments in the current study.

Erskine (2015) reinforced the importance of attuning to the needs of the clients specifically in not repeating previous significant figures patterns of relationship failure.

In contrast he asserted having an individualistic and flexible approach to enable the clients to be met relationally. For example, some clients who required affirmation or confirmation of experiences may have benefited from small therapist self-disclosures to offer a sense of mutuality and affirmation of the same experience, which was likely to improve the alliance. He acknowledged that for other clients this boundary shift would be inappropriate and potentially harmful to the alliance, for example if the clients relationally needed the therapist to be reliable and protective (Erskine), highlighting the importance of adapting the boundaries to the individuals.

The findings of greater flexibility and openness to the clients in the current study were mirrored in Gutheil and Brodsky's (2008) study that highlighted the differences between boundary crossing and boundary violation, giving two examples of improved alliance in situations where the boundaries became flexible. The therapists adapted their clients' request for a hug and agreed on a hand shake, so as to meet the clients halfway, while also protecting the therapeutic relationship. The need for security and stability in the alliance with flexible boundaries was also studied by Dalenberg (2000). He surveyed trauma clients at the end of treatment. Non-disclosing therapists were found to be the hardest for clients to relate to. This involved disclosing present moment experiences of therapists, rather than personal content (Dalenberg), highlighting the importance of transparency in the therapists and being present with their clients. Both of these studies involved more flexibility to the clients' boundaries and aligned with the results of the present study.

The issue of navigating the boundary path with survivors of childhood trauma was found to be complex at times in the current study. Psychologists described a consciousness around managing boundaries, while maintaining a responsiveness to their clients, with decision making applied to each individual client. Liz (P) explained,

“This is where it is that tension balancing act, particularly with complex trauma clients where you need to be clear about boundaries, but you also need to be responsive....I was pretty clear at the start about when we would meet, how we would meet. I have also been clear about when you are suicidal or are about to cut, I am not the person to call. Um, these are the services that you would go to, although having said that, that had to be adjusted over time, because she had a bad experience in the public system....so we adjusted that agreement that if she wasn't able to get responses elsewhere, that I was at the end of the list, but she could try to contact me, but that I was clear that I may not

respond, and I may not respond, not because I didn't think she was important enough to respond to, but I may have turned my phone off in the evening, because in order to care for others I needed to care for myself, or I might be out, or my phone might be flat" (Appendix L, p104)

As can be found in the above example, the boundaries when working with survivors of childhood trauma were found to be complex to navigate, and required a balance between therapists' and clients' needs, as well as a protection of the professional, therapeutic relationship. The therapists were found to maintain their transparency, caring and openness with their clients consistently, and to clarify decisions to help their clients to understand their motivation.

5.1 Adapting Boundaries to Individual Clients

Psychologists in the current study found that the boundaries needed to be adapted to the individual clients, with some clients requiring a more direct approach than others. With a small group of clients, firmer, more overt boundaries were needed. The psychologists did not pathologise these clients or speak negatively about them, rather maintained a non-judgmental and caring stance and addressed the client's behaviour. The same clients appreciated their psychologists' directness. For example, Olivia (C) said,

"She has guidelines, strict boundaries and if she didn't want to do it, she wouldn't. She'd be honest and tell me, it's not my place...I moved into a new apartment and I asked her in for a coffee and straight away she said no. It's not appropriate (said with warmth). So straight away she put the boundaries in place, so it was good. I need that. People might think oh, that's not very nice that she won't visit, but I like that. I need to know the boundaries" (Appendix K, p126)

Olivia (C) appreciated that the boundaries were clear, firm and fair however, they were also delivered empathically. Karin (P) delivered the tighter boundaries to protect Olivia (C), instil responsibility and to be clear about her professional obligations. She clarified,

"I had to be much more boundaried, much stricter with her, in terms of if you ring me when you are feeling like you are going to harm yourself, before you are going to act, I will talk to you for this amount of time. I will not talk to you, once you have done the act, you call an ambulance, you go to the doctor. So it's much more challenging work in

getting that balance in not reinforcing really harmful, unhelpful coping strategies but also not being too, or appearing to confirm sort of rejection, judgment and criticism, punitive” (Appendix L, p105)

Deep acceptance of the clients was also conveyed by therapists, as described in the above examples. The management of boundaries was navigated thoughtfully. There was the high level of client focus with careful decisions made balancing boundaries to meet the clients’ needs as well as their own. Boundaries were adjusted depending on the clients and their own situation. Clear explanations of the limits of their boundaries were consciously made to reassure clients that if the therapists were unavailable, a clear explanation was given, rather than the clients feeling it was a rejection of them. Therapists also let clients know when they would be available to connect with them. Offering realistic expectations was highlighted as important by Liz (P) to protect the clients from negative alliance triggering,

“Being mindful of boundaries and expectations, so not setting things up so they would feel that they are somehow being ignored or rejected. So not setting up something that cannot be sustained, or not setting up expectations that can’t be met” (Appendix L, p107)

Felicity (P) also reiterated,

“I usually set them up at the beginning, so there’s a feeling of containment at the beginning” (Appendix L, p25)

Discussing the length of sessions and contact outside the session in form and timing at the beginning of therapy, to clarify these boundaries and to avoid setting the clients up for unrealistic expectations and disappointment, has also been highlighted by Mooren & Stofsel (2015).

Psychologists accepted the need to be responsive and accessible to some clients beyond the therapeutic hour. Occasionally, the flexibility became problematic with the clients making too frequent contact in between sessions. Psychologists described strategies including speaking openly and empathically to their clients about the problem and setting up a structured format outside of sessions to manage this. An example follows. Georgie (P) took a structured, firm approach with Troy (C),

“He would ring me all the time. And I said no you can’t ring me. And so I had to get a chart and I said you can ring me on this day. I will text you on this day. So we structured

it. And interestingly enough, he still has that structure today, and that helped to contain him” (Appendix L, p260)

The psychologists interviewed displayed a strong motivation to meet their clients’ needs in a flexible, focused manner. They described an awareness around responding to their own needs in order to take care of their wellbeing, which sometimes meant that they were unavailable, temporarily for the clients. For example, the importance of taking time off when unwell was emphasised by one psychologist in order to protect the alliance, due to the risk of resentment building, therapist burnout, and loss of patience with the clients. Becoming too client focused was highlighted as a problem. To this end taking annual leave, sick leave, having boundaries around therapists’ hours were seen as useful in protecting psychologists and the alliance. The clients were offered empathy, reassurance and support through the process of establishing boundaries and explaining their unavailability. This approach worked according to therapists and clients. It extended beyond rule bound guidelines and described how therapists managed this complex area, in collaboration with their clients from a position of mutual respect and trust in their clients.

5.1.1 Boundaries adapted for neglect

Too much of a rigid approach may also risk reinforcement of clients’ patterns of self-reliance and of not asking for help with those, who have learned to survive alone since childhood. For these clients, reaching out to their therapists during vulnerable times was exceedingly difficult. They appreciated being offered the opportunity to make contact with their therapist in between sessions. For example, Tina (C) said,

“Yeah, I know there was one ongoing thing where I would, she would always say if you are ever struggling, email or call me, and there were certain times where I would contact her and say, if you have got any extra appointments. I would like, it only happened once that she emailed back and said nothing available. It was just a short response and I would find that a bit confronting sometimes. I know exactly why it happened as I am falling apart inside and present as though everything is fine, but if you have got some time that would be great. On face value, and I would feel dismissed, and I should have said, I really need some help right now, in which case even if she didn’t have an appointment she would call” (Appendix K, p138)

The psychologist in this instance was unable to offer Tina (C) another session, and did not hear through Tina’s (C) message, how overwhelmed she was at that time.

This example emphasises differences amongst clients and the importance of therapists' attunement to the individual clients through subtle nuances, which may be barely detectable. The complexity of the relationship and difficulty for some clients to speak out and ask for what they needed during vulnerable moments was underscored by clients and psychologists in the present study.

Irene (P) reinforced a more direct message to clients who have a history of neglect, related to making contact with her. She said,

“With neglect and the fact that you need to reinforce to him or remind him or letting him know that he can make contact with you and that he can come and use your service, because he has nothing of that as a child, that you need to really spell that stuff out to him” (Appendix L, p88)

There was an openness offered to Ken (C) by Irene (P), that encouraged him to make contact when he wanted to, to overcome patterns of managing alone, while providing a corrective experience for him. Complexities in the alliance such as this appear to be unexplained in the literature. The literature generally was found to emphasise how to manage a lack of boundaries, rather than how to encourage these clients to reach out when they need help.

Another example from Tina (C) explained her experiences further,

I think it was also Connie's (P) commitment to me. I had a big, one of my fears or beliefs was that what I was bringing wasn't significant enough, wasn't worthy enough. Particularly with Connie (P).....I felt like my taking of one spot in her caseload had to be really valuable, but she never, ever treated me like that at all, so I think that was really important that constant validation that you need to be here. I think your issues are more significant than you do. You know because I was down playing them. That was really importantAnd I never felt as I did with the previous one, let's wrap you up in a year, you know, this is what you presented with, now let's get you out the door. Whereas with Connie (P), other things emerged onto the surface and she never, she was just happy to see me whenever she wanted” (Appendix K, p132)

In this example, Connie's (P) openness to providing counselling to Tina (C) for an indefinite period of time, helped Tina (C) to feel worthy and as though her problems were valid, counteracting childhood experiences. This highlighted the importance of collaborating with the clients when working with survivors of childhood trauma. It also

indicated the potential to reinforce negative self-perceptions originating from childhood experiences when therapists discontinued therapy on their terms or expected clients to manage on their own outside of therapy hours during vulnerable periods of time.

5.2 The Consequences of Rigid Boundaries

When boundaries were experienced as too rigid, clients in the current study reported the alliance was affected negatively. Some examples of this occurred when the sessions were ended too abruptly giving the clients an unpleasant surprise, and when the therapists became too impersonal and business like when arranging payment. Both scenarios seemed unnatural to the clients and the therapists' behaviours were perceived as cold, harsh and uncaring. It was perceived as a business transaction in which they were just another fee paying client, depersonalising the experience and devaluing themselves.

For example, Daisy (C) had a negative experience with a previous therapist. She said,

“She just kind of wanted to fix this one issue, and then she kind of herded me off, said we are done now and ended the sessions” (Appendix K, p62)

Kristen (C) reported that a therapist parroted abruptly and self-righteously,

“I am only available for these counselling sessions. I do not take phone calls. I don't want to know anything about what is going on in between our session times and its 50 minutes!” (Appendix K, p277)

When practitioners separated themselves too much from their clients, some clients found this difficult. For example, Tina (C) asked where a previous psychologist was going on holidays, and was given an abrupt response,

“I asked the psychologist, you know chit chat stuff at the end of the session when I was paying, and she said I am going away for 3 weeks so I can't see you for a while. And I said oh, where are you going? (enthusiastically) and she said, I don't discuss that with clients (said firmly), and I felt like an idiot, because I should know, well I thought I should know that she was not going to discuss that with me, but it was just in an informal chit chat, I felt quite confronted by it, or quite cut off” (Appendix K, p135)

As a result of the psychologists' shortness and absence of self-disclosure, Tina (C) was left questioning herself. A loss of trust and increased feelings of fear in relation to her psychologist occurred as a result. Tina (C) described her hesitation to self-disclosure in later sessions. When asked by the interviewer what the underlying message was that she was left with Tina (C) said,

"I am available in session but very much not outside. I don't trust that you can contain yourself. I don't trust that you won't do this every single week if you get away with it once. That kind of whip" (Appendix K, p136)

The potential for survivors of childhood trauma to feel untrusted by their psychologists through the therapeutic process was demonstrated, potentially reinforcing negative childhood attachment messages of being untrustworthy and too much to handle. It highlighted the risks of retraumatisation of clients when the boundaries were managed too rigidly. This notion was supported by some of the more recent literature (Erskine, 2015; Holmes, 2014).

Sometimes clients were left in suicidal states at the end of a session which was ended suddenly, and that was perceived as dangerous and uncaring by the clients. Kristen (C) stated,

"Many a time we would just start to get into something difficult and it was like, no strategies to give you until the next time....it was like, sorry, see you next time. And I would be out there thinking I might go and kill myself now, because there was this huge raw emotion" (Appendix K, p277)

This example highlighted the fragility of clients' emotional states which might require additional support in that moment.

Harsh cancellation fees when clients were in very vulnerable and unpredictable states were also considered unreasonable to some clients, and negatively affected the client's perception of therapist empathy. Cas (C) said,

"And she didn't have a receptionist and my appointments used to be Monday and she wanted 24 hours and in those days I was very anxious. So it would start by the Thurs, Fri but I would never know, so by Sat or Sun, if I cancelled she would charge me the hundred and whatever it was dollars, and I hated every second of it. She was in East Melbourne and it was very um, upper class and very distant and very uncaring and she didn't give a hoot at all" (Appendix K, p272)

Survivors of childhood trauma participants in the current study highlighted the negative effects of boundaries that were too strict, which was not found to be emphasised generally in the trauma literature, for example in the process of trying to create safety and to protect the clients some previous practitioners had inadvertently elicited painful feelings of abandonment and rejection in clients, highlighting risks of retraumatisation of the clients when too great an emphasis was placed on strict boundaries.

Rigidly discouraging therapists' flexibility around fee payment or length of sessions by some authors (Fisher, 2001; Kinsler, Courtois & Frankel, 2009) was not supported in the findings of the current study. In the literature, therapists were also guided to identify underlying attachment meanings such as wanting specialness or destructive relationship behaviour (Kinsler, Courtois & Frankel) and were advised not to give into these yearnings. Yalom (1980) found that to meet the needs of the clients' feelings of being special to their therapists, the therapists needed to give the clients their full presence, in contrast to reducing the fee or lengthening the session. In contrast, the findings of the current research highlighted that clients' attachment needs of being special or loved that emerged through clients' contact outside the therapy hour, fee payment and other areas occasionally, were found to be an additional opportunity for a positive client experience which deepened the alliance. The therapists' flexibility and generosity helped the clients to feel more cared for and significant, which assisted the clients to deepen the trust in the therapists, and to overcome negative self-perceptions.

5.3 The Boundaries between Therapists and Clients

Maintaining therapists' own connection with self while working emotionally close with their clients was deemed important by psychologists. Miriam (P) clarified,

“You need really good boundaries. There can't be an enmeshment..... step in, see the world. Step out. It's a real separateness..... I am naming things constantly, and I have to be out of their system to be doing that. So, yeah, I am in and out, but in a way that they feel respected and understood and safe..... I am not always looking at them. I am kind of letting myself get a picture. Of what their world looks like. You know, but yeah then I step out and I think, what do they need to develop?” (Appendix L, p270)

Jenna (P) also explained the togetherness and separateness between client and self,

“Even though I am giving so much of it to the other person, I um, I can uphold myself as well. And um, so the other person doesn’t have to give anything back..... Somehow because I am upholding myself, there is a clear message of boundaries there” (Appendix L, p254)

The psychologists explained how they managed the boundary between the clients and themselves, adapting it depending on the client, and generally the information matched with what the clients said. Psychologists described a complexity around this matter, however were found to be client focused and able to separate their own and their clients’ experiences, while attuning closely to the individual. Liz (P) said,

“How much is my countertransference, you know how much is about I’ve got all this other stuff going on in my life and I don’t need this other pressure. How much of it is that? What are possible responses? What would be driving each response? In which response do I think would be in my client’s best interests and why, and how am I going to convey that to them, and in a sensitive and compassionate way. To get it right, for that individual person. And I think you have to say to your client, I am not always going to get it right” (Appendix L, p107)

The notion of maintaining separateness yet closeness with the clients goes back to at least to the 1950’s when Schafer (1959) described the therapists entering the emotional space of the clients to assist understanding, and also the maintaining of therapists’ separateness to the clients through the observer self. Furthermore, Kohut and Rogers (1985) described the need to be together with the clients’ experience, yet separate enough not to be enmeshed. Within the psychoanalytic field, countertransference reactions have been recognised for a long time. These referred to the reactions that emerged in the therapists, while in the presence of their clients. It was widely acknowledged not to attempt to inhibit these feelings, rather to be aware of them and to understand them (Kudler, Kruprick, Blank, Herman, & Horowitz 2009).

The findings of the current study aligned with Roger’s (1967; 2007) definition explaining the boundary between therapist and client,

“That the therapist is experiencing an accurate, empathic understanding of the client’s awareness of his own experience. To sense the client’s private world as if it were your own..... To sense the client’s anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it” (p243)

Aligning with the findings of the current study, the above comment captured the attunement to the clients' experiences while also maintaining awareness of the therapists' feelings that emerged with the clients. Psychologists in the current study were able to separate and understand their own and their clients' experiences. They presented as though they had an ease with their clients, in contrast to avoiding or being overwhelmed by them, and hence focused on the clients' need.

Jenna (P) summed,

"I can test them. I can come closer to you and what does that mean for you. So there's different levels that you are testing. How much can you handle of me? To come forward and what's the best and safest way to give them what they need. So it is knowing me and also knowing the client and what they need. Of me to keep them safe as well as to keep them supported" (Appendix L, p256)

Jenna (P) described awareness around the distance between herself and her clients, demonstrating her ability come closer or give space. A client focus was maintained in the psychologists, in attuning and responding to what was optimal for their clients therapeutically with regards to distance between them.

Not surprisingly, the clients in the current study gave more straight forward responses in this area, however they had an awareness and acuity to the distance between themselves and their practitioners. They knew when the therapists were too distant or too close. An example was with Cas (C) who felt too much separateness with a previous therapist. She said,

"It was all observation. She may as well be in a glass room" (Appendix K, p272)

Jake (C) described a similar experience in reference to his therapist at an earlier time,

"It was like he was still in his bubble" (Appendix K, p359)

In contrast, Kristen (C) described that the distance between herself and Jenna (P) allowed her to see Jenna's facial expressions and to know that she wasn't fearful. This created safety for Kristen (C) as she then knew that Jenna could handle her, and wasn't going to leave. Kristen (C) explained,

"Because you can feel that the compassion is there. It can hold the whole process, even if you are a person who likes touch which I do. But even if that person comes closer, you

have this awareness that you might offend them, more so than if you keep their distance.....and so they are sitting there really comfortably. They are not looking like they are wanting to leave either, so I am very sensitive to how people are feeling....she is making eye contact, and I can see in her eyes that she is understanding, that she is not going anywhere....she has compassion but she is not panicked or freaking out. Which a lot of people are, I have noticed” (Appendix K, p281)

The high level of awareness and acuity of many childhood trauma survivors ability to read signs in their therapists was depicted in Kristen’s (C) conversation. Kristen’s (C) ability to read Jenna’s (P) non-verbal cues reassured her of Jenna’s (P) presence and ability to tolerate her content. The clients knew when their therapists were scared, overwhelmed, dishonest or distracted, all of which impacted the alliance negatively. Knowing that their therapists were fully open and present to their clients, and the therapists adjusting their level of closeness accordingly, assisted clients to feel safe and to trust.

As mentioned in the chapter on Empathy, clinicians have expressed concerns about too much separateness between the therapist and client when the therapists were taking an observer stance without emotional depth with the clients, due to the clients’ perceived lack of therapists’ authenticity such that this compromised secure attachment (Courtois & Ford, 2013; Paivio & Pascual-Leone, 2010). In contrast, the risk of losing objectivity when overinvolved with an insufficient observer role (Chu, 2011; Cloitre, 2015; Courtois & Ford) can lead therapists to overlook issues of safety for the clients (Cloitre, 2015), or lead therapists to engage in rescuing behaviours with clients perceived as victims. These were all considered unproductive therapists’ behaviours. Too much distance from their therapists was also found to lead to empathic strain if therapists engaged in their own avoidance or disengagement with clients (Courtois & Ford). Hence, the dance to negotiate between closeness and separateness with clients, as described by the psychologists in the present study was found to be aligned with past research. In addition Elliot, Bohart, Watson, & Greenberg (2011, p48) described the adaptation of empathy by the therapists to be at the “optimal therapeutic distance” to the clients while respecting their boundaries. Geller and Greenberg (2002) suggest,

“With presence the therapist is as close as possible to the client’s experience while maintaining a sense of self as separate and whole” (p84)

Therapists balanced their awareness of selves, the clients and the relationship, attuning sensitively and acutely to all three while maintaining a boundary between therapists and clients (Erskine, 2015). This was revealed in the findings of the current study.

Recently Chu (2011) articulated the therapists' boundaries with separation of their feelings from that of the clients, and the importance of being able to regulate difficult feelings such as anger and anxiety in their therapists. Taking responsibility for their own sometimes intense feelings that emerged in the presence of complex trauma therapy, and being able to regulate their reactions, was seen as a necessity to ensure clarity in separation of clients' and therapists' experiences, and to avoid reacting or responding in a way that may retraumatise clients (Chu). Elliot and colleagues (2005) elaborated, that to be genuine the therapist needed to be able to remain in the presence of her own uncomfortable feelings as well as the clients', maintaining their own self-awareness and processing of internal conflicts, so that they can be separated from the clients' concerns. The therapists needed to be consistent and integrated in themselves in contrast to being split between conflicting parts, to enable an integration between themselves and their clients. Transparency involved being honest and open without pretending or faking. There was a straight forwardness and humbleness in being one's true self (Elliot et al.). These findings aligned with the messages from the psychologists in the current study.

Within the findings of the current study, therapists were found to adapt themselves to their clients depending on the individuals' needs and comfort level in relation to closeness. They did this with awareness and deliberation attuning closely to the clients and to themselves, in the moment, noticing and adjusting to non-verbal and verbal messages. Therapists' management of their own level of involvement with clients, as well as withdrawal has been highlighted in some trauma literature, while also adapting the distance between therapist and clients (e.g., Courtois & Ford, 2013). Client attachment style can be a guide for therapists' comfort and tendencies with closeness or distance from the clients, as preoccupied types tended to yearn for closeness and engagement, whereas avoidant types needed more space for optimal therapeutic comfort. Disorganised types presented with confusion in this area (Cloitre, 2015). Clear and firm boundaries were particularly advised for preoccupied types who may present with high levels of arousal and neediness related to needing attachment and reassurance.

Hence these individuals can be demanding of their therapists' time and energy, and without clear and firm boundaries may result in the therapists becoming exhausted by their clients with resultant reactivity and withdrawal, risking repetition of childhood trauma experiences of attachment figures being unavailable and unable to cope with them (Alexander & Anderson, 1994; Courtois & Ford). Therapists needed to be aware of their own attachment styles that may vary their tendency for increased closeness or distance with their clients even when working from a secure position (Courtois & Ford). A complex dance between therapists and clients was depicted with a high level of therapists' self-awareness, attunement to and understanding of the individual clients' tendencies and needs. Although attachment styles were not discussed in the current study, psychologists were found to be generally self-aware and engaged in careful tracking and responding to their clients' needs.

5.4 Navigating Therapist Self-Disclosure

5.4.1 Therapist personal self-disclosure

Boundaries were also found important in the findings of the current study in the area of how much the psychologists disclosed of themselves, through sharing personal information and present moment experiences, with their clients. This included factual information, as well as allowing aspects of their own personality to become more transparent in sessions. Responses were made by both psychologists and survivors of childhood trauma clients in this area.

Some clients reported feeling closer to their psychologist, with increased demonstrated genuineness as a result of the psychologist's self-disclosure. Bess (C) said the following after her psychologist had shared a mutual, broad childhood experience,

“It helps the healing. Because I see that there is a woman on the other side who is real, who hasn't had the silver spoon, and who has had bad things happen in her life. Not that she has told me everything, because she hasn't, but just shared one or two things”
(Appendix K, p173)

Another example in which Georgie (P) shared a brief detail of childhood trauma, reportedly deepened Tracy's (C) trust in Georgie (P) and reassured her of deep understanding. She said,

“This woman really gets it..... It (the self-disclosure) made me feel really connected and there was this understanding that she really did know what it was like for me. She had that inside understanding of what that is, which I don’t think anyone else really can. And so in a way she was saying we, there’s a kind of togetherness around that. This sort of, I have walked with, both walked this path. And there was also in about wow, here she is a successful therapist..... It’s like if she can do it, I can do that too” (Appendix K, p222)

Tracy (C) described having been instilled hope and confidence in her therapeutic potential through Georgie’s (P) brief self-disclosure. For Tracy (C) and other clients the psychologists’ sharing normalised having problems, and reduced shame. It also assisted to transform a sense of being flawed.

Michael (C) found that when Cody (P) shared occasional, specific common experiences with him, his confidence increased in Cody’s (P) level of perceived understanding, which he *really* knew what he had been through. Michael (C) said,

“He hasn’t said much about his life. There were certain situations where I got in trouble with drugs and got suspended, and he told me about the time when he was 18 where he had to face court himself for stealing some stop signs at the university. And I loved hearing that story, because he understood what it was like having to go to court” (Appendix K, p351)

Psychologists did not self-disclose often. It was occasional and targeted to the specific situation. Michael (C) gave another example,

“He got it. So that was fantastic actually. And so he is not so uptight that he won’t tell me things like that. And he told me when he was about my age, he quit a really lucrative and well paid psychologist’s job to go and work in a shop for 3 months, because he was stressed out. Obviously relating completely to what I was doing in my job, like highly paid, but bullied. And then leaving to start afresh, so it was that empathy and knowing what I was going through” (Appendix K, p352)

Like Michael (C) clients reported that knowing that their psychologist had been through a similar experience as themselves strengthened their perception of *genuine* empathy, extending it beyond basic cognitive understanding. It also seemed to reduce the clients’ shame around different life experiences and choices knowing that their respected therapists had also made similar mistakes or been through equivalent difficult times. This seemed to increase the clients’ sense of safety enabling them to be more able

to share their own intimate concerns, and minimised the power differential between therapists and clients.

Furthermore, Bess(C) said about Georgie (P),

“I love listening to what she is doing. You know, I love to hear about her as well, because I am sitting here opening up here. Just give me a little bit. I’ve given you lots. But I think she might know. Because I know when she tells me something, it won’t go out of the room, because its trust. Well I am trusting her” (Appendix K, p172)

By the psychologists occasionally disclosing brief information, the clients sensed that they were trusted by them, which was perceived favourably, and was expected to have contributed towards the clients learning to trust themselves.

One further example of the benefits of self-disclosure was spoken of by Bess (C). Her psychologist’s self-disclosure elicited a sense of specialness and humanness for Bess (C). She said,

“She shares things with me that she might not share with others..... because she is identifying She is just trying to tell me that she is real” (Appendix K, p165)

Psychologists also shared in more subtle ways such as through common attachment yearnings. Sam (P) said,

“Sometimes I will make examples like with him. I will share with him.....You know a particular idea, about the desire to be responded to, or the desire to be connected to” (Appendix L, p293)

About a third of psychologists mentioned brief sharing of their own parenting stories with clients, when session content involved issues with children. Cody (P) shared details of his own child’s attachment distressed behaviour, to explain and normalise Michael’s (C) experiences. Clients found hearing about their psychologists’ families useful when it was delivered within a relevant context. The briefness was important, so that it did not intrude heavily on the session. The self-disclosure was only made if it was indicated as useful for the clients. For example, Felicity (P) said,

“I’d only talk about my own parenting if it was someone who was coming who had you know just had a baby, and it would be in a very general way, you know like everyone struggles when they’re sleep deprived and you know that kind of stuff. But with Peter, I’d say that he would know very little about me. He knows that I have kids and sometimes I

cancel and I'll give him a real reason. Rather than being mysterious. Or school holidays and things like that. But I don't think he would know much else" (Appendix L, p24)

Clients reported that knowing that their psychologist had their own children, increased their confidence in their psychologist's understanding of parenting challenges, once again deepening perceived empathy. The self-disclosure by psychologists though was brief, targeted and did not take away the focus of the client away for more than a short moment. Another example of this was with Peter (C), who said,

"Part of what has enabled me to feel very comfortable with Felicity (P) is that probably our ages are similar, so we're both parents, and as much as I understand that she doesn't talk a lot about her kids, the fact is, there probably have been some barriers that have been broken down" (Appendix K, p20)

All of the psychologists in the current study were found to partake in careful decision making around self-disclosure that was focused on clients' therapeutic benefit. The therapists weighed up whether to disclose or not. It was delivered with tentativeness and careful decision-making.

Knox, Hess, Petersen, and Hill (1997) differentiated revealing of personal information by the therapists, in contrast to sharing the present moment experiences that may emerge in the session (Knox et al., 1997). Most literature addressed present moment affective and bodily experiences in contrast to personal disclosures by the therapists, with variations of opinion amongst psychotherapeutic approaches, research findings and experts in the field of trauma.

As found in the current study, therapists' personal self-disclosure has been found through research to be an area of psychotherapy that was commonly used, however it has also been found to be rarely spoken about (Maroda, 2002). Ninety per cent of therapists used self-disclosure (Edwards & Murdoch, 1994) and yet most training therapists did not get educated in this area, beyond being warned of its potential dangers (Henretty & Levitt, 2009; Pope, Keith-Spiegel, & Tabachnick, 1986). Self-disclosure has been found to have a minor presence amongst therapeutic interventions (Hill & Knox, 2002) and as a result therapists were thought to make decisions around self-disclosure that were not necessarily grounded in research (Glue & O'Neill, 2010). Personal self-disclosure has been a topic that has been found to be controversial amongst therapists (Hanson, 2005), particularly so with survivors of complex trauma

clients who were thought to carry high risk of retraumatisation (Kinsler, Courtois & Frankel, 2009).

The findings of the present research, have aligned with the humanistic approach supporting humanness, honesty, responsiveness and intimate mutuality between the therapists and clients. In Humanistic Therapy, therapist transparency, openness and congruence were thought to require some level of self-disclosure, and this assisted the clients to trust and deepen perceived empathy (Henretty & Levitt, 2009; Knox et al., 1997; Kottler, 2003). As found in the examples above, this was described by clients in the current study.

Through a qualitative research study by Hanson (2005) good therapist personal self-disclosure has also been found to benefit the alliance in enhancing trust, a sense of understanding, closeness, warmth, power equalizing, validation and normalizing of experiences, and to be useful in small talk at the beginning and end of the session. The study involved interviews with 18 clients engaged in therapy. A total of 157 incidents of disclosure or non-disclosure were examined, finding that both self-disclosure and non-disclosure by therapists affected the therapeutic alliance both positively and negatively. One survivor of sexual abuse in Hanson's study reported increased perception of therapist's empathy following brief self-disclosure, also aligning directly with the findings of the current study. Nonetheless, the area of therapists' self-disclosure has been a controversial one, particularly in relation to survivors of childhood trauma.

Trauma experts were generally found to emphasise humanistic conditions of genuineness, openness, transparency and mutuality in therapy (e.g., Chu, 2011; Kinsler, Courtois & Frankel, 2009; Paivio & Pascual-Leone, 2010). Therapists' self-disclosure related to personal material however, was not elaborated in detail, beyond being cautious in the decision to self-disclose. When working with survivors of childhood trauma, some trauma experts advised against personal disclosure at all, due to the risk of misinterpretation or retraumatisation being too great (Kezelman & Stravopoulos, 2012; Kinsler, Courtois & Frankel). These findings differ from those of the current study.

Furthermore, clients with more severe pathology including personality disorders were frequently found to be contraindicated with therapists' self-disclosure in research studies (Glue & O'Neill, 2010; Kelly & Rodriguez, 2007). For example, Henretty and Levitt (2009) found through summarizing research findings on self-disclosure that

therapy with clients with personality disorders and those who had poor boundaries was likely to contraindicate self-disclosure. Similarly, Glue and O'Neill interviewed six psychologists, three each from Denmark and England. Their study's findings examined therapists' personal self-disclosure, mistakes made by clients and disclosure related to the alliance, with findings that supported therapists' self-disclosure and the potential to impact the therapeutic alliance positively. However, psychologists in the study believed that clients with personality disorders needed stronger boundaries with less self-disclosure (Glue & O'Neill). These latter findings about more severe clients did not align with the current study, which revealed self-disclosure as beneficial, to varying degrees, for a range of survivors of childhood trauma clients. Although the current study did not assess for personality disorders or boundary issues specifically, arguably survivors of childhood trauma could be considered a complex cohort. Perhaps the differences in use of therapists' self-disclosure from the current study could be explained by the lack of studies that involved real, long-term clients, and self-reports by the same client cohort. A lot of the self-disclosure research involved analogue studies (e.g., Goldstein, 1994; Matthews, 1988; Simone, McCarthy, & Skay, 1998) rather than actual clients and did not involve therapists in long-term therapeutic relationships (Henretty & Levitt). Furthermore, the present study involved long-term clients and experienced psychologists and so may have captured more depth of the complexity and scope of therapist self-disclosure in an established alliance, given that the therapists were more skilled at making clinical and wise judgments in this area.

Knox and Hill (2003) made recommendations for using therapists' self-disclosures based on their extensive knowledge and review of research in the area, guiding therapists away from self-disclosing material that was more intimate. This was intended to avoid evoking fear or burdening the clients through the therapists' self-disclosure. The findings of the current study found that occasionally psychologists did reveal intimate self-disclosures related to their childhood trauma including highly vulnerable therapists' experiences, and sharing of more recent, sometimes shameful experiences, with resultant positive effects on the alliance. The clients found the disclosures beneficial and powerful in deepening trust, perceived empathy, and in encountering a corrective experience different to their childhood, in contrast to finding the disclosure frightening or harmful. This may have been as a result of the therapists'

skill at determining appropriate levels, timing and delivery of personal self-disclosures within a strong, long term alliance. The research is generally silent on these issues.

A further example in the present study of therapists' sharing intimate details was the sharing of the therapist's sexuality with their client. Psychologists made decisions based on each client to decide whether to self-disclose or not. Damian (P) revealed his gayness to Stan (C), with the intention of providing an alternative, inclusive experience with him that contrasted his segregation within his family of origin, who held judgmental views about gay sexuality. Damian (P) reported deepening trust in Stan (C), through the self-disclosure. Damian (P) said,

"In his family he is just the crazy one, who is doing this thing to be gay in his religion is really bad, so I think it has helped him to know a little bit about me" (Appendix L, p54)

However, with many other gay clients, Damian (P) chose to withhold this information. It was decided with Simon (C), that it would be unhelpful to reveal his sexuality.

"I had this guy who was struggling, in the course of the sessions together started to question his sexuality and then started having relationships with men. He was 22 or something. I never disclosed anything to him" (Appendix L, p57)

Damian (P), like other psychologists made the decision based on what he thought would be useful for the individual clients at that time. If uncertain, they tended not to self-disclose. Psychologists in the findings of the current study were found to be less fearful of self-disclosure and at times took thought through risks.

For example Tina (C) said in relation to Georgie (P),

"She made it clear that she adjusted those boundaries depending on the client, and then I know if I said to Georgie (P), oh where are you going on holidays she'd answer that quite honestly. There were some personal disclosures from her, and I didn't ask for them, but I suppose that she is more human. It certainly changed my opinion of self-disclosures" (Appendix K, p135)

The above example also highlighted the client's control over self-disclosure through choosing whether she would ask her psychologist questions or not. Within a strong alliance, the clients contributed to their own therapy process through being able

to choose whether to ask the therapists questions or not, while confident that they would receive an open, contained response.

The self-disclosure of content and sharing of therapists' present moment experiences were often found to marry in the present study. For example, Sam (P) who shared his raw vulnerability during a personal crisis, revealed briefly the content of his grief. Interestingly, he found that this had the effect of deepening the session. He suspected that his client would intuit that something was going on for him through non-verbal information, and chose to self-disclose to maintain honesty and transparency in the relationship. He also wanted to reassure the client of his well-being. Sam (P) said,

"I was very vulnerable and I was just opened up, I was just more opened up. Not just emotionally but I was more open to something. Like I couldn't even put it into words. I, I am going to try and write something about this one day. It's something about being more sensitive to my clients, whether they be struggling with suicide, it was easier to read it or dealing with life. Look there are life and death issues in everything" (Appendix L, p283)

Sam (P) also reassured his clients, during this time, that he was managing his issues and that he had his own support, hence protecting them from taking responsibility for his care.

"I wanted them to know that I wasn't sick, and that I was ok. And yes I was going through grief and I was sad, so they didn't have to worry or fantasise about me" (Appendix L, p284)

The self-disclosure by Sam (P) was about protecting his clients from worrying about him, knowing how astutely aware they were of his emotional presence. Psychologists reassured clients that they did not need to take responsibility for their issues. Kate (C) confirmed this, saying about Tom (P),

"Totally, he said I've got outlets, I've people I can talk to if I am feeling badly. I've got a supervisor if I want to talk to somebody. So he explained all his outlets to me" (Appendix K, p39)

When the topic of therapists' self-disclosure emerged in Michael's (C) interview, the interviewer asked whether it had been useful for Sam (P) to disclose this personal information. Confirmation of the positive effects were confirmed through Michael's (C) comments,

“I think it was good to hear that. He hasn’t gone into his personal life ever, but because I am fond of him and he has been amazing figure in my life, I genuinely cared and wanted to know what his situation was” (Appendix K, p351)

Although Michael (C) was intrigued by brief details of Sam’s (P) experiences, there was not a sense that he had responsibility to care for him. Sam (P) made it clear that he was able to take care of himself.

Miriam’s (P) experience of being vulnerable in her present moment experiences also involved a deepening in her sessions with a heightened self-awareness,

“No, not vigilant. It’s like a higher learning. I am very, because if I am vulnerable there is something that has happened in my life that has changed my configuration in some way. It has undone me a little bit in some way, so I become more acutely aware of what I am doing with clients. So it’s like oh my goodness, is that why I do that? I am working intuitively most of the time. And if you asked me after a session, oh what was that about, it will be based on something so familiar, like trusted or....that I don’t have to think about it. But if I am asked it will come up. But if I am vulnerable I feel like it’s more attentive, things are almost crystal clear. I become very aware of why I am doing what I am doing. I tend to drop a level in terms of seeing things with them. Um, so it’s like it ups my learning capacity. It’s like an expansive process” (Appendix L, p316)

These findings suggested that therapists’ vulnerability had the potential to enhance the therapeutic process that was not found elsewhere in the literature.

Some psychologists in the present study were found to be more withholding around sharing personal details than others, however all were found to share some level of personal material. Some shared information more subtly or disclosed through alternative means such as about previous clients. In all situations, the briefness was important and the client focus was maintained, with decisions based on individual clients and the interaction between therapists’ and clients’ experiences.

Supporting the findings of the current study, maintaining brief rather than extensive self-disclosure and not burdening the clients with therapists’ content has been supported by previous research (Hanson, 2005; Maroda, 2002). Also, occasional rather than frequent self-disclosure by the therapists has been recommended (Geller, 2003; Knox & Hill, 2003; Maroda). Self-disclosure being individualized, and responding to the individual clients’ need was found in the current study and aligned with the

literature (Henretty & Levitt, 2009; Maroda; Yalom, 1980). Taking into consideration the level of disclosure with deliberation was also similar to previous research (Henretty & Levitt; Knox & Hill). A delayed decision by therapists to self-disclose was conveyed as helpful by Geller, who advised to wait until the intuition to disclose surfaced several times before implementing in a session. However, he also highlighted the need to “balance restraint and spontaneity” in the process of self-disclosure of therapists’ affect and experiences (Geller, 2003, p548) given that opportunities to self-disclose often arise unexpectedly in sessions. This delayed response did not emerge in the findings of the present study, perhaps as a result of the experienced psychologists being able to make decisions readily with their clients who were long-term and whom there were established alliances.

Some benefits of therapists’ personal self-disclosure have been found. Through self-disclosure therapists’ imperfection were found to be revealed which could equalize power in the alliance, as well as a sense of mutuality, in contrast to the therapists being dominant and the clients having problems (Maroda, 2002), as found in the above examples. The clients knowing that they were impacted by their therapists may also instill a sense of self-efficacy and empowerment to the clients. In addition, self-disclosure had the potential to increase clients’ insight and acceptance of reality (Maroda). It was also thought possible to reduce shame in clients through helping to normalise their experiences (Varra & Follette, 2004).

5.4.2 Disclosing of therapists’ selves

In the findings of the current study, the survivors of childhood trauma clients had a knowing, sensing, and vigilance with observing psychologists’ body language and experiences. Psychologists’ transparency and honesty were found to be reassuring for them, clarifying what it was that they were actually sensing in the alliance between them. For example, Kate (C) said,

“He was really honest with me the whole way through which was really important to me, because I thought if he can’t just tell me how he is feeling at the time or whatever, then I am going to worry and make up something myself” (Appendix K, p39)

Sam (P) highlighted that we brought ourselves into the sessions with survivors of childhood trauma regardless of how much became overt self-disclosure.

“I think all of us are somewhere along the line, I probably, even though I have been trained a lot in disclosure I probably wouldn’t disclose as much as some people would. The counter argument is that we are disclosing all the time” (Appendix L, p284)

Miriam (P) also aligned,

“Well I have all this richness of my humanity and yes, my focus is squarely on the client but if I think my experience is not affecting them, maybe it will remain unconscious, but who I am is really in the room” (Appendix L, p315)

Antoinette (C) said, in relation to Liz (P),

“I think too, she has shown me different sides of herself. Like she has cried with me and she has laughed with me. She has sympathised with me” (Appendix K, p118)

The findings of the current study showed variation in the amount and the delivery of overt verbal self-disclosure of therapists’ selves, however the psychologists generally brought the essence of themselves into the room with a level of transparency, honesty and realness. These findings aligned with Rogerian and Existential Therapies. Moreover, Maroda (2002) argued that our clients have a desire to “know us, penetrate us, and transform us to the same degree that they wish to be known” (Maroda, 2002, p49).

Existential Therapies were also supported through the findings of the current study through the importance of humanness and transparency in the therapists with openness, honesty and mutuality (Greenberg, Rice, & Elliott, 1993; Yalom, 1980). Existential therapy has been described as having a strong emphasis on self-disclosure through therapists’ sharing of their present moment experiences with their clients (Yalom) in contrast to self-disclosure through personal information. The showing of therapists’ “humanity, weakness and vulnerability rather than strength, surety, and authority” (Maroda, 2002, p92) and the delivery of self-disclosure done empathically and sensitively (Geller, 2003; Quillman, 2012; Watson & Greenberg, 2000; Yalom) has been suggested. Yalom gave an example of sharing of present moment experiences with a client when he noticed himself distancing and bored in a session in the presence of a client who he sensed a dislike towards. He said gently to the client,

“I have felt distant from you for the last several minutes” (p415)

Yalom (1980) discussed with the client whether she had also felt this detachment, and how she was finding him as a therapist. He also introspected and tried to understand his own avoidance (Yalom). Attachment messages of being accepted, understood and valued were also considered important when self-disclosing (Hanson, 2005). As described in Chapter 3 Empathy and Chapter 4 Acceptance, these findings aligned with the results of the current study.

Therapists' self-disclosure through sharing of present moment experiences was practised by numerous psychologists in the present study and supported by other researchers. It was delivered tentatively and gently, without blaming or shaming (Quillman, 2012).

Tom (P) said,

“And I have fed back to him very clearly how he was at any point in time. I was very open about that. He didn't have to guess that. He appreciated that I think. I would say I feel closer to you after sharing that or I feel pushed away or trying to divert from something. So I constantly was letting him know” (Appendix L, p296)

Troy (C) appreciated that his psychologist was honest and shared words describing her own feelings of fear in the presence of Troy's (C) anger, in the present moment. He said that it assisted him to develop insight and to take responsibility for the effect that his anger had on others, especially Monica (P). Troy (C) said,

“She said I was waiting for you to jump up, get all angry with me, maybe get physical with me, and get violent whatever. She said you absolutely frightened the crap out of me. I said, are you serious. And she has gone I am. And that was the my first insight into how I left feeling other people” (Appendix L, p313)

Although Troy (C) had anger issues at the time, Georgie (P) was able to risk delivering a self-disclosure about his anger, with a secure alliance and at a time that elicited a positive change in Troy (C).

Quillman (2012) applied neuroscience concepts to therapists' self-disclosure. She considered self-disclosure of therapists' bodily and present moment experiences as a technique to connect more deeply with the clients' right brain through the therapists' right brain. The therapists made explicit information that was implicit to the clients through their own resonations of the clients' experiences (Gendlin, 1978; 2007; Paivio

& Pascual-Leone, 2010; Quillman). This was thought to assist with a reduction of anxiety through the sharing of negative emotional experiences, which assisted the clients to remain present to their bodily and emotional experiences and thus deepened relationships and increased a sense of safety. It also assisted transformation of the inner world of the clients through facilitating the clients' noticing, accessing and understanding their experiences with a caring other. Hence, the clients had the therapeutic opportunity to build a tolerance to painful emotions within the window of tolerance. This was also thought to overcome a sense of isolation through connection with painful, hidden parts of selves (Paivio & Pascual-Leone; Quillman).

According to recent neuroscience findings, accessing the right hemisphere of the clients' brain through emotions and emotional regulation in contrast to a cognitive left hemisphere logic and reasoning, is now considered to be the pathway to psychotherapeutic change. The overall goal was integration of the two hemispheres. The importance of enhancing functioning of the right hemisphere to assist functioning of the left hemisphere is recommended, reinforcing beneficial effects of sharing bodily experiences in session (Schore, 2012; Siegel, 2012)

The notion of transparency and overt therapists' vulnerability being beneficial contrasted the traditional psychoanalytic approach that reinforced neutrality in therapists, and Freud's notion of losing objectivity if the therapists opened up to their clients (Hanson, 2005; Paivio & Pascual-Leone, 2010; Yalom, 1980). Nevertheless, clients have been found to differ in their preference for self-disclosure, with some clients appreciating the separateness, while others liking to merge (Henretty & Levitt, 2009). As a result, some authors suggested asking the clients whether they like therapists' self-disclosure or the more traditional neutrality (Collins & Miller, 1994; Henretty & Levitt). As far as the interviewer was aware this conversation did not occur overtly within the findings of the current study, however as described in the former Chapter on Empathy, psychologists maintained a strong understanding of and attunement to each client and adapted therapy accordingly, to meet their clients' needs.

Therapists' self-disclosure has been found to be useful across several studies. In a review of research studies by Henretty & Levitt (2009), they found benefits such as; assisting the alliance; being a role model; increasing client autonomy; validating reality; normalization of feelings; repair work in the alliance; helping clients to name emotions; increase their self-esteem; and to deepen the relationships (Henretty & Levitt, 2009, p

72). More literature was found to be focused on self-disclosure of therapists' affect and present moment experiences rather than personal information (Maroda, 2002; Yalom, 1980).

The sharing of the therapists' experiences in response to clients' self-disclosure has been found to reassure trauma clients of therapists' intentions, perceptions and responses to clarify clients' negative perceptions. For example the therapists could affirm a client's courage through their self-disclosure, negating clients' perceptions that the therapists might be disgusted with them as a result of disclosing a narrative related to difficult trauma material (Quillman, 2012). Examples have been given in all of these areas in the current study. In addition, the findings of the current study included benefits of instilling a sense of hope and confidence in the clients' potential through therapists' self-disclosure, as well as a sense of shared openness, to combat a sense of exposure and aloneness in these clients. Details were infrequently given however, on how and when to deliver the therapists' personal self-disclosure in previous literature.

5.4.3 Detrimental effects of therapists' self-disclosure

Some clients reported negative experiences related to previous therapists' personal self-disclosure. For example, clients did not like therapists talking too much about themselves in sessions, because it left the clients feeling burdened, not included and it wasted their session time. Robyn (C) had an experience with a previous therapist that involved too much therapist self-disclosure. She said,

“Well quite often I could have sessions where she would spend half the session talking about herself. And it was like I really like you, and as a friend. If we want to do this, let's do it over coffee, not here. And if I drew attention to it I think subtly, I wasn't wholly comfortable” (Appendix K, p376)

Unfortunately Robyn (C) believed it may have been her fault that this happened, and questioned herself. She went on to say that extensive details of the therapist's history were shared with her in that encounter. She said,

“But nonetheless it wasn't at all helpful when she started bringing too much of herself into the session.....So it was a little bit prickly and I thought I was doing well. But maybe I was on a really high manic..... All of that and that's a lot too, a lot of a burden to tell someone” (Appendix K, p376)

This highlighted the vulnerability of clients to too much therapist personal self-disclosure and the risk of the clients taking on too much responsibility, becoming confused, and being burdened, as well as the therapeutic process being interrupted considerably.

Another example was with Henrietta (C), who spoke about her previous therapist,

“Yeah and the other counsellors I had, I had a psychologist who um, just used to tell me lots of her own stories and filled the space with that (Appendix K, p159).....I feel that the other counsellors have done too much self-disclosure, or talked too much and they haven’t allowed me to feel my emotions. To express my emotions, yeah. So they have interrupted the flow, whereas I think with Andrew the flow is perfect, because he reads me well and he is just with me” (Appendix K, p156)

For Henrietta (C) too much therapist personal self-disclosure interrupted her emotional experiencing in sessions and took the focus away from herself. She goes on to talk about her different experience with her current psychologist,

“It’s funny because I don’t know much about him. Other counsellors have shared much more. I am curious, I would like to know a bit more about you” (Appendix K, p162)

However when questioned by the interviewer, who asked if she did enquire, would Andrew (P) share with her? Henrietta (C) replied,

“Yeah I think I did ask if he had any kids because I was trying to work out, is he a parent? It was as I was walking out. But he has said a few things, when he is going on holidays. I know he has a partner. In some ways I don’t really want to know much about him too. I quite like that I don’t have to think about him, about his life. Because the other counsellors have shared too much. And yeah, I want it to be about me. I want to be selfish. In other relationships I am always doing the asking, the listening. I want this to be about me” (Appendix K, p162)

Extensive therapists’ personal self-disclosure was found to be unhelpful whereas brief, targeted, occasional therapists’ self-disclosure was found to assist the alliance. Felicity (P) cautioned against too much self-disclosure becoming a burden to the clients,

“I think it kind of burdens the other person and um, they don’t need to be, it kind of takes them off in a direction that I think is really unhelpful. And they need to feel that you have got your own stuff kind of managed” (Appendix L, p56)

One psychologist shared a negative experience of her personal self-disclosure with a client in relation to the impact on herself. Maryanne (P) shared an experience that was still raw for her with her client, in an attempt to convince the client of her understanding. She said in response to a previous hostile client that she was,

“Angry with me, that I wouldn’t be able to understand it, and in response to that angry with me that I got pulled into this “you don’t understand” attack kind of thing....and I told her that I did have an understanding of having lost a baby, but I regretted it afterwards, and I said to myself, I will never do that again,..... because she then turned around the next session and she said to me, you haven’t dealt with your own stuff, and that might have been true, but that part I could have worked with, but she was kind of an angry, hostile kind of woman” (Appendix L, p59)

It seemed that the combination of a hostile client and vulnerable therapist created a situation in which the therapist risked being injured by the client, highlighting that it may be that self-disclosure was safer when the issue was more resolved for the therapist. In this example, it may have been problematic using the self-disclosure as evidence for empathy, in contrast to the self-disclosure used to deepen empathy, reduce shame or minimise power differential. Some researchers advised against therapists’ self-disclosure that was related to an issue that was unresolved within themselves, to maintain the client focused therapist self-disclosure and therapist clarity and boundaries within the dialogue (e.g., Knox & Hill, 2003).

Differing findings amongst empirical studies have been found about self-disclosure generally, including whether it was useful or not (Kelly & Rodriguez, 2007). However, of the studies reviewed by Henretty and Levitt (2009) self-disclosure was found to be supported when the alliance was strong (e.g., Bishop & Lane, 2001; Myers & Hayes, 2006; Rachman, 1998). What also became apparent in the current findings was that therapists’ vulnerability had the potential to risk harm of the therapists when client hostility was present. It was not clear in the examples in the findings of the current research whether the alliance was strong before the therapists self-disclosed too much or not. It may be that a good alliance enabled the therapists more room for error, or as Kottler (2010) suggested it may be that how clients perceive the self-disclosure depends on how strong the alliance is.

Some literature and research described problems that occurred as a result of therapists’ self-disclosure generally. Trauma researchers cautioned against therapists’

self-disclosure with survivors of childhood abuse due to the potential detrimental effects (Courtois & Ford, 2013; Fisher, 2001; Kezelman & Stravropoulos, 2012; Kinsler, Courtois & Frankel, 2009). Too much self-disclosure has been found to have a negative effect on the therapeutic alliance (Giannandrea & Murphy, 1973). As described by Henrietta (C) in the above case example, the therapeutic alliance has been found to be negatively affected when clients' needs were interrupted due to self-disclosure in sessions (Coady & Marziali, 1994; Hanson, 2005). Poorly administered self-disclosure has been found to have a deleterious effect on the alliance in reducing trust and safety for the clients (Hanson) aligning with the findings of the present study.

There has been some evidence to show that non-disclosure also affected the therapeutic alliance negatively (Hanson, 2005). For example, when therapists withheld information from clients they were found to feel invalidated, which inhibited self-disclosure. Another one of Hanson's clients described being triggered into feelings of being unloved when the therapist refused to self-disclose. A similar effect emerged in the findings of the current study when Tina (C) asked where the therapist was going on holidays, and was given an abrupt response with an absence of any content. These findings supported the Humanistic approach, whereas the notion that neutrality, found in the traditional psychoanalytic stance, was put into question. Non-disclosure was found to be particularly unhelpful when there was a lack of empathy and too much rigidity (Hanson) which aligned with the present study. Overall therapists made careful decisions related to self-disclosure to protect themselves, their clients and the alliance.

5.4.4 How to do personal self-disclosure

Therapists' personal disclosures emerged in the findings of the current study as complex with different variations of self-disclosure applied by the therapists.

For example, Miriam (P) sometimes shared details of her animals as a means of connecting and beginning the session with Robyn (C), a dog lover. Miriam (P) said,

“They know bits and pieces about me, but they don't know about me because the focus is squarely on them” (Appendix L, p315)

Talking about personal issues as a way to warm up at the beginning of the session helped the clients to feel comfortable and ready for their session. Brief connecting through animals or interests assisted Robyn (C). She said,

“She talks about the girls and I talk about my boy. So yes, they are the other identity things in terms of personality. I’m not a great truster of people who don’t like animals.... And it was like this instant. Once we started talking about dogs it was hysterical. And it’s that commonality. Joining the threads. Making relationships is so much easier” (Appendix K, p375)

Small amounts of self-disclosure were thought to be beneficial when psychologists were going on leave or cancelling appointments to help clients to understand why they were unavailable, commented on by both clients and psychologists in the findings of the current study.

The client focus was usually maintained with the psychologists. When clients asked a specific question, they appreciated a response from their therapist. For example, Daisy (C) said that when asked,

“She’d (Felicity (P) give me an answer yeah. So that was good” (Appendix K, p68)

The answers were then delivered by the therapists in a thought-through way. Felicity (P) explained,

“So it depends on the context. If someone asked me and it wasn’t just about clarifying, am I in a safe place, this is who I thought, I would probably ask them what it meant to them either way, you know to try to understand and I would only answer it if I felt it was going to be helpful” (Appendix L, p57)

For example, in one instance in which the shared experience of growing up with family members in the police force occurred, the alliance was consciously protected through withholding details of Felicity’s (P) personal life, with the intention of maintaining clear boundaries. The risk of merging was assessed as too great by Felicity (P), due to the similarities in their childhood experiences.

“This is my own stuff, but I could really relate to him because my father was a policeman too.... With that it is really loaded and his whole life is caught up in that. And I don’t feel like I am separate enough in my own experience to do it in a small way” (Appendix L, p239)

Some psychologists, including Felicity (P), believed that the deepened level of empathy and understanding through a shared experience, would seep through during interactions without disclosing it openly. They did not find therapist self-disclosure

always beneficial. It was a choice that they made. Sometimes therapists' self-disclosures were delivered in subtle ways, with intention. For example Jenna (P) shared the following comment,

"It doesn't have to be a disclosure, it can just be a couple of little words, or you let them know you understand, by saying something like "we all do" or you know. A little comment to know that I am human too. That I get it. That as the professional I have ongoing struggles in life as well" (Appendix L, p252)

Jenna's (P) self-disclosure was intended to deepen the sense of humanness and mutuality, with the effect of minimisation of power imbalance. It kept the focus on her clients. Making sure the focus returned back onto the clients soon after the self-disclosure was supported in the literature (Henretty & Levitt, 2009; Knox & Hill, 2003).

Another example of brief and subtle delivery of therapist's self-disclosure was commented on by Tracy (C). Her psychologist disclosed a shared childhood experience. Tracy (C) said,

"Well there was something about feeling vulnerable about what's happened to me. She didn't give me any details. Um, she was saying we, you know, for people like us that have had this happen. And suddenly I realised that she had been through something similar. So, that's what it was. It wasn't that she told me anything that had happened or anything like that" (Appendix K, p221)

The psychologist conveyed her message sensitively, maintaining the client focus in the session, and deepening the sense of humanness and togetherness with Tracy (C). No further details were shared by the psychologist.

Alistair (C) appreciated Tom's (P) sharing of brief disclosure of other clients' experiences that assisted him to normalize the effects of childhood trauma. Alistair (C) said,

"He might draw a parallel to another person's similar experience" (Appendix K, p77)

The importance of minimal details shared of the other clients was important to Alastair (C), as it reassured him of Tom's (P) confidentiality. He felt reassured that if he ever shared his details with other clients, that it too would be brief. Geller (2003) also suggested using an example of a well-known public figure or movie to deliver the message, as an alternative to using examples from the therapists themselves.

Psychologists in the present study tended to report conscious decision making based on clients' need and potential therapeutic benefits when self-disclosing. Felicity (P) made decisions around self-disclosure through not disclosing if she was uncertain about whether to disclose or not. Generally the emphasis was on minimal self-disclosure to maintain the focus of the session on the clients. When disclosures were made they were delivered subtly and gently, giving just enough information to the clients to convey the message.

Aligning with the current study and the Humanistic and Existential Therapies, Elliot and colleagues (2005) supported the importance of therapist openness, humanness and transparency, however they highlighted the importance of the consciousness and self-awareness related to the decision for therapists to self-disclose personal information. The therapists required a level of self-acceptance, an absence of impulsivity or reactivity, and therefore, also agreed upon by other researchers, needed to be thought through carefully with a client focus (Elliot et al.; Geller, 2003; Glue & O'Neill, 2010; Hanson, 2005; Yalom, 1980). Therapist self-disclosure needed to be done for the clients' benefit not for the therapists' release of tension (Quillman, 2012).

In the literature, some unhelpful markers have been found related to therapists' self-disclosure. These included, for reasons such as controlling or manipulating the client; attacking the client; highlighting differences between clients and therapists; something unrelated to the clients' needs; or expressing anger when not focused on clients' therapeutic benefit (Henretty & Levitt, 2009). Also expressing intense emotional experiences that may not be fully in control by the therapists, and giving in to demanding or coercive requests for the sake of the clients were thought to be unhelpful (Maroda, 2002; Quillman, 2012). These issues did not emerge in the findings of the present study. The psychologists were unlikely to be engaging in the above behaviours, given their expertise and experience, confirmed by the fact that it did not emerge through the clients' comments. Negative experiences of therapists' self-disclosure by clients were related to previous therapists, and were described in general terms of clients' experiences, rather than analyzing therapists' behaviour.

Delaying therapists' self-disclosure until the alliance was established has been suggested by some researchers (Geller, 2003; Hanson, 2005). If the newness of the self-disclosure was too unexpected this can instill fear in the clients, which was one reason to delay (Geller). The therapists needed to censor what they tell clients, and respond to

what the clients could handle. Particularly early in therapy it is wise to self-disclose only positive messages which conveyed “acceptance, empathy and encouragement” and to wait until the relationship was stronger before disclosing more negative feedback (Geller, 2003, p547). The importance of timing and pace of therapy was emphasized as important (Geller; Hanson; Yalom, 1980). In the present study one example of therapists’ self-disclosure emerged in the findings of early alliance that assisted the client’s trust to be established early supporting an individualized approach to therapists’ self-disclosure. Louise (P) shared her sense of intimidation with Jessica (C) who had been to a number of psychologists prior to her, with one of them publically well known. Within the first four sessions, Louise (C) self-disclosed her sense of intimidation to Jessica (C). Louise (P) said,

“So she (Jessica (C) was very intimidating and really testing me. And I said wow. I feel really a bit intimidated by all these therapists you have already seen. And something in that moment, I saw her trust me” (Appendix L, p202)

Louise’s (C) genuineness through her transparency of her feelings facilitated a shift in trust with Jessica (C), early in the alliance. These findings reinforced that a rigid, checklist approach was not suitable for the decision-making around therapists’ self-disclosure.

Complexity around the issue of therapists’ self-disclosure emerged in the current study. Aligning with previous research, therapists’ self-disclosure was found in the findings of the present study to require skill by the therapists to determine when and whether to self-disclose (Hanson, 2005), negotiating the timing, and the sensitive, thought through delivery of self-disclosure. Decision making was required by the therapists in the moment during the sessions with patience and humbleness (Geller, 2003; Knox & Hill, 2003; Yalom, 1980). There was not always time to reflect and think it through (Geller; Quillman, 2012; Schore, 2007) because it needed to be adapted to each situation, and cannot be simplified into a manualized workbook. Some authors believed that teaching required the development of clinical decision making skills and intuitive thinking rather than a simple checklist (Geller; Henretty & Levitt, 2009). The findings the present study aligned with this notion. As Felicity (P) said,

“I don’t really have a hard and fast rule about it.....but sometimes you don’t know actually, it’s an instinct I suppose and then if I do tell them, it sounds like I am disclosing all the time” (Appendix L, p58)

Hence, therapists’ self-disclosure may be an intervention for experienced therapists rather than novice therapists, due to the high level of wise decision making that is required in the moment. A judgment requiring self-awareness and trust in self as therapist was necessary (Maroda, 2002). It may also depend on the individual therapists’ ability to attune to the clients in the moment, and to respond to their own bodily experiences, as well as having a theoretical framework to guide their decision making.

Given the risks involved with therapists’ self-disclosure, monitoring of the clients’ responses through non-verbal behaviour, and checking in with their clients following the self-disclosure may be useful (Knox & Hill, 2003; Maroda, 2002). From here, either resolving an alliance problem if there was one (Geller, 2003; Henretty & Levitt, 2009; Hill & Knox, 2001) or using this information to guide more or less disclosure in the future was recommended (Maroda).

5.5 Summary of Findings Related to Boundaries

Psychologists’ and clients’ information related to boundaries generally matched each other, although psychologists described increased depth especially in relation to the boundary between themselves and their clients. Therapists defined clear separation of self and their clients, adjusting the physical and emotional closeness and distance to their clients. This supported previous theory and more recent research that elaborated with more detail in this area.

Overall, having a structured format within a professional environment with firm, transparent and sometimes flexible boundaries was found to be optimal for clients. From previous therapy experiences, clients described rigid boundaries that resulted in a suddenness that shocked clients and triggered doubts about the therapists’ genuine care and concern. This had a deleterious effect on the alliance. On the odd occasion above and beyond behaviours initiated by the psychologists in response to clients’ need were implemented. These outside usual parameters acts of kindness were found to deepen the alliance reinforcing the genuineness of therapists’ emotional empathy perceived by the clients.

Attuning to clients' needs and responding flexibly to them whilst also protecting the therapists and clients were found to be supported by some researchers (Elliot et al., 2005; Erskine, 2015; Holmes, 2014; Paivio & Pascual-Leone, 2010; Schechter & Goldblatt, 2011), whereas others took a firmer, stricter approach with boundaries (Fisher, 2001; Kezelman & Stravropoulos, 2012; Kinsler, Courtois and Frankel, 2009). The findings of the present study differed to these stricter recommendations in emphases and delivery. The therapists in the current study tended to take a firm, however less strict and more flexible and empathic approach around boundaries, with ample patience. Similarly, the boundaries were explained overtly to clients, however there was an understanding that some clients needed more direct instruction with boundaries than others. Regardless, the boundaries were delivered with warmth, an absence of judgment and with a sense of trusting the clients.

In relation to therapists' personal self-disclosure, therapists withholding or sharing too much of themselves to their clients was perceived negatively by many clients and therapists in the findings of the current study. Psychologists' self-disclosure was brief, client focused and transparent. The decision to self-disclose was thought through carefully and was adapted in response to clients' needs and potential therapeutic benefits. Clients and therapists found small amounts of self-disclosure had the potential to deepen clients' perception of therapists' genuineness, reduce clients' shame, and to assist in correction of negative self-perceptions. Psychologists in the present study were found to be less fearful of personal self-disclosure than some trauma specialists, using brief sharing of personal material on occasions with specific clients. This was perceived positively by clients. The differing findings may be as a result of experienced therapists in the present study, who had strong knowledge, wisdom, experience and skills required to implement effective self-disclosure and the ability to manage alliance repair work competently if necessary.

CHAPTER 6 POWER AND CONTROL

This chapter incorporates therapeutic goals and directions when working with adult survivors of childhood trauma, however the predominant theme that has emerged in this area is related to power and control. Findings from both clients and psychologists were summarised and examples are given below, across the areas of: pace of therapy; minimising the power differential; managing the dance of leading and following; goal development and expectations; and dealing with a crisis. Discussion was held comparing and contrasting the findings of the current study with previous literature and research.

6.0 Slow pace

Many clients emphasised how important it was for them in sessions not to feel rushed or pressured to achieve certain goals within timeframes. A slow pace assisted clients to feel safe. Some examples of clients' comments follow; Belinda (C) said,

"She let me ride it out" (Appendix K,p10)

Edward (C) said,

"It's the truth, wrapped up in a blanket. Or wrapping paper. And slowly undo it"
(Appendix K, p305)

Mia (C) said,

"And when she comes in the door she always says (slowly) breathe" (Appendix K, p218)

Henrietta (C) said,

"And I was how are we going to manage this? (Teary) And um, he just brought me back into slowing my breathing down into the moment, and calming me. And that was really powerful, and affirming, that I don't have to rush. That I don't have to go ahead into it, like I do in my life. I am always going ahead and achieving things. I don't have to do that. I can just take it really slowly" (Appendix K, p161)

Taking time in sessions enabled clients to learn how to slow down, regulate and become more present. It counteracted tendencies to over achieve and assisted them to self-soothe. Henrietta (C) added,

“He just recognised that I was getting in a panic and projecting into the future too much. And he got me to physically slow my breathing down and um relax my body. Just him saying that helped me to calm down” (Appendix K, p162)

Therapeutic progress was unrushed. Belinda (C) said in relation to her weight loss,

“So I could comprehend and understand what she was trying to tell me. That’s how I got there and it wasn’t until then I realised I had to go gently, and that it was going to be slow. That helped” (Appendix K, p2)

Daisy (C) noted how developing trust took time. She said,

“I guess the trust was probably a very slow process. It probably happened over six months or so, and in a way it’s still developing now” (Appendix K, p54)

Psychologists described that a slow pace was required in each session for the duration of therapy. They recognised that changes were incremental and drawn out, and displayed a patience and an ability to regulate themselves, if changes were slow. The ebbs and flows of therapy sometimes went through periods of time when change was not evident at all. Therapists were client focused, allowing the clients to unfold at their own pace, and as they were capable of doing. Jenna (P) described it as,

“A real adherence to acceptance, being open to talk about any issue for an endless number of sessions” (Appendix L, p10)

Allowing an endless length of time for therapy gave clients freedom from pressure. Psychologists described allowing the clients to wander sometimes, before redirecting. They realised that trauma work could continue over years and they had a flexibility and tolerance for setbacks, contrasting pressure that was often conveyed through the implementation of evidence based practice with limited time frames (Moloney & Andrew, 2016; Norcross & Lambert, 2011). They also allowed for repetition of stories and experiences. Miriam (P) reframed this notion using a neuroscience perspective,

“You know they weren’t setbacks. It was just having another look at this thing from a different perspective, you know as these neural networks conglomerate around one event, but have associations with other events. They might revisit the same neural cluster thing for many sessions” (Appendix L, p123)

When asked how she treated complex trauma differently, Rowena (P) reiterated that slow pace was important,

“Shoot small. Shoot safe. Try and be reliable. Try and be predictable. Try and put some words on it for them. ..On what they are relating to, but not necessarily feel like you have to EMDR it, and frisk them away.....and go slowly” (Appendix L, p181)

Rowena (P) also commented that experientially slowing down in the therapy process was counteracting Mia’s (C) anxious vigilance and increasing her insight into her usual fast pace. This had the effect of assisting her to slow down. Rowena (P) said,

“That thing about being a meerkat and being vigilant. I think she has understood that and I think that (slowing down) has given her an understanding of just what her relationship to life is” (Appendix L, p181)

Psychologists used a slow pace and gentleness to deepen clients’ safety through exploring defence mechanisms and shameful feelings preceding disclosure. It also facilitated a sense of control in the clients. Adriana (P) said,

“And so rather than pushing him to talking about it, I would say, “Let’s talk first about what might be making it hard to talk about”. We actually spent time during the session talking about the feelings that he had talking about what it was he was going to talk about, before he would actually tell me, understand you know feelings of shame and anxiety, you know thinking that I would judge him, think he was a bad person” (Appendix L,p19)

Felicity (P) described slowing down within her sessions and being present in the moment, without expectation of interventions, which assisted her clients to open up. She said,

“I’ll notice there’s some sadness and I’ll feel it in her. And I’ll also see it in her when she is starting to talk in her eyes. As the story unfolds and the things she is talking to me about and then I’ll notice it and give space to it. And then yeah, slow it down. And she is used to that work, so it’s like I am not thinking about what I need to say next, or what intervention I should use next or where I should direct it, it’s about bringing awareness to that experience and by doing that, it opens it up for her. It’s a bit like a pressure valve gets released. So instead of being all locked up in there and tightly bound, it’s like, oh (sigh)” (Appendix L, p157)

Andrew (P) explained the powerful effect of slowing the process using the breath within narrative to assist his clients to remain experientially present. He said,

“Other times it’s just more, even though more subtle resonances, you know, when she breathes, you breathe, you know. You take a deep breath and they know that you are there. And you might say, just take it, just slow it down, in a sense of it’s not about stepping back from the emotion and then kind of starting to say a problem. That’s a crass way of putting it, but instead of that, let’s just stay here. This is really important. Just slow down your breathing so you can be with this a bit more. And therefore reinforcing the quality of the connection to the intra psychic process” (Appendix L, p139)

Felicity (P) described slowing down the therapy to process the emotions. She said,

“I would slow the process down. You know tell the part of the story and then ask how they feel about telling that part of the story” (Appendix L, p27)

Andrew (P) elaborated by describing the effect of the slow attunement and presence with Henrietta (C) which assisted her to remain present with herself,

“And I noticed she switched. She can be there for herself now. Like there’s a calmness that wasn’t there before. She didn’t know how to slow that down and how to be with herself. It just got that thing of bigger and she got more and more distressed. It almost like an internal misattunement. It got played out in like a childlike, like being with that adult who doesn’t respond and you get more and more until you get to the next level, and you get more and more dysregulated” (Appendix L,p146)

The slow pace facilitated by the therapists elicited a sense of being deeply and attentively heard, actively attuned to, experiencing of therapeutic presence and assisted the clients to emotionally regulate and to self-soothe. It aligned with Rogerian conditions involving careful attention to the present moment experiences of the clients which was delivered in a tentative, unrushed manner by the therapists. In contrast to being focused on symptom reduction, Rogers (1980) endeavoured to explore the clients’ world to increase understanding and insight, which was not pressured by time limits.

Furthermore, therapeutic presence as described in Chapter 2 Acceptance, involved a slow holding of the clients while offering validation, understanding and reassurance (Elliot et al., 2005; Erskine, 2015; Geller & Greenberg, 2002, 2012; Schechter & Goldblatt, 2011). Remaining present with the clients without rushing the

clients to move on, was found important, particularly during silence and uncomfortable feelings (Geller & Greenberg, 2012). Slowing down the pace of therapy to enable deep processing and letting go of trauma memories aligned (Elliot et al., 2005; Paivio & Pascual-Leone, 2010), as well as an attentive attunement and deliberate tracking of the clients, moment by moment as emphasised in Process Experiential Emotion Focused Therapy (Elliot et al.; Greenberg, Rice & Elliot, 1993; Paivio & Pascual-Leone) and Attachment Theory (Bowlby, 1988; Holmes, 2014; Johnson, 2004). The findings of the current study also aligned with Buddhist philosophy and mindfulness, being present in the moment with an absence of time pressure or attachment to achievement or progress (Kabat-Zinn, 2003). The approach found in the current study did not support time-limited, efficiency models developed for evidence of therapeutic progress and to justify services (Foa & Mc Lean, 2011). Therapists in the present study were found to be focused and informed by therapeutic theory and research, however worked with the clients in their own time, without unrealistic expectations of achievement or pressure.

Aligning with the notion of slow paced therapy found in the current study, were the findings of a qualitative study by Harper, Stalker, Palmer and Gadbois (2008). They interviewed 30 survivors of childhood trauma who had completed a six week inpatient trauma program, on questions related to what they found helpful in the treatment. Results found that a patient and understanding therapist who allowed them time and an absence of pressure to work through their issues, was useful. Therapists' patience that facilitated a slow pace of therapy has not been separated out specifically in alliance research as a contributing factor in the alliance research.

The approach described in the findings of the current study indicating the importance of slow pace with an absence of pressure and expectation to meet goals within a certain timeframe, contrasted and contradicted the pressure that many psychologists experienced as a result of specified goals to be attained within a limited number of sessions, funded by Government organisations and insurance companies (Norcross & Lambert, 2011). The findings of the current research indicated that such pressures may have interfered with the alliance negatively, as the slow pace with an absence of time limited goals enabled clients to relax, feel safe to disclose and have the opportunity to learn to manage emotions and dissociation. This highlighted a difficulty in the system when working with survivors of childhood trauma that may compromise client care if therapists feel stressed by deadlines and clients rushed or coerced.

Sam (P) said,

“Yeah, and that doesn’t mean I alter the times or whatever but I have a different expectation or I am thinking about, how can I help contain the client. So thinking about that intelligently..... Medicare⁴. I mean having that was a mixed blessing really, you know it creates an expectation of a result in a number of sessions. We are way beyond that. So clarifying what the expectations are going to be, and they are long term for someone with complex trauma. We are talking about something more core to their being rather than something. There are different ways of describing that I suppose. Michael(C) has had some very unsatisfactory relationships with caregivers in his life, particularly men, so part of his work is a reparative experience in a way as well as trying to learn something about himself. What he missed out on. Was damaged” (Appendix L, p290)

Rowena (P) described being stressed by the expectations of Government funded bodies. She said,

“It’s a rationalisation. But I have never worked out the APS⁵ when they talk about scientific practitioners; I have never seen any statically analyses as to why the magic number of sessions is six. And four. If they said three because we have worked out the average mean or whatever. And I think that perverts the course of what you do. So I know it’s a stress I feel all the time. What is an adequate goal? Am I meeting what this person needs? So for a complex trauma person you really have to back down in terms of what it is that you are expecting them to do” (Appendix L, p181)

In the findings of the current study, therapists’ ease with silence elicited a feeling of space for clients and of being unrushed. Taking time to trust and building up slowly in sessions, allowed time for the clients to ground themselves, to manage dissociation, and to learn to emotionally regulate. This was emphasised by psychologists and appreciated by clients. Giving clients the time to reground before leaving the session at the end was also thought to be important.

Being able to put the brakes on therapy as Babette Rothschild (1999, 2000) referred to, was also noted as important within the safe therapeutic space by both psychologists and clients. Georgie (P) put it this way,

⁴ Medicare is a government body that provides rebates for psychological services with a registered psychologist for up to 10 sessions per calendar year

⁵ APS is an abbreviation of Australian Psychological Society

“I would be the facilitator basically, holding the space for her, providing an environment that was safe for her to be able to go wherever she needed to go and also to be able to stop if needed to” (Appendix L, p117)

Psychologists adapted their approach for individual clients. For some clients slowing down the pace was facilitated actively by the psychologist. For example Georgie (P) said,

“We need to do the work, but we are not going to blow you out of the water.....and I kept pulling her back a little bit, so that she didn’t do too much. So that again, I wasn’t another person that reiterated that” (Appendix L, p115)

Cathy (P) was aware of giving her clients time to trust,

“Yes. That’s right. If it went too far too fast. Sometimes I worry with clients that they might trust me too quickly and so I wanted to give her lots of permission around taking her time to get to know me as well. It’s kind of both, like two-way kind of thing. A lot of the earlier work was trying to understand her experience and empathising with it” (Appendix L, p214)

Accepting where the client was at in their progress or emotional availability was also found important for both clients and psychologists. Clients did not like feeling pressured to be somewhere else, other than where they were presently at in relation to their therapeutic progress. Psychologists needed to put aside their own wishes for the client to be more emotionally available or to be making more rapid changes.

Miriam (P) acknowledged the need for clients’ repetition of the same material over and over again as many times as was needed,

“You know it’s, I reckon it’s quite repetitive with people who have had trauma. You know you just keep repeating it and repeating it, and it’s the tone and the gentleness.....So it’s that gradual, gradual, gradual. Put that toe in the water” (Appendix L, p270)

Adriana (P) explained how she worked with the feelings that emerged in the session rather than directing into memories giving Eleanor (C) control and a pace that did not overwhelm her. Adriana (P) explained,

“Stabilisation, emotional regulation and also, and I hadn’t thought about this before but, the memories were in the room. Were often in the room....she couldn’t talk about them. But they were here.... because we would talk about the feelings.....so she would present

with an issue. But I would work with the feelings. Often it was the anger and I would ask, what was that about? And it may be the impact of what she had lost.....in her life. It might have been her childhood. It might have been her innocence. So then the Uncle would come up. And I would say what are you angry about? And she would say, well I am angry that he treated me this way.....so we would go that way.....she just couldn't cope with the direct memory work. So, it was too much" (Appendix L, p165)

Rowena (P) commented also on balancing a slow, controlled pace,

"And when we talked about the things on trauma, on some levels she would dictate the pace.....and I think that has probably been good. So she can control it. And sometimes she'll say, ok that's enough for today. And sometimes over time we will just hang it a little longer. Not to stick her in the stew, but not to have her to flee necessarily. To realise that there is something in addition to her horrible story. So she probably has extended her ability to... tolerate. But she is in the driving seat and we will skim in and out. I think has been good" (Appendix L, p175)

A number of trauma specialists including those interviewed in the current study, reinforced the need to take time to establish safety in the alliance before proceeding to memory work (Courtois & Ford, 2013; Chu, 2011; Herman, 1992; Kinsler, Courtois, & Frankel, 2009; Mooren & Strofesl, 2015; Paivio & Pascual- Leone, 2010). The slowing down of the trauma work was emphasised at the beginning of therapy, to ensure that the clients had developed adequate safety, stability, emotional regulation skills, management of symptoms and self-care prior to memory work (Chu; Courtois & Ford; Kinsler et al.; Paivio & Pascual-Leone). It was important to consider whether clients were continuing to live in situations of abuse, either by others or self-inflicted harm. In these cases defences were seen as a necessary means of coping and memory work was deemed inappropriate before the client had first established safety (Courtois & Ford). The establishment of trust within the therapeutic alliance was emphasised strongly, at this early stage. The findings of the current study, however found that it was throughout therapy rather than during the initial alliance that slow pace was important. The clients interviewed had been in therapy for a minimum of two years, some up to 10 years, and the slow pace was still considered important for safety and therapeutic effectiveness by clients and psychologists, even once trust was established. Clinicians in the literature agreed though, that building trust was a difficult and prolonged process for survivors of

childhood trauma clients (Chu; Courtois & Ford), often requiring an ongoing, complex development sometimes taking years (Chu).

Furthermore, within the literature there was recognition that dealing with issues related to childhood trauma was a gradual process of developing trust. Survivors of childhood trauma were described as often split between yearning for closeness with their therapist and also experiencing fear and anxiety arousal related to deeper intimacy (Chu, 2011). This was thought to be as a result of early relationship dysfunction disrupting the normal development of trust as described by Erik Erikson (1968). If the child does not have the emotional needs of nurturing and caring met by primary caregivers, the development of self-worth, trust and sense of safety in the world were not established (Chu; van der Kolk et al., 2005). This carried over into adult years as a mistrust in relationships generally and of the world as dangerous (Chu; van der Kolk et al.). It made sense that to develop trust in the therapeutic relationship under these circumstances, would take considerable time and an absence of time pressure, as found useful in the present study. Sometimes, a matter of years passed before certain disclosures emerged or issues were addressed.

Timing related to disclosure of material and working on particular issues emerged in the current findings, which recognised that clients brought their own contribution to therapy. Antoinette (C) in the current study had worked through complex issues with her psychologist Liz (P) productively over many years, however continued to have more narrative that she wanted to share, however was not ready to do so.

Antoinette (C) said,

“I am not ready to tell her yet. Every time I try and bring it out, I choke on it. I can’t do it. And that’s got nothing to do with Liz (P). It’s me...” (Appendix K, p127)

This highlighted that clients chose when to reveal disclosures with trusted therapists, regardless of how effective the therapist client relationship was. Liz (P) described in relation to Laura (C), that she knew there was more scope for therapeutic work in the area of her relationship with her mother, however was awaiting her lead and readiness to tackle the issue.

Liz (P) said,

“When I think about Laura (C) and her 3 years of therapy, we didn’t talk a lot about her mother. We touched on it and we had some conversations, but there’s probably a lot

more work that is to be done there, but I guess I was taking cues from her in that I don't think she was really quite prepared to dismantle herself in that way, and to make herself vulnerable. And so I took a non-verbal directive from her and didn't push that too much" (Appendix L, p134)

Another example of clients' readiness was given by Michael (C) who presented for a few sessions with Sam (P) and then did not reappear for another four years. The issue that arose in those early sessions, according to Sam (P) was that he was not ready to work through those concerns yet. Michael (C) however, described a fear response,

"It spooked me and made me not want to trust him" (Appendix K, p343)

Perhaps there was more going on in the alliance than Sam (P) realised, or was it that Michael (C) was not yet ready to address the issues, given that he did return several years later. Even for very experienced practitioners, there may be issues within the alliance beyond their awareness. This was explored further in Chapter 7 on Repair work. Nonetheless therapists were not rushing their clients, and clients were found to control their self-disclosure and attendance regardless of the therapists' intentions. Clients appreciated psychologists' respect in this area. For example, Ken (C) said,

"If the time isn't right or, because I find that the moment has to be there...And for whatever reason it is not, she is happy to just let it go and we carry on chatting about something else" (Appendix K,p108)

Psychologists recognised that clients moved through change at their own pace depending on the level of abuse and client factors. Irene (P) shared the differences in the paths taken among clients through metaphor,

"Therapy is like climbing a mountain. Sometimes you get to a plateau and you think that is enough and some people want to keep climbing forever" (Appendix L,p92)

In alliance research, clients have been shown to have their own contribution to the development of strong alliance (Constantino et al., 2010; Errazuriz et al., 2015) with differences such as whether they were more or less agreeable, hostile, insightful, or emotionally engaged affecting outcomes. In the findings of the present study, strong alliance over many years was developed between the therapists and a variety of clients, however the clients even when the alliance was strong, were found to withhold issues from their therapists, even after years of safe disclosure and secure attachment. This

highlighted the importance of respecting client timing, and allowing issues to emerge at the clients' pace. As therapists we create a safe therapeutic space, deliver evidence based interventions and practise effective therapy, however there were clients' factors that cannot be controlled, and need to be respected by therapists and organisations.

6.1 Mutuality and Minimisation of Power Differential through Collaboration

Both psychologists and clients in the findings of the current study were aware of the power differential, and many clients had both positive and negative experiences with professionals related to power. A sense of mutuality and a minimisation of the power differential, with clients given control in as many opportunities as possible throughout the therapeutic encounter was highlighted, by both clients and psychologists.

Jessica (C) appreciated the absence of being dominated and the mutuality in explanation,

“Early on she took the lead, but everything was checked in with me, her approach. Things were explained to me as I have progressed with my studies I have understood myself, so I know what is going on, which I find helpful. I don't know if that is for everybody, it works for me. I have always felt included because I have never liked the dictatorship aspect” (Appendix K, p245)

In alignment, Bess (C) said,

“She doesn't play “I am the big psychologist”. I don't get any of that” (Appendix K, p168)

Josie (C) explained,

“I have low self-esteem but she never made me feel that way when I talked and I think that I wouldn't have kept talking if I did feel.....She never spoke down to me. And on the same level” (Appendix K, p326)

Jessica (C) also summed the gentle guidance that the therapists frequently described,

“I was being taught and coached in a way, rather than being directed and having things forced upon me...it was making that distinction between pushing me to do something and helping me to help myself” (Appendix K,p241)

Psychologists agreed in the importance of minimisation of power. Throughout the interviews they spoke respectfully towards their clients with a humbleness and an absence of superiority. Felicity (P) said,

“I just can’t stand it when therapists are defensive and expert” (Appendix L, p28)

Georgie (P) summed,

“She really likes the idea that I don’t treat her like a patient. You know she is not here to somehow learn something for me. There is something about a mutual sharing of our space together. It feels as though it’s validating to her. It feels really important to her” (Appendix L, p156)

Clients liked being “*treated intelligently*”. They liked that psychologists shared trauma or neuroscience theory with them, as it was perceived to even out the power differential through the sharing of the knowledge. Jessica (C) said,

“I didn’t feel disempowered, and so instead of her being more intelligent or more empowered or more sure of herself, like my experience previously. It was more of she knew stuff I didn’t and was prepared to teach me and share it and guide me, rather than lecture at me” (Appendix K, p241)

Belinda (C) commented,

“That they explain what they are doing and don’t just assume, that I am the doctor and you are the patient, so this is how it is. It’s about assumptions……. Not to explain to me like I am a child. You need to explain to me, like I might not have the same knowledge as you, or the same comprehension as you” (Appendix K, p17)

Clients wanted practitioners to communicate to them in a language that they could understand and in an informative, respectful manner.

Peter (C) said,

It’s never a case where Felicity (P) says “This is what you need to do”. We’ll come up with suggestions and we’ll come up with options. How do you feel about that?” (Appendix K, p25)

Psychologists gave clients choices, avoided being too instructive and collaborated on ideas. The mutuality was important and even though therapists had more knowledge in the area, there was a genuine equalising that was conveyed to the clients from their therapists.

The Person Centred stance emphasises minimisation of the power differential between therapists and clients, aligning with the findings of the current study, and other psychotherapeutic theorists (e.g. Elliot et al., 2005; Kohut, 1977; Moloney, 2016; Paivio & Pascual-Leone, 2010). This differed from early behavioural approaches that advocated for change in the clients through manipulation, control and persuasion (Strupp, 1973). The Person Centred stance was thought to increase safety for complex trauma clients who have often experienced powerlessness and lack of control through childhood trauma experiences (Paivio & Laurent, 2001). Creating safety through secure attachment was supported by researchers (Dozier, Cue, & Barnett, 1994; Courtois & Ford, 2013; PAVIO & Pascual-Leone) and neuroscience studies that suggested safety that enabled openings for growth of new neural pathways and neural integration (Allison & Rossouw, 2013; Siegel, 2009; Siegel, 2012), which counteracted the disintegration, hyperaroused or hypoaroused neural states and fixed patterns that can occur with trauma (Siegel, 2014).

Trauma specialists generally encouraged mutuality and a lack of the therapist expert stance (Courtois & Ford, 2013; Kezelman & Stravropoulos, 2012; Paivio & Pascual-Leone, 2010; Varra & Follette, 2004). They agreed on the importance of client control and collaboration (Cloitre, Bryant, & Schnyder, 2015; Kinsler, Courtois, & Frankel, 2013; Maltzberger, 2011; Paivio & Pascual-Leone), aligning with the findings of the present study. However, some trauma approaches (e.g., Weathers, Keanne & Foa, 2009) tended to align with a medical model approach, endorsing extensive structured assessment and treatment focus, that arguably have the potential to exaggerate power differential, while overshadowing factors such as genuineness, deep emotional empathy and presence with the clients, as was found important in the current study and by several trauma specialists (e.g., Chu, 2011; Courtois & Ford; Paivio & Pascual-Leone). Furthermore, the tone used in some of the literature to convey the requirements for trauma therapists (e.g. Mooren & Stofsel, 2015; Weathers et al., 2009) was less empathic and more instructive and directive, eliciting in the reader a certainty and rightness that contradicted the tentativeness and humbleness advocated by this cohort in the findings of the current study. Hence, therapists risked becoming too 'in charge', all knowledgeable and instructive, which may unbalance the power differential between therapists and clients, compromising client safety and risking retraumatisation.

Clients in the present study were aware of the power differential being exaggerated by practitioners and they disliked it. An example of this was described by Edward (C),

“Oh, the way he said it.....it wasn’t clinical. It was just a cruel label. It was a judgment.....And what’s more I have had to handle this situation, overbearing authority all my life. When I went to boarding school” (Appendix K, p306)

Clients responded negatively to perceived arrogance, superiority in professionals, and sensed the difference with therapists who practised equality with them. For examples, Eleanor (C) said,

“I feel like she has empathy. She is not condescending at all. Um, she understands where I am coming from. I don’t want somebody to pity me. I just want somebody to understand me. Yeah. Sometimes when I go to the doctors and things like that, I feel like they are talking down to me. Um. And I don’t feel that at all with Adriana (P)” (Appendix K, p199)

Kate (C) explained, in relation to Tom (P),

“He doesn’t say well psychologically this is this (in a posh, demeaning voice). He’s again very gentle. He says, what do you think about this Kate? And I like that” (Appendix K, p44)

Power imbalance was found at times to reinforce negative childhood experiences eliciting feelings of distrust in the practitioners, and interfering with the therapeutic relationship negatively. Belinda (C) found that her therapist’s expertise reinforced a sense of her madness. She said,

“So I think if she comes across as being expert. This is what we are going to do. Yeah, like I am mad” (Appendix K, p17)

In the findings of the current research, therapists were found to be unassuming, respectful and without a sense of self-righteousness. They had a humbleness that involved questioning themselves and not perceiving themselves as superior to their clients. Therapists’ self-doubt, thought to be related to humbleness, has been supported in alliance research in contributing towards positive early alliance development (Nissen-Lie, Monsen, & Ronnestad, 2010).

The importance of collaboration with survivors of childhood trauma was explained by Kezelman and Stravropoulos (2012) as being different to and counteracting childhood experiences of compliance during periods of abuse. Clients having a sense of power and control was thought to provide an alternative experience, hence minimising the chance of retraumatisation in the therapeutic alliance, and thus highlighting the importance of attending to this balance within sessions. The findings of the current study highlighted the potential to reinforce negative self-perceptions through therapists' superiority. Psychologists in the present study used opportunities to minimise the power differential as much as possible and displayed a high level of respect towards their clients, aligning with other researchers (Chu, 2011; Courtois & Ford, 2013; Paivio & Pascual-Leone, 2010).

The therapeutic relationship was found to be challenging at times for the therapists when working with survivors of childhood trauma, as once the alliance had deepened the clients at times acted out in ways that were destructive to the alliance, in response to fear elicited in the clients. Often the complex trauma clients anticipated that the therapists would also become an abusive other, and behave in ways that were perceived as obstructionist and uncooperative (Chu, 2011; Courtois & Ford, 2013; Kinsler, Courtois, & Frankel, 2009; van der Kolk et al., 2005). How the therapists dealt with this potentially difficult interpersonal interaction in the moment was important. The potential to exaggerate expert stance or power differential through therapists' own need for control or to react defensively was risked. It was found paramount by researchers and in the current study, that the therapists did not repeat old patterns of relating and react angrily or demeaningly to this behaviour, rather that they see beneath it and understand where it may be stemming from. To this end an approach of empathy, validation, client control and firm boundaries was advocated by trauma specialists (Chu, 2011; Courtois & Ford, 2013; Kinsler, Courtois, & Frankel, 2009; Paivio & Pascual-Leone, 2010; van der Kolk et al.). This entailed a delicate dance that required flexibility and adaptation by the therapists in the moment, as well as a strong sense of self, clear boundaries with the clients, and self-awareness of their own triggers. The approach in the findings of the present study and by researchers always respected and empowered the clients and created opportunities for corrective experiences.

6.2.1 Collaboration and enhancement of client control

A common theme that emerged through the data of the present study was the dance between therapists and clients leading and following, which occurred without a power struggle and maximised clients' control, while the therapists maintained an active role in guiding. Peter (C) summarised,

“She allows things to be very free flowing, like I can talk a bit sometimes. She’s good at, “Ok, that’s enough”. So I just feel that I am managed well (Appendix K,p20).....I guess Felicity (P) is able to read me very well as far as ok things are going, let’s push the envelope a little bit, or this week, we’ll back off a bit” (Appendix K,p23)

Some clients needed to adapt to mutuality and absence of hierarchy, however they found freedom within this approach. Ken (C) was used to being led each session by professionals, having experienced a number of different therapists. It felt very different when his current psychologist was considerably less directive. He questioned this initially, however soon realised that within this space he was more fully ‘heard’. Ken (C) said,

“And it took me quite a while to get used to the fact that yeah, actually this is my time, and that has evolved from me the first few times, wanting her to be prescriptive or, wanting her to....you know to be a bit more, you know ok we are going to talk about this today or whatever....but she didn’t.....what I realised at the time, was what I said to you before was that she allows me to feel that I am heard, and what she was doing right back when we first met, was just that. And I didn’t realise that at the time (Appendix K, p113....but the fact that it was an environment in which I felt very confident was much more helpful.....I think in retrospect it was that actually this was the only place where I could talk and be free. I don’t even think I realised it to begin with” (Appendix K, p114)

Trusting and respecting clients to make their own decisions was emphasised. This included allowing clients to leave therapy and come back when ready, with an openness to having them back on their terms and timing. Clients were given control, flexibility and choice. Cathy (P) summed,

“So getting on with life and then coming back when she hits some snags” (Appendix K, p212)

Tina (C) stated,

“And I never felt as I did with the previous one, let’s wrap you up in a year, you know lets this is what you presented with, now let’s get you out the door. Whereas with Georgie (P), other things emerged onto the surface and she never, she was just happy to see me whenever she wanted” (Appendix K, p132)

Therapists making the decision to end the alliance without consultation with the clients, were found to reinforce childhood experiences of being “too difficult”, feeling “ditched” and abandoned. Kristen (C) explained how she felt too difficult when she wanted to return to her counsellor after a break,

“Because it is very hard to see someone new. To trust yourself, which is so hard. So she said alright. We’ll organise it. And a couple of weeks later she said, no that’s not going to happen actually because she refuses to see you. She feels that she, basically I am too hard for her....And the funniest thing is she counsels prisoners, in prison and I thought, and I am hard for her!” (Appendix K, p278)

Daisy (C) described her prior negative experience of the therapist choosing when to end therapy,

“She just kind of wanted to fix this one issue, and then she kind of herded me off, said we are done now and ended the sessions” (Appendix K, p62)

Clients in the current study reported negatively their experiences of the therapists making decisions independently and being too directive. For example, Tina (C) said,

“I guess there was one particular issue I am thinking of, that I brought up, and I guess we spent one session on it then she thought, oh well, that’s done, and if I felt like I needed to talk about it more. I would bring it up again, I guess it wasn’t open for exploration. We did that it’s done and dusted. I got the impression from the psychologist that I don’t think that’s important to the issue that’s presented, whereas Georgie (P) was very open to think it was important” (Appendix K, p129)

Clients liked having control over the detail of trauma content disclosed. They did not appreciate practitioners who were “fishing” for details as if they were somehow entertaining them, or when practitioners were too directive with accessing trauma material. Clients differentiated when it seemed like the motivation was to meet the need of the therapists rather than the clients. Therapists hanging on too tightly to the therapy

goals or expectations may have interfered with therapeutic presence with their clients. Hannah (C) articulated,

“In the first couple of counsellors it was almost like oh, it was almost like watching a horror movie. They are waiting for the good bits That they kept digging and digging until we got to the really gory bits. And I didn’t want to give that up” (Appendix K, p259)

Ken (C) said in his sessions with Irene (P),

“It has always been me who has dictated what we will talk about and what is ok to talk about, which is really helpful in the sense that I have never felt that she has wanted to push me into any particular direction or tried to lead me down any particular path” (Appendix K, p107)

Henrietta (C) stated,

“And I don’t feel like he ever moves me on further than what I am ready for” (Appendix K, p156)

Psychologists were flexible when interventions did not progress as planned. Belinda (C) in reference to Adriana (P) said,

“She just lets it go....She didn’t make me feel like it had to happen” (Appendix K, p208)

Therapists were able to let go of their own need for control. They did not hang on so tightly to their own agenda, again aligning with the Buddhist principles of non attachment to outcome. Therapists were able to be present with whatever arose in the moment and to attend to this, rather than being pressured to meet an expectation or deadlines (Kabat-Zinn, 2003). It was a flexible stance, free from therapists’ own need to complete an intervention or achieve a certain goal.

Psychologists adapted to their clients and the situations in the moment. Jessica (C) requested that Louise (P) take a more directive approach. Louise (P) said,

“She came in and said, I don’t want to set the agenda each time. I want you to start the session and so I said, ok, I’ll do that but I said you have to make me a promise, if at any time in the session we are heading in the wrong direction, tell me (said softly and firmly). And it was in that moment of collaborative, you know respecting her and also hearing ok this is what you want from me..... So there was message in your response that was like, I

am not sure about that, I'll give it a go but it was also responsibility in that, tell me if it doesn't work" (Appendix L,p202)

Louise (P) altered her usual approach to counselling, however collaborated with the client and rearranged the boundaries to protect herself, her professional standards, and to instil responsibility in the client. Therapists described leading with a minimum of power differential or manipulation. This finding aligned with Erskine (2015), who highlighted the need to carefully attune and to respond to the needs of the individual clients. Some clients were thought to have the relational need for the other (therapist) to initiate contact, hence benefitting from the therapists taking a role in leading. It was important that clients were not pathologised by their therapists and labelled as manipulative or resistant during these moments, which was thought to be counterproductive to a healthy therapeutic alliance (Erskine).

Irene (P) guided Catriona (C) in relation to her readiness to cease therapy,

"It's not an ownership, but is certainly a lead. And I said to her, I don't think you are ready. You are still having a lot of problems with the people at work, you know, have a think about it. You know it has come up, in different ways. I said Catriona (C), it's great you are feeling a lot better and it's great that you are having annual leave, but my wish for you is that you get a bit further really taking care of your health, now that's my wish, it might not be your wish. It's a standing joke, that I am always nipping at her heels, going for walks and she told me that she had taken the dog for a walk. And I said Catriona, "You've got a life ahead of you" (Appendix L, p78)

Irene (P) who asserted her views with an absence of expectation or manipulation, and was clearly motivated by Catriona's (C) well-being. Ultimately, Catriona (C) was responsible for making her own choices, with the message of, deep acceptance, whatever she decided to do.

Psychologists were flexible, yet solid in their therapeutic methods. Numerous clients commented on liking being given a choice about specific therapeutic interventions or tasks. For example, with more evocative experiential tasks (e.g., Gestalt methods) it was seen as important to both clients and psychologists to be able to choose to opt out of the task, at any stage. Psychologists, however also recognised that sometimes clients responded to nudging and encouragement, which enabled them to

continue through evocative moments. The clients were always given the final choice and supported. Jenna (P) said in relation to Cas (C),

“I offered the empty chair with Dad, but she didn’t want to do it. She said I’ll go home and I’ll find my own way of doing it. And I was absolutely staggered when she came back and she said she had written to him” (Appendix L, p168)

Eleanor (C) shared her dislike for chair work sometimes used in EFT to resolve issues with a significant other. Adriana (P) responded to her wishes and adapted her approach to the problem. Eleanor (C) said,

“And she said that’s fine. You need to tell me what’s comfortable for you. And we’ll find another way. Things like the empty chair and that sort of thing, I hated that. We did one, where we had two chairs there and we were switching backwards and forwards, to say something to somebody, and I hated that sort of thing. And after that we just, it was easy just having a conversation and discussing the issues. I felt more in control then” (Appendix K, p194)

Tom (P) adapted his intervention with Kate (C),

“And then I’d work towards doing EMDR. But clients like Kate couldn’t do arousal reduction, and she couldn’t do EMDR. So I couldn’t do any of that, so I let it all go. Yeah and that’s fair enough. Some people don’t like to be boxed in, or feel threatened by losing control to gain control, and don’t want to do exercises” (Appendix L, p43)

Therapist flexibility was supported generally by trauma specialists (Chu, 2011; Courtois & Ford, 2013; Erskine, 2015; Kezelman & Stravropoulos, 2012; Kinsler et al., 2009; Paivio & Pascual-Leone, 2010). Furthermore, therapist rigid adherence to interventions was found to impact negatively on the alliance (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010) giving empirical support to the notion of collaboration with the client throughout the treatment process. In a recent review of 16 randomly controlled trials by Ehring, Welboran, Morina, Wicherts, Freitag, and Emmelkamp (2014) involving childhood abuse survivors specifically (in contrast to studies on PTSD), eight trauma focused protocols emerged in the findings of the study. Four of these had sequential and multi-faceted qualities. The multi-faceted ones were found to have greater statistical significance than the pure form of Trauma Focused Cognitive Behavioural Therapy, which highlighted the need for a more flexible, and

individualised approach to the treatment of complex trauma in contrast to rigidly imposed structures (Cloitre, 2015; Moloney & Andrew, 2016).

Collaboration and client control were key findings in the above examples from the current research study. The Adults Surviving Child Abuse (ASCA) guidelines had collaboration as one of the five key domains endorsing maximisation of control to the clients whenever an opportunity arose, including administrative procedures such as appointment times (Kezelman & Stravropoulos, 2012). Harper and colleagues (2008) found that survivors of childhood trauma clients appreciated a sense of control in the direction of therapy and liked finding solutions themselves with the therapist's guidance. In addition, Ullman, Filipas, Townsend & Starzynski (2007) found childhood trauma survivors experienced lower levels of distress when having a perceived sense of control in therapy. Furthermore, recent neuroscience studies also support empirically the impact of individuals having control as important in reducing stress levels (Bryant et al., 2014). This may have implications for how directive the therapists were and whether the clients had a sense of control over when to go into memories, stepping in and stepping out.

6.2 Leading, Following, Managing and Creating a Safe Space

6.2.2 Managing avoidance while also maintaining client power and control

Psychologists were found to become more directive in the management of avoidance with some clients in the present study, which was more evocative and focused on accessing trauma material. They had a certain amount of structure to the sessions, although the interventions varied. Some led with specific EFT or CBT based interventions, whereas others described a more free flowing narrative approach. All psychologists worked experientially and collaboratively with their clients and gave clients choice and final control, with an absence of manipulation or coercion. For example, Alistair (C) said,

“There was a discussion about how we might do that earlier, and pick up some of those things at the start of the session, rather than waiting for it to come out. That was very useful” (Appendix K, p72)

Josie (C) said,

“At the beginning I wouldn’t talk, or the real problems I would fluff over like it was nothing and avoid those situations or whatever, but she got me talking and that’s a very good thing because if you’ve had a bad childhood, you don’t talk and I have never said very much. And she cajoled it out of me. Not too hard and fast” (Appendix K, p325)

Peter (C) said,

“Yeah, because my whole, my conversations with my wife, my family, you know I have always been able to have them on my terms. You know if I don’t want to talk about something, I won’t talk about it, and that has caused issues. Felicity knows there’s a time when not to let me off, and I respect her professional knowledge.....And that’s why I let her do that, otherwise I probably wouldn’t let her” (Appendix K, p21)

As demonstrated with Peter (C), when the alliance was strong and when the clients felt safe, they were more likely to relinquish control and to take risks psychotherapeutically.

Survivors of childhood trauma have been known to frequently present with behavioural patterns of avoidance of their emotions and trauma memories (van der Kolk et al., 2005; Pavo & Pascual-Leone, 2010), and yet amongst trauma specialists it was generally recognised that healing occurred through confrontation of their difficult experiences (Pavo & Pascual-Leone). If the clients developed cognitive schemas of others as untrustworthy and also became skilled at avoidance patterns (Pavo & Pascual-Leone; van der Kolk et al.), then how did the therapists navigate the level of directiveness that was required to access painful and evocative experiences?

Psychologists in the present study managed a deliberate, careful dance between allowing the client autonomy and addressing avoided issues that were thought to be important. Daisy (C) said,

“I tend to take the control of that in a way. So he allows me to do that. But he does it sometimes too. An example of that is that I will come into counselling with a whole lot of things I want to say and debrief about...Yeah, and he will let that go on, but he might pick up on a pause or a comment or something like that. At some point to explore a certain direction and he has had that discussion with me about how I do that” (Appendix K, p76)

With the direct trauma work, Jessica (C) described a more direct approach by Louise (P),

“I think with the trauma therapy that was more structured. And I think that part needed to be structured so that that work was getting done, rather than me getting caught up in the smaller details, which I really appreciated I think. It was really good, knowing I had to do the hard work. Yeah the goals have always been very flexible and adaptive, which I think is important” (Appendix K, p246)

Sometimes psychologists in the present study became more directive, describing a balance between imposing discomfort, giving client control, avoiding retraumatizing and being able to access the material needed to process and transform. For example Georgie (P) said,

“As the sessions passed and when she found that she wanted to address certain issues, she decided that, and so then I would work with that, and then we would work collaboratively again, around whatever would come up around social anxiety issues. So it was very much following and leading and sometimes that would change. But I would be the facilitator basically, holding the space for her, providing an environment that was safe for her to be able to go wherever she needed to go and also to be able to stop if needed to” (Appendix L, p117)

The more structured therapists were found to collaborate and gave the client choice. Jenna (P) said,

“This is where I am leading you but you don’t have to go anywhere. So it’s the opposite of manipulation” (Appendix L, p276)

She elaborated that she allowed the client to express sadness without the expectation that they have to cry, accepting and being with the client. So even within a framework and structure, the client had a lot of freedom, choice, slow pace and control while the psychologists guided. Georgie (P) also said,

“Then that actually helps the client process their early memories.....And to feel safe in the process.... Gives structure.... And the client needs to know that you can bring them out again. That they know that there is a process..... so they have control. If it’s uncomfortable, and I check in with them all the time. Can you feel your toes? Can you notice your breath? What’s going on for you right now? So you can monitor the dissociation even within the process” (Appendix L, p159)

Georgie (P) elaborated explaining that the structure created safety for the clients.

“Because there is a lot of processing that goes on with no structure. And people feel really unsafe.....You need to have set process, so they know. And that maintains the safety” (Appendix L, p159)

Kristen (C) depicted her experience of a more directive approach,

“Particularly something that has been deep. She prefers to continue with that and clear it out, rather than open something deep in one session, then the next session open something else. Because then it closes up again and starts to fester” (Appendix K, p280)

Kristen (C) was clear about the therapist’s rationale, and trusted that Jenna (P) was leading her in a productive therapeutic direction.

Clients such as Jessica liked that therapists managed their avoidance, sometimes through increasing structure in the sessions. Psychologists made comments that paralleled client feedback. Jenna (P) explained managing avoidance of painful emotions. She said,

“There was a certain amount of leading of getting out of that cognitive space to get into an emotional realm. So I had to do a lot of leading with that, but very much the message of acceptance of wherever you were was ok. So I am not manipulating you in this space” (Appendix L, p276)

Although agreement was held on the importance of kindness and tentativeness generally when working with survivors of childhood trauma, sometimes therapists became increasingly directive and evocative with certain clients in managing the therapeutic alliance. The findings of the current study indicated that some survivors of childhood trauma responded positively to gentle redirecting by their psychologist, whereas others benefited from a more directive and structured approach, to access trauma memories and painful experiential states. Perhaps for some clients creating a safe and secure attachment within the alliance was sufficient for them to bring forward painful material. In the findings of the current research for example, Adriana (P) said,

“So her reaction, her physiological arousal and her flashbacks and everything was that she couldn’t talk about them and I never probed them. Um, didn’t need to because she would tell me what she needed to tell me, she knew what she needed to deal with” (Appendix L, p1)

With other clients the avoidance patterns may have been more entrenched. If the concerns were primarily related to fear based responses, assisting to control optimal

levels of arousal, deep empathy, profound non-judgment and strong therapeutic presence may be sufficient with gradual exposure or bringing forward of material spontaneously by the client, whereas the process may have been more complicated when shame based experiences were involved.

Exposure based approaches have been found to be effective in dealing with clients' fear, however less so with other emotional experiences such as shame, guilt and sadness (Paivio & Pascual-Leone, 2010). Perhaps if the clients' concerns were layered heavily with shame, guilt, sadness or a mix of emotions that were related to negative core perceptions of self, then a more intricate approach was required, including increased skill and individualised directiveness by the therapists, to enable accessing of deeper experiential states and meaning. This may have occurred through a more structured intervention. Counteracting the action tendency of shame based feelings to withdraw and hide (Elliot et al., 2004) a delicate leading may have been sufficient enough to draw out the clients, without heightening fear or triggering a sense of being controlled. Depth of empathy, therapeutic presence and acceptance by the therapist as well as client characteristics including courage, motivation, responsibility and ability to handle painful states may also have contributed to the level of directiveness needed.

Courtois and Ford (2013) highlighted the need for therapists to be aware and actively manage the avoidant client with a tendency for self-reliance and distancing when feelings of discomfort emerge through emotional closeness. These clients sometimes were found to minimise their problems, or negate the therapeutic relationship and needed the therapists to engage actively or else risk reinforcing their avoidance patterns or developing a dislike for the client (Courtois & Ford; Paivio & Pascual-Leone, 2010). Being able to identify with the vulnerability of the client beneath their exterior mask of self-reliance or disengagement was considered important, also found in the current study. An active yet refined approach was required to connect with these clients with an absence of power tension (Courtois & Ford; Paivio & Pascual-Leone). A gentle, curious approach was recommended (Courtois & Ford; Elliot et al., 2005; Moloney & Andrew, 2016).

Furthermore, understanding complicated attachment systems that involved a yearning for connection on the one hand, while also actively avoiding it on the other, as a result of early childhood rejection by primary attachment figures, may also have assisted the therapists in knowing what level of direction the clients needed to take at any given moment, without the therapist becoming avoidant. The therapists needed to

be aware of their own avoidance patterns which may impact negatively on clients, by non-verbally reinforcing shameful states or content (Paivio & Pascual-Leone, 2010). Furthermore therapists required awareness of their tendency to direct clients in a specific direction (Follette et al., 2010) for their own need for control or sense of competence, in contrast to being guided by clients' needs, as described in the example of Hannah (C) above. Psychologists were carefully navigating the dance between leading and following, while sometimes more actively managing avoidance tendencies, in collaboration with the clients.

6.2.3 Creating a safe place for issues to emerge

Numerous psychologists described dealing with issues as they arose, rather than probing for certain issues through a more directive intervention. This was intended to maintain client stability, rather than risking unravelling the client. Their approach involved addressing moment by moment concerns that emerged in the session. For example Adriana (P) said,

“She would tell me what she needed to tell me” (Appendix L, p1)

Miriam said (P),

“That’s I think why she has kept coming back. Because I haven’t had an agenda that I have had to impose” (Appendix L, p166)

Even though the client had a known childhood trauma history, Tom (P) allowed Jake (C) to decide on the content of each session,

“So of the 18 sessions that we have seen each other we have hardly talked about his childhood” (Appendix L, p296)

Felicity (P) said,

“I don’t set agendas for therapy.the only instruction I would give is to bring what is on their mind.....Get them to focus on the internal world” (Appendix L,p243)

Georgie (P) said,

“It’s about creating a space where she feels she can bring what she brings” (Appendix L, p155)

Georgie (P) described following the lead of the material brought forward by the client on the day, in the moment, which usually led to childhood trauma issues emerging.

“So even though she might come to talk about her ex-husband, or she had had a conversation with her brother or something like that which would then trigger some of the childhood stuff again” (Appendix L,p190)

Psychologists, in conjunction to having broad, overall goals, were found to be responsive to their clients on a session by session basis in the present study. They displayed a flexibility with goals, and worked in the present moment experiences with their clients in sessions, aligning with Existential Therapy (Yalom, 1980) and Experiential Therapies (e.g., EFT, EFTT, Gestalt Therapy). This involved attending to subjective internal experiences and was consistent with trauma treatment generally. It created space for the emergence of new understandings of trauma experiences and transformation of negative self-perceptions (Briere, 2004; Elliot, et al., 2005; Paivio & Pascual-Leone, 2010; van der Kolk, 1996. Tom (P) said,

“So my style is always moment to moment” (Appendix L, p43)

Georgie (P) said in relation to Bess (C),

“So with someone like her it’s a matter of allowing her to bring what it is that is alive or present and exploring that” (Appendix L,p156)

Liz (P) said,

“I would also involve her in individual sessions. Like what would be really useful for you today?” (Appendix L, p108)

Therapists adjusted their approach depending on the needs of the client. Georgie (P) took a less directive approach with Xavier (C),

“I made him run the agenda and I think that really empowered him that he was his own master of his life” (Appendix L, p251)

Whether more directive or less, therapists in the present study generally empathic and consulted with the clients along the way. There was an absence of coercion, domination or pressure towards the client to complete an intervention. Therapy occurred slowly, with explanations of the process delivered in confident and

caring ways. Therapists led the path through the trauma work, letting the clients know the purpose of interventions and reassurance of likely outcomes, supported by research (Elliot et al., 2005; Paivio & Pascual-Leone, 2010). Clients trusted that their therapists were taking them in positive directions.

Aligning with the findings of the current study, empathic attunement was thought to be particularly important when working therapeutically with survivors of childhood abuse, due to the high risk of retraumatisation by some trauma specialists (Chu, 2011; Paivio & Laurent, 2001). Through the noticing, presence and tracking of present moment client experiences of hypoarousal or hyperarousal or feelings of vulnerability, the therapists were guided to “mirror or follow client processes rather than direct, teach or interpret client experiences from an expert stance” (Paivio & Laurent, 2001, p 218). The approach was gently delivered with a humility by the practitioners. Paivio and Pascual-Leone (2010) elaborated further in bringing attention to therapists’ responsiveness as important for collaboration and goal setting with the clients to increase a sense of safety and control. The findings align with other trauma specialists (Chu; Courtois & Ford, 2013; Erskine, 2015; Kezelman & Stravropoulos, 2012; Kinsler et al., 2009; Paivio & Pascual-Leone) as well as the current study.

Attachment Theory also aligned with the above sensitivities and attunement in the warm and empathic response to the clients, tracking and responding to their experiences carefully and compassionately, however being aware of areas of avoidance (Bowlby, 1988). Hence the client and therapist took turns in leading and following, in an attentive dance, which was also captured in the findings of the current study. This was described in more detail in Chapter 3 on Empathy.

6.3 Goals and Expectations of Treatment

Therapists described broad purposes or goals for the clients to establish a context for therapeutic work and were guided by knowledge in psychotherapeutic theory and methods with clarity and focus during the interviews in the current study. However, these goals were not always shared with their clients.

Many clients did not find goals important and appreciated that therapy was free flowing and flexible, although they liked a sense of being guided back to the necessary work by their therapist. Less formal, broad goals tended to be integrated into therapy, such as creating safety, to feel better about oneself, improve relationships, resolve trauma, to emotionally regulate and to enjoy life. Sometimes clients initiated goals, and

brought them to the therapist to be discussed and negotiated at the beginning, and occasionally throughout therapy. Overall, though goals were found not to be a strong focus of the therapy for clients in the present study, according to the clients.

Robyn (C) said,

“I don’t think we ever talked about direction. She has probably got some nice, formal direction in her head. Nothing we have broached” (Appendix K, p374)

Edward (C) stated broad life goals,

“This has been a goal (therapy itself). The fact that I have stuck with it. This is a goal to be able to get on with life” (Appendix K, p309)

Josie (C) described an inability to be able to connect with goals in her life generally at the beginning of therapy. The therapy was said to simply flow,

“It just flowed and I never had goals really for anything. I never thought about the future. And now I have Cancer and I think she, I didn’t care if I lived or died” (Appendix K, p333)

These findings highlighted that for some survivors of childhood trauma, having specific behavioural goals to work towards was not necessarily useful. It was possible that broad goals were integrated smoothly into the therapy, which meant that clients may not have recognised them as goals. For example, Liz (P) said,

“I guess what I would do is, people might talk for a while in a session and in a way they might not look like counselling goals, but in a way I might reflect what they have said to them, and then I might be able to tease them out. Then, I would say something that might be useful for you in this process might be, um, you could look in the mirror and say, “You are ok”. Would that be something I could write down and come back to from time to time and see how we are going with that?” (Appendix L, p108)

It made sense that clients were uncertain about goals and that goals were a low priority considering that many of the clients in the present study, entered therapy for reasons related to symptom relief such as anxiety or depression, not aware of the therapeutic potential for more fundamental change. At that time, they did not necessarily know what impact the childhood trauma had had, or what they were going to find useful to work on. The level of trust obtainable with their psychologist was unknown, which would determine how much they disclosed. It sometimes took time for

the goals to emerge in therapy. For example, Rowena (P) said in response to a question related to her goals and directions of therapy,

“Well it’s a funny one to answer, because I don’t know that I would have known the depth and complexity of her trauma when she first turned up. It has probably evolved over time. Um. I think, I think it might be to do with getting a sense of what is an adequate goal for this person?” (Appendix L, p181)

Goals became clearer for psychologists as they got to know the individual clients, highlighting the need for an open-ended approach to goals. For these clients rigid, imposed goals may have actually interfered with the emergence of trauma work.

Daisy’s (C) comment aligned with this notion,

“I don’t think that would work for me the goals, or too much of a tight structure. Yeah, because there sort of controlling the direction then aren’t they. And I don’t know that that would really work for me. I don’t think that a lot of quite full on stuff would come out” (Appendix K, p68)

Goals that were too imposing and rigid were perceived as too controlling and pressuring of the client, negatively affecting the therapy process. Henrietta (C) said in reference to a previous therapist,

“And I had another one who was quite prescriptive and gave me lots of notes and work and I felt pressure with her. Pressure to achieve, which is not helpful to me because I put myself under pressure all the time anyway, so. I needed someone to not put me under pressure” (Appendix K, p159)

Georgie (P) elaborated on the importance of unrestrictive goals for Bess (C),

“If she was given homework or any of that solution focused sort of stuff. I think she would really struggle with that. She would be oh, “I have to do this”. And then she would just lose her feet and walk. She wouldn’t talk to me about that stuff. I think because we have built this relationship, if I do something now, I think she would be able to tell me. I wouldn’t want to do that. It has been really important to let her, and it’s not like I let her run amok or anything. It’s more that I let her have the space. Well, what she brings we work with, and she always finds it very useful that I do that” (Appendix K, p184)

Therapists relieved pressure, rather than loading or stressing their clients with expectations and deadlines in the findings of the current study. Behavioural goals were found to have the potential to risk setting the clients up for failure. Having specific

goals to meet by a certain time, was found sometimes to not only elicit client and psychologist stress, but had the tendency of adding further shame related to non-performance to the clients, reinforcing negative self-perceptions. Therapists tended to manage the occasional homework tasks tentatively, especially with clients who did not respond well to the more structured approach. Tom (P) described how he approached behavioural tasks. He said,

“I work with the here and now. Even if there is homework, I’ll let them bring that up, raise it or say,” How did it go?” It’s always a suggestion” (Appendix L, p43)

Sam (P) said,

“It’s not so much my style but I don’t generally do this with him either. But sending him with homework, loading him up with things to do. I have never done that much with him. Some people’s issues are different. They want to go away and work on things. He is not so much of that nature” (Appendix L, p289)

Unrealistic expectations were removed by therapists with facilitation of client control. Henrietta (C) confirmed her appreciation of this approach with Andrew (P) in enabling her space to process trauma issues. She said,

“I think with that really deep work on the trauma, it’s important not to have any pressure, for me. Well for anyone. So, yeah. I think that is the key with him” (Appendix K, p159)

Infrequently, in the findings of the current study clients reported appreciating very clear, regular behavioural goals to work towards. For example, Kristen (C) liked having weight loss as a goal of her therapy. She said,

“We have goals. So we have a set of goals that we have written down. And we are always working towards those goals” (Appendix L, p300)

Clients varied in what they benefited from with respect to goals. Overall, clients did not like rigidly imposed goals, and were often unaware of what their goals were, as they were integrated smoothly into their therapy. Psychologists adapted their approach with the individual clients in the beginning and over time, as different issues emerged.

Felicity (P) said,

“It unfolded, rather than me having a format, you know goals or a schedule, it unfolded. We went in the direction that his energy was at. Also, sometimes his energy was being suppressed and covered up by superficial day to day stuff, so it was kind of going where

you know he was at, and trying to be mindful of where he was at and to try and focus on that” (Appendix L,p29)

For example, Henrietta (C) said,

“I mean I actually had a session with Andrew (P) yesterday and it started off saying that I felt that I had to be a bit more together and have a goal and you know make use of the time, and he just did a process with me to take me back into the present moment, to stop me panicking about time and pressure, and yeah” (Appendix K, p159)

Avoidant clients however, required more directiveness from the therapists with goals and intervention. Felicity (P) explained,

“So with Peter (C), he kind of had that avoidant bit, and so you um, had to at certain times work on that avoided bit, that you had worked out together that, that was what you were going to work on” (Appendix L,p61)

As described in the previous section, some psychologists became increasingly goal focused at times to address specific trauma work with clients, which involved collaboration and client choice, as well sometimes more directiveness from the therapists to facilitate the memory reprocessing work.

Individual differences were found amongst therapists and between clients in the present study, in addressing goals. For example, Andrew (P) described giving greater clarity around process goals for clients with greater insight. He said,

“Yeah, with some clients it is around when to be a bit more explicit around the EFT stuff. They’re the ones that have more explicit goals around emotionality or experiencing, when they say, I keep having these same experiences. What is that? I need to understand my feelings better or something” (Appendix L, p142)

Jessica (C) described having her goals adjusted after a crisis. She said,

“We didn’t ever write down a checklist, um, I think as new things arose in my life, those got dealt with, in the moment. I think a year ago I had a bad experience. You know I was doing pretty well then, that happened and then all of a sudden there was a shift into managing that and um, that was very much I want. I want as much as I can get, or as much as I can afford. And it was shifting through that. But it has always been very adaptive. What my needs were at that time” (Appendix K, p246)

Going back over goals was a way to build on strengths in the client and highlighted positive changes that may be overlooked in long-term work. Liz (P) said,

“When she finished therapy, it was because she had met her therapeutic goals. Because I would have taken a list of goals early on...And often I go back when I feel that they are doing really well, I often go back at what you hoped to do here and let’s see how you go”
(Appendix L,p132)

This finding aligned with a Positive Psychology approach (Hefferon, & Boniwell, 2011) of emphasising clients’ abilities and instilling hope.

Overall, the findings of the current study found that broad, flexible goals and working in the present moment experiences in sessions were supported, guided by the therapist. Flexibility and an absence of pressure emerged as paramount, and maximisation of client control, however an individualised approach in which each client was treated according to what was most beneficial for them, was carefully tailored by therapists.

In the literature, the nature and emphasis on goals was found to differ amongst trauma specialists, however there was general agreement that goals, structure and focus were important when working with survivors of complex trauma (Chu, 2011; Courtois & Ford, 2013; Fisher, 2001; Kinsler et al., 2009; Pavio & Pascual-Leone, 2010). Clinicians were guided to develop the goals together with clients (Kezelman & Stravropoulos, 2012; Paivio & Pascual-Leone) aligning with the collaborative aspect of alliance theory as described by Bordin (1979). This was somewhat supported by therapists in the findings of the present study, however was less so for many of the clients who were not particularly concerned about goals. For some clients, the goals seemed to be smoothly integrated into the therapy session in such a way that they did not recognise them as goals. The findings of the present study support the notion that therapists are more responsible for the alliance, also found in some studies that examined clients’ subjective experience in early alliance (Bachelor, 1995; Bedi et al., 2005b, Bedi, 2006), and contrasted to some extent the collaborative, goal consensus approach (Hatcher & Barends, 1996; Norcross & Wampold, 2011).

In support of these findings, Bedi (2005b) conducted research with 40 past or current clients who were interviewed in relation to critical incidences during the therapeutic encounter. Only 33% of clients considered their own contribution as important, indicating that the therapist was mainly responsible. These results put into

question the notion of collaboration with the alliance. Within the findings of the current study client goals were not a strong focus overtly for clients. Psychologists however, described detailed case formulations during the research interviews and described practice which was focused on understanding the clients' difficulties and needs.

It was possible that broader goals such as increasing self-awareness and being able to more freely express yourself in the world (Rogers, 1967; 2007) which were more covert were not considered as goals by the clients. Nonetheless therapists had a range of theory and research driven goals which were not always shared with clients. It may have been that the therapeutic relationship itself was a goal (Cloitre, Bryant & Schnyder, 2015; Courtois & Ford, 2013; Elliot et al., 2004; Paivio & Pascual-Leone, 2010), which was experienced rather than operationalised.

The less overt goal focus differed with literature by trauma specialists, and also with alliance theory. Perhaps the clients trusted that the psychologists were leading them in a productive direction, aligning with Bedi's (2005b) notion of therapist responsibility and not always requiring client input to reach their goals. It may also have been explained by the long-term nature of the clients interviewed, who may have had broad long-term goals that did not emerge as important during the interview process. It was possible that clients were noticing positive changes in their lives as a result of the therapeutic experience, and hence this was sufficient for them to trust their therapist and the therapeutic process, and as a result did not need the goals to be made explicit. Alternatively, the experienced therapists may have integrated the goals skilfully into the therapy and, hence they did not stand out as a main focus, while minimising client concerns with performance pressure.

The clients and psychologists examined in the current study, did regard collaboration as highly important, within interventions and tasks, as described in the previous section. An exception being during a crisis, when the therapists took a more assertive and directive stance. Hence the collaboration and mutuality were imperative, in this instance, again maximising client control and minimising pressure and expectation. Therapists articulated clearly therapeutic direction and intentions, and clients were confident and trusting in the direction of therapy.

Goal consensus and collaboration featured in Bordin's (1979) concept of the working alliance, have been shown to have positive effects in therapy across research studies (Hatcher & Barends, 1996; Norcross & Wampold, 2011). For example, Fitzpatrick, Janzen, Chamodraka, Gamberg, and Blake (2009) interviewed 15 depressed

clients finding that client and therapist factors were important. In some instances this has been supported in other alliance studies (Ackerman & Hilsroth, 2003; Hyman, 2011), while in other studies collaboration did not emerge as important (Bachelor, 1995; Bedi et al., 2005b, 2006).

The notion of specific goals was also somewhat complicated with trauma clients as their concerns have been found to be widespread and multifaceted, presenting with an extensive array of possible areas of assessment and intervention (Cloitre, 2015; Foa et al., 2009; Paivio & Pascual-Leone, 2010; Weathers, et al., 2009). The findings of the present study also supported the notion of broad goals with flexibility. Many of the clients presented for therapy with problematic symptoms initially, with trauma content emerging after the clients had established that their therapist was trustworthy. Even when the clients trusted the therapist, they made decisions about when to disclose certain issues themselves, with some clients continuing to withhold information after years of therapy, highlighting the importance of client contribution. This notion deepened the complexity of the alliance in establishing goals and direction collaboratively and overtly, around issues such as timing, content and depth of disclosure. It suggested an openness, uncertainty and flexibility within the collaborative process was required with survivors of childhood trauma in contrast to rigidly imposed goals within deadlines, often expected when Government funded bodies are involved.

Recently, trauma therapists have been encouraged to remain open when implementing evidence based trauma treatment in contrast to rigidly abiding by manuals or expectations within a particular method. Ongoing adaptation aligned with a more flexible and individualised approach (Cloitre, 2015; Moloney & Andrew, 2016).

6.4 Directiveness During a Crisis

Clients and psychologists in the present study described the importance of taking control and leading during times of crisis. This included taking decisive action as well as helping clients to emotionally regulate. Belinda (C) pointed out,

“Adriana (P) was able to calm me down” (during periods of hyperarousal) (Appendix K, p10)

Firm control by the psychologists was appreciated by the clients and found useful during a crisis. This included directiveness towards utilising other services,

increasing session frequency and asserting client activity. Antoinette (C) summarised in relation to Liz (P),

“She took charge and made me feel like we could get the depression under control, and straight away she put things in place. I needed someone who would say right let’s fix it. And although it is my ultimate decision, I am not always well enough to make those decisions” (Appendix K, p116)

Increased directiveness and collaboration during a crisis was indicated through the findings of the current study and was supported in the trauma literature generally. Empowering the clients with coping strategies while also assisting the client to restore safety was suggested by Kezelman and Stravropoulos (2012) in the Adults Surviving Child Abuse (ASCA) guidelines, using distraction, self-soothing, mindfulness and problem solving. Furthermore, increased directiveness through more focused probing was recommended by Elliot and colleagues (2005) while maintaining a mutual consultative approach. For example, asking the client if he has a suicide plan, and being open to the possibility of suicide, while also empathising and attempting to understand the motivation behind the client’s strategy, such as to gain mastery during an exceedingly difficult time (Elliot et al). Depth of discussion in this area was outside the scope of this thesis, however Konrad and Jobes (2011) offer literature related to the importance of the alliance with the suicidal client.

6.5 Summary of Findings Related to Power and Control

Clients in the current study who commented on the area of power and control appreciated being able to have control, and to say ‘no’ to an intervention that they did not like. Clients were challenged in ways that were adapted to them, from being delivered gently to being quite direct. Some therapists nudged their clients actively in to experiential discomfort, while others were less directive. Clients commented on appreciating both approaches. Clients described a slow pace, minimisation of power differential, and an absence of pressure on progress as important. Clients generally trusted that their therapists were guiding them in a productive direction and were often not aware of collaborative goals.

Psychologists gave their clients choices, control and collaboration with therapeutic events with a slow pace and absence of pressure to perform to deadlines. Therapists varied in their degree of directiveness with exposure or trauma processing

work. Some did not probe for details, rather allowed the client's story to unfold, whereas others set up an arrangement of working directly with the trauma material each session. Psychologists' approaches were delivered with deep empathy and acceptance and were adapted for the client. Goals were applied to psychotherapeutic knowledge, however these were not necessarily shared overtly to clients. Working in the present moment maximised client control and created flexibility of goals in any given session, although avoidant clients required increased directiveness from their therapists. This was made overt by therapists and was agreed upon collaboratively.

CHAPTER 7 ALLIANCE PROBLEMS AND REPAIR WORK

This chapter incorporates; an examination of both the fragility and the resilience in strong long-term relationships; the qualities that make up effective repair work; helping clients to take their share of responsibility in the alliance problem; an outline of the repair process; dealing with clients who are confrontational; the powerful effects of apology; and an exploration of clients who had undisclosed issues with their trusted therapists. The findings of the current study have been summarised with comparisons and differences discussed in relation to the literature and the research in this area.

7.0 The Fragility and Resilience in Long-Term, Trusting Relationships

The difficulties that complex trauma clients have with trust has been well documented (Paivio & Pascual-Leone, 2010; van der Kolk et al., 2005) and the findings of the present study on the one hand support the fragility of the alliance with these clients, as well as reinforcing the potential for repair work. As mentioned in earlier chapters, due to the neglectful or abusive childhood relationship experiences, survivors of childhood trauma have been found to frequently misconstrue therapists resulting in intense feelings of abandonment, rejection and blame (Kinsler, Courtois and Frankel, 2009; Paivio & Pascual-Leone; van der Kolk et al.). Disengagement from therapy was common if these issues were left unattended (Courtois & Ford, 2013; Kinsler et al.).

Some long-term clients in this current study, in their established and secure relationship with their trusted psychologists, were found to be easily triggered into feelings of abandonment, confusion, rejection, or negative self-perceptions. For example, Bess (C) found Georgie's (P) evocative words difficult to hear,

“And she kind of said, you know you need to be pushing your comfort zone in the outside world a bit too. And I went home and got pissed off with her I guess, and I guess I resolved it before I got to the next session, it was “she’s right”. Um, I guess it was more that nurturing and I found that quite abrupt, not that she wasn’t caring in her delivery. It was the first time that she got a bit assertive with me in that way, so I guess that upset me

a bit..... So resolving it, I told her I was angry with her in the next session and she said I thought you might have been and we laughed about it, and moved on” (Appendix K, p131)

The example of Bess (C) underscores how easily hurt some of the more sensitive survivors of complex trauma can be when challenged, even when delivered with empathy. It also highlighted the potential for a straight forward repair process, when the alliance was strong. The above issue was brought forward by the client with the therapist responding in an open, non-reactive and accepting manner.

Another example of an alliance rupture occurred to Bess (C) when Georgie (P) failed to hug her at the end of an evocative session which touched Bess’s (C) vulnerability. This ritual had been established for a long period of time. Bess (C) was left feeling uncertain and upset. Changing routine behaviours and rituals within the alliance was demonstrated as essential for maintaining safety for Bess (C), and when changed without explanation was found to be extremely triggering.

“There was one day I walked out and I started crying and she said, what’s wrong? And I said, you didn’t hug me. And then I got teary, and then she explained (at the next session) that she was having a hot flush and she didn’t want anyone touching her. I said I didn’t blame you.. And she forgot to tell me. And that’s how important.....She is always in tune, but of course to talk, to be mindful, and that’s what I have learned with my children. Talk. If you are feeling shit right now, tell me. I can’t read you. Communicate with me. And that’s what I say with my kids, I say Mummy’s angry, but it’s not you doing it” (Appendix K, p175)

The rupture was resolved easily again with Bess (C), initiated by the therapist noticing the client vulnerability, and enquiring empathically. When Bess (C) explained her reaction, Georgie (P) was able to give a reason which made sense, reassuring Bess (C) and resolving the sense of instability in the alliance through a brief discussion. Giving clients affection can be a controversial area of therapy which was not explored in depth within the parameters of this thesis.

Karin (P) described responding to alliance issues that emerged with one of her clients, Holly (C). She said,

“She would write me letters after a certain session. It didn’t happen regularly, maybe once or twice, when she would say, I felt criticised when you said this, or I felt you weren’t really listening or that you had closed off, or have I done something to offend

you, or am I not, am I boring you? These aren't her words but it was that sort of stuff"
(Appendix L, p)

Karin (P) adopted the approach addressing the concerns that had been expressed in the letter in the next session to inquire into Holly's (C) response and to clarify and correct her actual feelings and motivations in relation to Holly (C). This was implemented non-defensively and with compassionate understanding by Karin (P). Karin (P) described her approach,

"I got your letter and um, I was really worried to see that it seems that there's something that I might have said or that was done that made you feel this way and I am just wondering if we would be able to talk about it a little bit more, because I think there has been a bit of a misunderstanding" (Appendix, L, p98)

Karin (P) was open to taking responsibility towards the rupture when communicating with Holly (C). She was successfully able to reassure her and to resolve the problem and move forward on a number of occasions with Holly (C).

For Cathy (P) rupture repair work was a normal part of therapy. Sometimes a rupture occurred as a result of her forgetting client details. For example, Cathy (P) said,

"And sometimes there might, the rupture might just be sometimes that I have got a detail wrong, or I might have forgotten something" (Appendix L, p217)

She described noticing the alliance issue and being honest about her mistakes, in the moment. The issue was resolved through dialogue and apology with her clients.

A more complicated example of an alliance rupture with a long-term client and trusted, psychologist involved Sharni (C). In this instance dropout was threatened and a longer, more extensive repair process was required to mend the rupture. Dann (P) sent a text message right at the end of a session responding to an urgent personal matter. Intense and painful feelings were elicited in Sharni (C), including a deep sense of rejection. She felt confused and angry, and as though the trust between herself and Dann (P) had been disrupted. She had a sense that *"not even you can listen to me"*. Sharni (C) cancelled her next appointment via email. Dann (P) was able to repair the alliance rupture through initiating and maintaining email contact initially before Sharni (C) was able to return to sessions and they then explored what had happened for both of them.

The examples of Sharni (C), Holly (C) and Bess (C) highlighted the fragility of the established and strong alliance when working with survivors of childhood trauma,

throughout all stages of therapy. In all of these examples, the clients experienced considerable distress as a result of the alliance rupture, however the therapists both noticed the clients' reactions and non-verbal behaviours, and responded proactively to address the issues promptly, with a resultant positive resolution. Most of the alliance ruptures described by clients in the present study involved previous therapists or practitioners rather than their current psychologists. This may be as a result of clients sorting out problems with their current psychologist, and moving forward within a strong alliance. Cathy (P) stated,

“I imagine that there were many things like that but because I am following and checking in with her step by step, because that part of the way I work is really important because you are guaranteed of ruptures, but if you notice them at the time, you pull it in. I imagine there may have been a time that I didn't notice it, but if that was the case she was still able to keep coming back so. There was enough of that moment to moment checking in with her that enabled us to get through that kind of stuff” (Appendix L, p217)

As described by the psychologists in this current study, misunderstandings have been considered by experts as a naturally occurring part of the therapeutic encounter with complex trauma clients (Chu, 2011; Courtois & Ford, 2013; Paivio & Pascual-Leone, 2010). They have been found empirically to be a frequently occurring event in therapy with Exposure Therapy for those with and without PTSD diagnoses (Aguirre McLaughlin, Youngstrom, Keller, Feeny, & Zoellner, 2014). Overall the resolution of ruptures has also been found to have the potential to yield benefits in positive alliance changes once the rupture was resolved (Barber & Safran, 2010; Hill & Knox, 2009). If these ruptures were left unresolved there was a risk of dropout, disrupted trust and interruption to the therapeutic process (Watson & Greenberg, 2000) as exemplified with Sharni (C) in the current study.

Attachment Theory expert Jeremy Holmes (2014) likens the therapeutic alliance to the relationship between parent and child. Just as a parent needed to repair ruptures in parenting with children, so too does a therapist need to address ruptures that were expected to occur in the duration of the therapeutic relationship. Therapists making mistakes was seen as normal practice. The importance lies in having the skills, knowledge and emotional openness to repair the ruptures within our therapeutic alliance with our clients (Elliot et al., 2005; Hill & Knox, 2009; Holmes). Relational repair has also been found important in the development of secure relationships. Without this the

therapeutic relationship risks becoming insecure, and can repeat childhood experiences of attachment figures being unavailable and unreliable, thus reinforcing insecure attachment styles in the clients (Holmes; Kinsler, Courtois and Frankel, 2009; Paivio & Pascual-Leone, 2010). This would be considered a therapeutically damaging experience and likelihood of dropout would be extremely high. The findings of the present study also highlighted the fragility of a secure therapeutic relationship becoming temporarily insecure, even when the relationship was trustworthy and established, and how the security of the alliance was rebalanced once the repair work had been completed effectively. Within a strong alliance this was sometimes straightforward, and at other times it required more extensive repair work.

7.1 Qualities of Effective Repair Work with Survivors of Childhood Trauma

Clients in the current study appreciated their therapists' openness to discuss issues or potential concerns with clients related to the alliance, having the courage to bring them up directly with their clients early, perhaps with preventative benefits. Cathy (P) described responding to her own intuitive sensing related to a possible alliance rupture related to her unavailability,

“And you know to be able to talk through things, you know to be able to name, I thought that you were really annoyed with me because I didn't have any appointments with you last week” (Appendix L, p107)

Cathy (P) probed for alliance difficulties when she pre-empted that Antoinette (C) may have been upset about Cathy's (P) inability to schedule her a session. She did not wait for Antoinette (C) to bring the issue forward, rather initiated the conversation herself.

Jenna (P) was honest about her own uncertainty related to Brad's (C) progress,

“Because you can really struggle with clients at times. Really, really struggle. And sometimes to be honest with the client about that. You know. I have said to him. I am wondering about me. I am wondering about where we are getting to. In a way that conversation helps to work out what's in him, what's in the therapist and what's in between” (Appendix L, p278)

In each of these examples there was an absence of power issues or expert stance taken by the therapists. The therapists were unassuming, and unreactive. They were able

to take initiative and responsibility related to the alliance rupture with an absence of defensiveness or criticism. The approach was mutual and collaborative, explored with therapist care and concern, and in a non-blaming manner.

Tina (C) after describing some alliance irritations related to her therapy with her psychologist Georgie (P), affirmed that perfection was neither possible nor necessary for effective therapeutic alliance,

“Having said that, her overall attitude to you carries you through little things like that. Because I can go oh, it feels like she really doesn’t care about me at the moment, but I know that that is my stuff. I think that is the other thing about Georgie (P), she’s um, lived a lot of this stuff,.....um, whether I knew that or not, I get a real sense that she really gets the pain of certain things and about how absolutely difficult it is, and with other psychologists I got the impression of that professional understanding and again it’s that genuineness” (Appendix K, p139)

It seemed that Georgie’s (P) empathy, genuineness and presence with Tina’s (C) painful experiences helped to alleviate the impact of triggering that may have occurred through the alliance ruptures.

Jessica (C) found that she felt comfortable enough with Louise (P) to bring forward the issues to her also. She said,

“I guess I found that I didn’t really have stuff that I hid from Louise (P). There were times when I really wanted to, not bring stuff into the room, but I trusted her enough and believed in her ability to do that enough, that I wouldn’t do that” (Appendix K , p247)

Jessica (C) also described a responsibility and risk taking that she was prepared to partake in to disclose to Louise (P). It was perceived as safe and manageable enough. Ten of the psychologists had clients who responded that there were no hidden alliance issues with their current psychologists. They had been able to share their issues and resolve them, either initiated by themselves or their psychologists. Some of these clients continued to withhold information about themselves, sometimes after years of therapy, however they claimed this was not reportedly as a result of the alliance. These clients said that the timing was not right for them, highlighting a blend of therapist and client factors affecting the disclosure.

An example of a collaborative rupture repair involved Dann (P). She had an incident which triggered Sharni (C) into disengaging temporarily from her counselling,

as mentioned previously. Dann (P) recognised Sharni's (C) withdrawal as an alliance rupture and actively initiated a mutual repair process. Dann (P) engaged with Sharni (C) with a minimisation of power differential, in an exploration to find out what had been elicited in both Sharni (C) and himself. Dann (P) said,

Working out your part, and also working out what may have been triggered for herand working through it together (Appendix L, p49)

This repair process was non-blaming and worked through calmly and empathically. Dann (P) was able to make contact with Sharni (C) after she cancelled her session saying,

"I wasn't happy with it, um, and I think I'll end the relationship, but you know I have been very happy with you, except for this bit..... because I also said to her in the email that I thought that he wasn't interested." (Appendix K, p55)

Dann (P) recognised the alliance rupture and actively reengaged with Sharni (C). Dann (P) firstly responded to the initial email with an appreciation of receiving Sharni's (C) email, an acknowledgement of the problem, an explanation of why he had made the text message, and she gave an apology for what had happened. Dann (P) encouraged Sharni (C) to return to her sessions with an absence of power or coercion. He said,

"I'd really like to be able to talk to you about it in person. I'll leave your appointment free on Saturday, so let me know if you want to come between now and then" (Appendix L, p48)

Dann (P) apologised in the initial email and requested to speak to Sharni (C) in a session about what had happened. She gave Sharni (C) choice, however also actively engaged in a way which encouraged reconnection. Sharni (C) felt safe enough to return to therapy. The issues were then discussed further at her next few appointments, with reference to present moment experiences as well as childhood parallels in relation to unmet needs and triggering points. In the end an action of not ever using the mobile phone again in his sessions, was agreed upon. Sharni (C) seemed satisfied with the resolution.

Although Dann (P) disagreed with some of what Sharni (C) had stated, she maintained her own position in the relationship and assisted Sharni (C) to take responsibility for her part. Dann (P) said,

“She said, you weren’t very interested in the session, which wasn’t true. I was quite engaged” (Appendix L, p47)

There was nonetheless an absence of a power battle or of defensiveness in Dann (P) during the repair process. She reassured Sharni (C),

“I said in response to your feeling that I am not interested in you and your sessions, that’s not my experience, that I do feel interested and engaged in your therapy” (Appendix L, p48)

There was also further evidence that Dann (P) took responsibility for his part in the rupture through verbalising to the interviewer that he was “feeling bad’ and ‘stressed’ about the event, and through his apology. He questioned his own behaviour thoroughly during the repair process.

“Was I attentive or wasn’t I? And how to kind of use that” (Appendix L, p49)

It was an enquiry with a client focus.

“To think, oh maybe, what’s going on for her” (Appendix L, p49)

Dann (P) was able to manage his own difficult feelings with the support of his colleagues without reacting or taking it out on Sharni (C).

“But those kind of ruptures are hard kind of ruptures are hard you know.....It’s like you are kind of impacted” (Appendix L, p49)

A successful resolution was achieved through working through this process. Dann (P) acknowledged the difficulty of the repair process during the interview, and explained that he had sought supervision to assist him in managing the situation effectively, and to process the impact on himself. He also commented that doing his own therapy had assisted him not to react,

“But also I think the more work you have done on yourself (counselling) the more open you are able to be about your mistakes. There are these practitioners in my course and they are so defended. They are always experts, you know, always diagnosing people, you know this is what I do (said assertively)” (Appendix L, p60)

Dann’s (P) humbleness was apparent in this example, as was his lack of expert stance and willingness to seek assistance in order to resolve the situation effectively for Sharni (C) and himself.

Therapists in the current study emphasised taking a decent share of responsibility in dealing with difficulties within the alliance themselves, as well as assisting their clients to take responsibility for their part of it. When therapists owned their part in the conflict, the clients reportedly felt validated and reassured that they were not being blamed. This process strengthened the alliance and had a positive effect on how the clients related to themselves in the current study.

Psychologists described a balancing of responsibilities between the clients and themselves. Irene (P) points out,

“And you know iron them out when they mistreat the relationship, but in it we could own a little bit more of it. It is our job to predict a little bit” (Appendix L, p75)

She explained that we can expect that clients will stretch the limits of the relationship, as a teenager does with parents. She added that therapists were required to manage this, compassionately and actively, while also giving these clients some leeway. A balance between empathy, flexibility, transparency and responsibility emerged.

As found in the current research, therapist openness and attentive listening to the clients' problem without reactivity, sharing the therapists' experience, owning the therapists' contribution, as well as also instilling a sense of responsibility in the clients, was agreed upon in alliance research and literature (Barber & Safran, 2010; Elliot et al., 2005; Hill & Knox, 2009; Kinsler, Courtois and Frankel, 2009; Paivio & Pascual-Leone, 2010). A non-blaming approach in which the therapists take responsibility for managing the alliance difficulty between the client and therapist, has been supported in previous research (Elliot et al., 2005; Hill & Knox; Rhodes et al., 1994). Furthermore the importance of therapists admitting that they have made mistakes and having the flexibility to make changes and work through the problems has been supported (Elliot et al., 2011; Watson & Greenberg, 2000).

The findings of the current study extend previous findings in that several psychologists were prepared to take on relatively more responsibility in the rupture, and allowed a high level of flexibility related to the event and in the repair process. This may be as a result of many survivors of childhood trauma having had experiences of being blamed during childhood, with resultant high sensitivities to feeling responsible and blamed by others during adulthood. By the therapists taking on a generous proportion of responsibility, they may be perceived as safer and overtly different to

early abusive, blaming adult attachment figures who failed to take adequate responsibility.

7.2 Client Responsibility during Alliance Repair Process

Although clients in the findings of the current study responded well to the therapists taking on a good share of responsibility in the alliance difficulty, they also reported wanting to be held accountable in the therapeutic relationship. They appreciated being held responsible relationally by the therapist. Catriona (C) said,

“She wouldn’t let me get away with just cutting off” (Appendix K, p88)

Catriona (C) went onto to explain that Irene (P) insisted that she discuss the concern rather than avoid it, which she liked.

Psychologists had difficult conversations related to the alliance with their clients and sometimes it was hard for the clients to hear the negative feedback, however clients appreciated it in the long-term. Michael (C) was challenged by his psychologist Sam (P), who raised his dishonesty and attitude to fee payment. Sam (P) managed the situation firmly, empathically and flexibly. He described,

“He would promise me he would pay me next week and he would turn up with no money.....He was 10 minutes late, and so we had to attend to some of these. And I think the issue for me was to use these as therapeutic material rather than punishing him, which was his fantasy that I was going to yell and scream at him. So what I attempted to do was to use those occasions to bring it into the dialogue between us.....So that if he didn’t pay I would say well I am disappointed that you didn’t pay me today, but I am not going to reject you. And I expect that you will pay me when you can. But there is a limit. I don’t want this to go beyond \$500 or that would begin to worry me” (Appendix L, p285)

Sam (P) responded to Michael’s (C) behaviour through actively avoiding repeating his childhood trauma experiences, and with a motivation to use the alliance problem as a learning experience. There was an absence of overt judgment, pathologising or impatience with Michael (C) and an underlying deep sense of caring for his well-being. Michael (C) reported appreciating Sam’s (P) directness related to confronting him on his lateness and fee paying issues, while also enhancing a sense of genuine caring for him through his fee paying flexibility. Michael (C) said that Sam (P) held him responsible by saying,

“I am a straight shooter. When you tell me you are going to do something I do it.....yeah. And it was cutting as well, because I knew that he was annoyed at me. But he was right” (Appendix K, p349)

Whilst feeling somewhat hurt and triggered, Michael (C) described handling those feelings and beginning to take responsibility related to the alliance and his problematic behaviour.

7.3 Alliance Repair Process

The rupture repair process has been investigated by Safran and Muran and colleagues since the 1990's (Safran, Muran, & Samstag, 1994; Safran & Muran, 1996) through task analyses which identified different steps that were required to achieve successful rupture repair resolution. These steps involved the therapist recognising and addressing the rupture directly, examining with the client what happened during the problematic event, finding mutual understanding of the event through discussion with the client, identifying fear and avoidance behaviour, and determining if there was an underlying unmet need or wish of the client. This may involve clients' experiences of vulnerability (Coutinho, Ribeiro, Hill, & Safran, 2011). Since this time various other alliance repair process models have been proposed (e.g., Bennett, Parry & Ryle, 2006; Elliot et al., 2005; Rhodes, Hill, Thompson, & Elliot, 1994; Safran & Muran, 2000). Although all models involve similar collaborative steps as those described by Safran and Muran (1994; 1996), there was variation in the emphasis on delivery of the repair process.

In the current study a high level of compassion, humanness and openness in the therapists was found during repair work, which has been more emphasised by Elliot and colleague's (2005) alliance repair approach. Elliot et al. suggested a five step process which parallels Safran and Muran's (1996) model which elaborated on the therapists sharing of their experience, and with increased emphasis on an empathic and transparent delivery throughout the process. They emphasised Rogerian conditions of genuineness, therapists' presence, empathy, responsiveness, and validation during the repair process. For example, inquiring of the client using a slow, warm voice, and maintaining an openness to what the client was saying. Aligning with a strong Rogerian stance the psychologists in this current study demonstrated high levels of compassion,

responsiveness and presence with the clients, while also taking on a good part of the responsibility in the alliance rupture during the repair process.

Metacommunication has been emphasised as important and restorative by some alliance researchers (Hill and Knox, 2009; Safran & Muran, 2000; Watson & Greenberg, 2000). This refers to a discussion held between therapist and client about what happened in the moment of the alliance problem, including exploration and acceptance of feelings related to each other that may have emerged. In working through this process together, the opportunity to resolve problems and difficulties within the alliance can occur. This relational approach was thought to be therapeutic in and of itself, as a vehicle for change, and with the potential for improved relationships outside of the therapeutic space (Hill & Knox; Safran & Muran; Elliot et al., 2005). Psychologists in the current study were found to sometimes work through a more elaborate repair process aligning with alliance repair models and including metacommunication, while at other times the problem was resolved briefly and simply through a short dialogue. The strong, established alliance, with advanced empathy, deep levels of acceptance and an absence of power and control issues may in some instances have reduced the need for an in depth repair process, with these survivors of childhood trauma.

Some qualitative studies have revealed important factors related to therapists during the alliance repair process which aligned with the findings of the current study. Rhodes, Hill, Thompson, & Elliot (1994) retrospectively examined 19 therapists or therapists in training through questionnaires about their experiences as clients. They specifically examined resolved and unresolved rupture events, finding that when the ruptures were resolved, therapists were told by clients what the problem was, had worked through to explore the problem together, the therapists were willing to take responsibility, and to sometimes apologise to the clients. Conversely for unresolved ruptures, therapists were found to not be open to hearing the client concern, they did not explore the issue adequately and were rigid in their stance (Rhodes et al., 1994).

Hill, Nutt Williams, Heaton, Thompson, and Rhodes (1996) qualitatively researched 12 experienced therapists through questionnaires and interviews, regarding situations in which the clients discontinued therapy as a result of an alliance rupture. All of the therapists except one had explored the situation with the clients with reference to past and present relationship experiences, however were unsuccessful in repairing the

alliance rupture. Therapists were found to be unable to establish goals and tasks that the clients were agreeable with, were too directive, had negative reactions towards their clients, used incorrect diagnoses or shifted strategies too frequently. These findings aligned with Rhodes and colleagues (1994) that negative therapist factors interfere with good resolution.

7.4 Dealing with Confrontational Clients

Sometimes clients in the current study confronted their psychologists directly when they had experienced a difficulty in the alliance, and were able to successfully resolve the problem. Some examples have been highlighted below.

Catriona (C) who presented as a strong, direct, and straight to the point individual, felt at ease to speak honestly to her therapist, Irene (P). For example, when asked about any negative interactions with Irene (P), Catriona (C) said,

“We have very open communication, and I feel completely confident that I can say whatever I want to. So I could say, so that’s not right, or no, I totally disagree with you or, whatever...On occasions I have said no, that’s not quite the way it is for me, and she listens and hears my alternate point of view and we move on” (Appendix K, p113)

Catriona (C) described feeling safe to express herself freely with therapist, Irene (P). She responded well to Irene’s (P) ability to actively hear Catriona’s (C) experiences with an absence of reactivity, defensiveness, or a sense of superiority. During the interview, there was an absence of Irene (P) feeling intimidated or threatened by Catriona (C) expressing herself directly.

Another client, Hannah (C) also presented as a forthright, individual who expressed herself overtly, with strong opinions. She confronted psychologist, Cathy (P) directly about a mistake in her recall of Hannah’s (C) narrative. Cathy (P) described feeling a ‘twinge’ when this happened. Regardless, Cathy (P) was able to remain non-defensive and contained her emotions. Cathy’s (P) strategy included noticing the critical comment, exploring how this impacted on herself, and having a discussion with Hannah (C) about the issue. Cathy (P) then apologised for her mistake. During the interview she said,

“Because I can’t possibly hold everything, and so sometimes, they are the ones that you might make. They might say oh, that’s such and such and sometimes I can feel it. That’s

in terms of myself that I have got it wrong. So in terms of clients that I would own up to that, that I have got it wrong” (Appendix L, p217)

Cathy (P) was willing to admit that she had made a mistake and was transparent in her explanation to Hannah (C). She presented with an absence of expert stance, and even though in the moment she felt attacked, did not reactively attack back at Hannah (C).

Louise (P) responded to confrontations from Jessica (C), a feisty, upfront young woman in a calm and non-reactive manner.

“It happened once when she called me on something.....(When asked what her response was..) Well, non-defensive which was I think was really important, because her father is almost violently defensive” (Appendix L, p203)

Louise (P) was client focused and conscious of not repeating Jessica’s (C) childhood experiences through avoiding expressions of aggression. She went on to describe the importance of an honest, genuine approach with an absence of authority. Louise (P) did not appear to be negatively affected or intimidated by Jessica’s confrontational approach.

In the above examples of clients who confronted their psychologists with alliance problems, the therapists were found to maintain a non-defensive and non-reactive stance aligning with research findings (e.g. Coutinho et al., 2011; Hill & Knox, 2009). Safran & Muran (2000) differentiated two types of client response to alliance rupture; firstly, that the client withdraws; and secondly, that they confront the therapist. Similar patterns have been observed by various trauma experts who found clients to withdraw and avoid during alliance concerns, while at other times they were found to confront their therapist through challenging or critical attack (Elliot et al., 2005; Holmes, 2014; Paivio and Pascual-Leone, 2010).

In some research studies client confrontation has been found to be often delivered in a hostile manner, with clients having shared their disapproval through critical attack or rejection of the therapist’s intentions. Clients at times have been found to become directive and somewhat demanding in these events that can be difficult for therapists (Coutinho, et al., 2011; Hill et al., 1996; Hill et al., 2003; Safran & Muran, 2000). Some therapists have been found to have had difficulty with clients’ hostility and anger in qualitative research studies with a resultant sense of therapist incompetence

(Hill et al.; Hill et al.). Reactivity in therapists' responses has also been found to be common in response to client hostility (Coutinho, et al.; Hill et al.; Hill et al.; Safran & Muran). Some psychologists in this present study, described complexity around the rupture repair process and difficult feelings that were evoked internally, however they did not report feeling overwhelmed or reactive about their clients' responses. They were able to separate client and self-reactions non-defensively and to take responsibility for their part while also assisting the client to work through their reactions.

For confrontational clients, therapists have been advised by alliance experts not to react or defend the client attack, rather to stay calm and to assist the client to deepen into underlying primary experiences and unmet needs and wishes (Safran & Muran, 2000; Coutinho, et al., 2011; Watson & Greenberg, 2000). Acknowledging and taking the clients' feelings seriously has been emphasised as important (Bennett, Parry & Ryle, 2006; Hill & Knox, 2009; Watson & Greenberg). Whilst maintaining boundaries, the therapist becoming increasingly vulnerable has been thought to alleviate a sense of power imbalance and restore safety in the relationship (Watson & Greenberg). A non-reactive approach generally and remaining present with the client while exploring clients' experiences in an empathic manner was supported in the findings of the current study.

Coutinho and colleagues (2011) interviewed eight therapist client dyads about alliance ruptures, including clients diagnosed with personality disorders. The doctoral student therapists were found to have difficulty managing the client confrontation, which resulted in them feeling incompetent and uncertain and reacting negatively towards their clients. Therapists' empathy tended to be affected by the clients' expression of anger. These findings differ from the current study, perhaps due to the psychologists' ability to manage the clients' anger and hostile feelings more effectively, as a result of their experience and ability to remain present to the client experiences, without taking it on personally. Psychologists may have been able to separate client and self-experiences with greater boundary clarity. It may also be as a result of the high levels of empathy and acceptance, and absence of power imbalance or expert stance, that may have diffused client hostility levels more easily with the psychologists.

Hill, Kellems, Kolchakian et al. (2003) interviewed 13 therapists about experiences with clients that involved either overtly hostile events or covert hostility. Hostile events were found to be more readily resolved when the therapists did not

exhibit challenging behaviour towards their clients, and attributed their clients' anger as related to the therapeutic relationship in contrast to personality problems. Therapists were also found to manage feelings of anxiety or incompetence that may emerge in themselves, and confronted the clients through discussion rather than avoiding. The findings of this present study found therapists were able to diffuse any power differential actively with their clients and to maintain an experiential presence with the client regardless of intense emotions, including anger. Therapists were found to be able to see beneath clients' anger to vulnerability and to remain experientially present to their clients as described in further detail in Chapter 4 on Acceptance. This contrasted with the factors found unhelpful in Hill et al's (2003) study, and seemed particularly pertinent with the survivors of childhood trauma in the current study.

7.5 Therapists' Apology during Alliance Repair Work

Psychologists in the current study were found to have a flexibility and openness to repairing alliance problems, to take on a good share of the responsibility and to be willingly able to apologise to their clients. Dann (P) said in relation to Sharni (C),

"She seemed really surprised that I took responsibility for my part in it, by apologising and saying I am sorry" (Appendix L, p48)

Another example involved Kellie (P) who said the following, in relation to her client,

"Recognising I have heard her. She has been a real complex trauma client..... She calls me a lot, she has been suicidal, over the holidays and that sort of thing. If I don't get back to her soon enough, I can injure, I can hurt her. Recognising that...You know because then I can become like her mother and I am traumatising her because she is calling me and I am not there when she needs it. Sometimes you stuff things up or, whatever. So recognising that I have hurt her ...and apologising. To heal" (Appendix L, p192)

Kellie (P) was found to be highly empathic towards her clients with a willingness to extend above and beyond usual therapist expectations of responsiveness, while maintaining a client focus and an insight into the impact of her delayed contact outside of sessions. Regardless of the client demands, Kellie (P) was consistently patient and understanding of her clients with an absence of overt reactivity or intolerance. She apologised generously, regardless of who was responsible. She said,

“Whether you are apologising for the injury to the client or the impact that it has had on the client, whether you are responsible or not. That verifies the approach that I took”
(Appendix L, p229)

Kellie (P) was broad in her approach of apology, being willing to be sorry for the impact it had had on her clients. She took a non-blaming approach, whilst also exploring from both client and therapist positions what had happened.

Hannah (C) stated in relation to her psychologist, Louise (P),

“At the end of the day Louise (P) is human too. If I said to her you have hurt my feelings, whatever, I have no doubt Louise (P) would apologise for it and try and rectify it”
(Appendix K, p302)

A confidence was conveyed towards Louise (P) in her ability to take responsibility and to apologise.

Therapist expression of remorse and ability to apologise during the process of alliance rupture repair has been emphasised in some of the alliance research (Elliot et al., 2005; Hill & Knox, 2009). Most recent alliance repair process models were found to highlight the importance of therapists taking responsibility in the alliance issue, however did not specifically define apology as a requirement (e.g., Bennett, Parry & Ryle, 2006; Safran et al., 2014). Some researchers have highlighted that an ineffective apology can have a negative impact on the alliance (Dalenberg, 2004; Hill & Knox, 2009) that has been explained below.

Some qualitative studies have explored apology during the alliance repair process. In Rhodes, Hill, Thompson, and Elliot’s (1994) study, 19 therapists or therapists in training were asked retrospectively about their experiences as clients through questionnaires. They specifically examined resolved and unresolved rupture events finding that when the ruptures were resolved, therapists were told by clients what the problem was, and had worked through to explore the problem together. The therapist was also willing to take responsibility, and to sometimes apologise to the client (Rhodes et al.).

Dalenberg’s (2004) study involved interviewing of 132 clients following trauma therapy. Questions involved exploration of therapists’ angry responses to the clients resulting in alliance ruptures. Therapists taking at least some responsibility,

psychoeducation about anger being able to be expressed in healthy relationships, and genuine apology were found to be effective. The apology was found to be most reparative, when accompanied by an attachment based explanation, for example explaining that anger was in response to deeply caring for the client. No response by the therapist was perceived as not caring, but the therapist responding angrily resulted in the client feeling pushed away. A hostile apology (Dalenberg, 2000) has been described as an apology that “simultaneously expresses sorry for the action and makes an excuse for the behaviour, typically by blaming patient pathology” (Dalenberg, 2004, p445). In an event involving client reactive anger the client’s condition is blamed in contrast to the therapist taking some responsibility. The therapist may apologise for the client feeling a certain way, however this approach was considered ineffectual. An insincere apology was considered least effective in the alliance rupture repair process (Dalenberg; Hill & Knox, 2009), highlighting the importance of genuineness and transparency which has been consistently found in the findings of the current study, and also reinforcing how powerful an authentic apology can be in assisting survivors of childhood trauma in the repair process.

Genuine remorse and apology was evident in the findings of the current study, with the therapists openly sharing their own vulnerable feelings including remorse during the repair process. As a result the apology was experienced as genuine and heartfelt by the clients, who were then able to forgive and repair the relationship.

7.6 Clients who Withheld Alliance Issues from Trusted Therapists

The clients in the current study were clear in their description of the negative events that occurred previously, however were not always able, or motivated, to speak up. This was not surprising given that the clients described experiences such as feeling judged, the therapist taking a superior stance, or lacking empathy, all of which compromised their sense of safety and trust. Several clients stated that they would not disclose alliance issues with their therapist if they did not feel safe and respected by their therapist, regardless of being prompted or not. Furthermore, some clients, even with a strong alliance, were unable to bring forward an alliance issue.

Four clients in the present study across three different psychologists presented negative material about the alliance with their current psychologist, which they had not been able to discuss with them openly. This highlighted how difficult it was for

survivors of childhood trauma to confront their therapists regarding a negative alliance issue, even when the alliance was established and strong. Presenting negative experiences related to the therapist or therapeutic intervention has been found to be difficult for clients, particularly highly pleasing clients due to the perceived risk of rejection (Safran et al., 1990). This predicament was found to emerge in several ways across clients.

For example, Shelley (C) noticed that her psychologist, Maryanne (P) tactfully shifted the direction of the counselling when she disclosed content related to death in the session.

“I get the impression that Maryanne (P) doesn’t want to go there, sometimes..... yeah a sense. Um. The conversation often gets diverted” (Appendix K, p193)

Shelley (C) had clearly identified Maryanne’s (P) avoidance patterns, however even though she trusted, respected and felt comfortable and safe with her, she was unable to share her observations. The interviewer encouraged Shelley (C) to discuss this matter with Maryanne (P), reassuring her of Maryanne’s (P) likely openness to hearing about her concerns. Shelley (C) did manage to discuss and resolve the issue with Maryanne (P) after the research interview, highlighting the potential for increased client openness in a strong alliance, when the client was prompted.

Ella (C) experienced triggering from James’s (P) regular lateness to appointments. A significant level of annoyance was triggered as well as a perception of self as unimportant in relation to him. Even though Ella (C) and James (P) had worked through other alliance problems during sessions, Ella (C) found it exceedingly difficult to bring forward this particularly behaviour. Something as simple as being on time was shown to have a profound effect on Ella (C), within the trusting therapeutic relationship. Ella (C) described James’s (P) lateness as,

“A bit of a distraction in terms of um, that I am thinking about that, rather than thinking about my counselling.....Yeah, we’re not talking about a major problem, of 20 mins late, he’s 5 minutes late. Sort of my parents are both people who don’t really care about that, about how I might feel or.....Well I guess it was a sense of being short changed, which for me, with my family of origin is a pretty constant experience... sometimes it could have created a bit of distance in some ways ...(Appendix K, p78)

During the interview Ella (C) thought that maybe it would be a good idea to discuss this issue with James (P). To date though she managed the situation herself by changing the appointment time. This example highlighted how as practitioners we can repeat childhood experiences in our clients without awareness (Holmes, 2014), with detrimental impacts of distancing and distraction in sessions, interfering negatively with the therapeutic process.

Therapist lateness was an alliance concern that also emerged with other clients interviewed in the present study. Simon (C) had experienced increased anxiety at times to unbearable levels when his therapist ran late. Although he justified her lateness because she gave her extended appointments on occasions, at times his anxiety spiked to a level that resulted in leaving and not waiting for the session. Factors such as therapist lateness, unavailability, fatigue and distractibility found in the present study have been highlighted as triggers to clients' attachment systems (Holmes, 2014), and may be sometimes outside therapist awareness.

Robyn (C) also experienced lateness with her psychologist, however was reassured through her therapist's transparency and brief self-disclosure which prevented an alliance rupture. Robyn (C) said,

"She will tell me if there is something wrong with her daughter, or if she is late because there is chaos going on somewhere. You know" (Appendix K, p372)

Brief therapist self-disclosure was a strategy described by Watson and Greenberg (2000) for the purpose of rebalancing the relationship after an alliance rupture. The above example however, appeared to have prevented the rupture from occurring. Clients reported that they withheld negative information from their trusted therapist because they were concerned about upsetting them.

Interestingly sometimes it was also found to be very difficult for the clients to bring forward positive material to the psychologists. Several clients believed that their psychologists had saved their lives. Riva (C) felt that Dann (P) had anchored her through a suicidal period, and had been unable to share this emotionally intense information with him.

"I think he was a lifeline.....that was the only thing to take a hold of , because everything else was further from me, whereas he was one of those life buoys on a piece of rope. That was the only thing I could feel I could snag" (Appendix K, p52)

The words barely capture the intensity of feelings of love and appreciation that Riva (C) depicted towards Dann (P) during the interviewing. Perhaps therapists can be reassured that there may be a depth of positivity in our clients that they also struggle sometimes to convey, which may also be outside of therapist awareness.

The responsibility that the therapists held in relation to life and death was depicted by Eleanor (C),

“If I didn’t put some sort of trust in somebody, (pause) I wasn’t going to make it at the other end” (Appendix K, p5)

The next client example highlights the significance of therapists’ role also. Dennis (C) said,

She is the only person on the planet that knows that much about me (Appendix K, p289)

Natalie (C), along a similar theme explained,

I just come to tell her because come to tell her because I haven’t got anyone (Appendix K, p362)

Henrietta (C) said that she would have appreciated increased feedback in sessions from her psychologist, Andrew (C), however had not been able to ask for it from him, even though the alliance was strong. When probed Henrietta said that if Andrew (C) had enquired, then she would have been able to ask him, indicating again the scope for enquiry into the alliance being potentially beneficial.

According to the clients interviewed in this present study, in some instances it may have been beneficial for the clients if the psychologists had prompted the conversation about the alliance. Recent recommendations from researchers involved talking openly about the alliance in sessions to clients as a means to detect alliance difficulties, perhaps using a questionnaire (Cloitre, Bryant, & Schnyder, 2015; Errazuriz et al., 2015; Miller et al., 2005; Moloney & Andrew, 2016). This was thought particularly useful for insecure clients who were less likely to disclose as openly (Errazuriz et al., 2015). Moloney and Andrew (2016) highlighted that therapists have limits to our capacity to hear feedback from our clients with therapists having a tendency to overrate their own effectiveness. Therefore a short, easily administered, validated instrument can be useful for providing feedback (Moloney & Andrew).

According to the clients interviewed in the present study, in some instances this may have been beneficial with their current therapists, however when the alliance was weak with previous practitioners, the clients reported that it was simply not worth the effort to tell their practitioner about the issues. When clients believed it was about the therapists' interests rather than their own, or if they did not experience the therapist as genuinely caring, then clients tended to withdraw, avoid and disengage. Hence ongoing monitoring and attending to the alliance (Cloitre, et al.; Errazuriz et al.; Miller et al.; Weinberg, Ronningstam, Goldblatt, & Maltzberger, 2011) was supported, however was found only to be effective when the alliance was strong, and the therapist was non-defensive and open to hearing what the client has to say.

The findings of the current study also indicated the need for therapists to be attentive to non-verbal and paralinguistic client indicators that highlight that there may be an alliance problem (Safran, Crocker, Mc main, & Murray, 1990; Watson & Greenberg, 2000), because not all clients were able to bring forward the issue. Some therapists initiated an enquiry about the alliance when they detected a negative reaction in their client. Some authors have also highlighted the need to attend to the alliance throughout therapy because at any stage, even though the alliance may be strong for some clients it can still fluctuate (Elliot et al., 2005; Hersoug, Monsen, Havik, & Hoglend, 2010; Paivio & Pascual-Leone, 2010) indicating a need for ongoing monitoring and attending to the alliance (Weinberg et al., 2011).

Being able to recognise and deal with alliance problems effectively has been agreed upon by experts in the field of the alliance and trauma as important (Elliot et al., 2005; Hill et al., 2005; Paivio & Pascual-Leone, 2010; Schore, 2012). Therapists have been guided to be attuned to clients' avoidance responses that may have occurred silently in sessions and to address these openly and actively with their clients (Elliot et al.; Hill & Knox, 2009; Holmes, 2014). Therapists in the findings of the present study were found to be attuned to minor changes in clients' behaviour and were able to bring forward tentatively the present moment experience for exploration, which had positive effects on the alliance according to both psychologists and clients. Noticing alliance rupture through attending to non-verbal and paralinguistic messages conveyed actively by the clients has been found to be necessary (Maroda, 1998; Schore, 2012; Siegel, 2012; Quillman, 2012) as well as initiating the dialogue related to the potential alliance difficulty for discussion (Watson & Greenberg, 2000). The findings of this present

study demonstrated how difficult it was for clients to share emotionally loaded issues within the psychotherapeutic context, even when the alliance was strong and established. This indicated a need for even experienced therapists to be vigilant to signs of alliance issues and to be open to a discussion on the alliance if any sign of an issue was detected.

Numerous other examples of negative events related to previous practitioners were reported by clients in the current study, however generally they were not spoken about with their therapists at that time. This may be explained due to client withdrawal, and/or the therapists not addressing the alliance issue at the time. Client withdrawal has been found to present as a problem during the repair process. When the client avoided the topic related to the rupture or appeased the therapist too readily, before the event had been thoroughly explored the repair process was interrupted (Coutinho, et al., 2011; Safran & Muran, 2000). Resolution for the withdrawn type has been defined through the therapist guiding the client to accessing the defences that were inhibiting full expression of emotions and experiences related to the rupture. This enables access to hidden underlying feelings and for unmet needs and wishes of the clients to emerge (Safran & Muran). The empathic and gently confrontational approach about the alliance issues found in the current study of psychologists involved an openness and acceptance of the client emotional experiences and a presence with the client that aligns with working through client defences.

Research has found that ineffective therapist behaviour has included responding to their clients with hostility (Coutinho et al., 2011), failure to apologise (Hill et al., 1996; Rhodes et al., 1994) and having difficulty with empathy during client confrontational repair work (Coutinho, et al.; Hill et al., 2003). Apart from the lack of empathy, the current research did not find examples of therapist hostility or failure to apologise during an alliance repair process. This may have been as a result of the questions largely being focused on what created a positive alliance. It may also have been that clients reported with previous therapists that they did not feel comfortable, safe or motivated to share their concerns with, and hence as a result of a perceived lack of safety withdrew rather than confronted these therapists. Strong alliance may be a necessity for survivors of childhood trauma to feel confident enough to confront their therapists with an alliance problem.

Numerous other clients from the current study did not recognise that they had had problems at all with the alliance with their current psychologists, perhaps because they were managed smoothly, and they had worked through the problems as they arose with resolution. Alternatively, some clients explained examples of working through small hitches in the alliance with relative ease, indicating variation in the impact of the alliance rupture. Differences in the depth of effects of ruptures and time taken to resolve has been noted previously (Safran et al., 2014), although several models that have been developed through task analysis involving a number of steps and an involved process of exploration and repair (e.g. Elliot et al., 2005; Safran & Muran, 2000; Safran et al.; Bennett, Parry & Ryle, 2006). It was possible that the strength of alliance, depth of acceptance and empathy, and the collaborative approach used by the psychologists in the current study may have influenced the resolution process positively, acting as a buffer or mediator for the repair process.

7.7 Summary of Findings related to Alliance Problems and Repair Work

The findings of the current research aligned with previous research and literature in highlighting the sensitivities of survivors of childhood trauma being triggered and having negative reactions, even within strong, established, secure therapeutic relationships. The characteristics of therapists' behaviours and the repair process found in the findings of the present study was supported in current alliance research generally (Elliot et al., 2005; Hill & Knox, 2009; Paivio & Pascual-Leone, 2010; Watson & Greenberg, 2000). A highly empathic, patient and accepting stance was taken by psychologists with an absence of power and control issues, and flexibility. Of the present clients who spoke about repair work in the alliance, the importance of psychologists' empathy, responsiveness, honesty, non-defensiveness, listening fully to the client's experience, owning a share of responsibility in the encounter and offering genuine apology and remorse, were expressed by both the clients and psychologists as important. The psychologists were found to take on more than their share of responsibility, although they did maintain boundaries and client responsibility also. Under these conditions repair work seemed to have occurred relatively smoothly. Most clients felt comfortable to bring up issues with their psychologists, who were open and non-reactive to their clients regardless of differing opinions. For the survivors of childhood trauma cohort, it may be particularly important to offer an apology and for

the therapist to take responsibility to counteract childhood experiences of being blamed and shamed.

Sometimes, however, clients were still unable to confront their psychologists. Prompting was found to assist the clients to disclose their concerns within the strong alliance. Sometimes signs of alliance problems were not overt or conscious, to even the experienced therapists. These findings highlighted the importance of being attuned to and bringing forward paralinguistic and non-verbal nuances that may indicate an alliance issue.

CHAPTER 8 CONCLUSION

The findings of the present study have revealed rich and insightful information that has highlighted essential areas that inform the alliance when working therapeutically with survivors of childhood abuse. In the final chapter, the key findings of the current study have been summarised, limitations are presented and suggestions for future research are outlined. Lastly, therapeutic implications are established in this important area, critical in advancing and improving treatment implementation for survivors of complex trauma.

8.0 The Main Findings from the Study

The aim of the current study was to deepen the understanding of the alliance with complex trauma clients, through learning more about clients' experiences and integrating these with insights from psychologists experienced in the field of complex trauma. The five broad key areas that emerged in the findings of the present study were; advanced empathy, deep acceptance, firm and flexible boundaries, mutuality in power and control, and effective repair work. Although these areas were separated for the purpose of understanding, they overlapped and intertwined, and it was in managing all of these areas while adapting to the individual clients, that enabled the survivors of childhood trauma to trust and remain engaged in therapy with their therapists.

An advanced level of empathy beyond basics emerged as essential when working therapeutically with survivors of childhood trauma. The depth of both emotional and cognitive empathy was found to be profound. Clients experienced a level of care and understanding from genuine, transparent therapists that extended beyond basic counselling skills. Clients were vigilant about their therapists' intentions, body language, emotional experiences, with clear judgments made from their observations. They were able to detect when therapists were distracted, bored, disinterested or disengaged, which reduced trust significantly. In contrast, a sense of genuine caring was conveyed through therapists' voices and presence, and also elicited from their occasional behaviours that went above and beyond usual parameters (e.g. contact outside the session, extra time in the session). The clients appreciated the close and careful tracking of their experiences by their therapists that deepened trust slowly over

time. Clients felt understood intimately by their psychologists who were able to link and make sense of past and present experiences. Therapists used their knowledge, theories and wisdom to understand their clients comprehensively. They were patient, willing and invested in their clients' experiences with a confident belief in their potential. Therapists refrained from rescuing and reinforcing avoidance patterns in their clients, and in contrast they instilled responsibility firmly, actively and empathically, adapting the level of sensitivity required as appropriate for the clients. The depth of empathy was also adjusted to attune to and to extend clients without overwhelming them, recognising that the optimal space between therapist and clients varied. Therapists were generally unassuming and humble, while also informed and knowledgeable.

The clients in the current study were a broad range of individuals with diversity in their cultural backgrounds, socio-economic status, level of education, religious orientation, appearance, age, behaviours and personalities. They however, felt deeply and fully accepted and valued by their therapists with an absence of perceived judgment. Clients detected when therapists were avoiding topics, were uneasy with intense emotions, and were distancing from them. When these concerns were not addressed in the sessions, the clients' negative self-perceptions risked being reinforced and frequently resulted in them not returning with previous therapists. They also had awareness of their current psychologists' ability to remain fully present, physically, emotionally and spiritually with them, and this reinforced positive perceptions of self-acceptance. Therapists were genuinely curious and involved with their clients and had an ability to remain present and open to their clients through their painful trauma narratives and intense emotional states. Although they had solid knowledge in diagnostic criteria, they tended to use diagnoses sparingly when with their clients. Hence, clients with their current psychologists did not generally feel restricted or labeled by diagnoses.

Safety through secure attachment of attunement and responsiveness emerged as fundamental to these clients. Some psychologists used humour and metaphor to engage and convey meaning to clients which often elicited a strong sense that the therapist was attuned to the client and reinforced a confidence in the therapist knowing the client comprehensively and being genuinely accepted as themselves. A sense of fun and trustworthy caring was elicited. However, when therapists used humour or metaphor

that were mismatched to the client, safety was compromised drastically with at times resultant client disengagement found with clients' past therapy experiences.

In relation to boundaries, psychologists were clear, consistent and transparent, and were also often found to be flexible. The occasional flexibility outside usual practice tended to reinforce genuineness of empathy and caring, which helped to provide a corrective experience for the clients and to deepen their trust. In contrast, clients were sensitive to slight changes in tone of voice that was abrupt or business like. They also disliked rigidly imposed boundaries. Sometimes this elicited a sense of not caring for the client when they were most vulnerable, for example, being cut off suddenly at the end of a session or perceiving therapist impatience when attempting to make brief contact inbetween sessions. These rigidly imposed boundaries risked reinforcing negative childhood experiences of attachment figures being emotionally unavailable.

Therapists needed to be clear about the boundary between themselves and their clients through self-observation. They managed the oscillation between observer role and emotional presence with their clients' feelings and experiences. Presence involved empathising deeply through feeling into clients' emotional experiences, including being aware of bodily sensations, while also being able to access an objective stance. This facilitated an ability to make cognitive sense of the clients' experiences and prevented enmeshment with their clients. At times therapists tolerated high levels of emotional discomfort through empathizing with their clients, while also maintaining a separateness to their clients' experiences. In contrast being emotionally distant from clients' experiences in order to prevent vicarious traumatisation was not supported in the current study.

Clients sometimes appreciated their therapists' occasional, brief self-disclosure of personal material. This had the potential to elicit a sense of being trusted by their therapists and was found to reinforce or increase perceived therapist empathy and understanding by the clients. It also normalised the clients' experience at times through the therapist sharing of a similar experience that reduced shame while also at times instilling hope in the clients' future potential; if their therapist could overcome the effects of trauma then maybe the client was able to also. Psychologists though were selective and cautious in their decision to self-disclose their own personal material. They made careful decisions based on the expected therapeutic benefit for their clients,

withholding disclosure if they were uncertain. Clients sometimes asked for information from their therapists directly, who often responded through brief sharing, enough to assist the clients to understand while also protecting the therapeutic relationship and the therapists themselves. At these times, therapists often gave messages to clients that they had their own supports. Deleterious effects were found when therapist self-disclosure was excessive, unresolved adequately in the therapist, was used defensively by therapists to give evidence for understanding, and when there was an absence of therapists actively taking responsibility for their disclosed material. Without therapists reassuring clients of their own supports, clients were vulnerable to taking on responsibility for their therapists' problems.

As frequently emphasised with these survivors of childhood trauma, instilling a sense of control was found to be prioritised by psychologists and essential to clients, in the areas of; content, pace, and direction of therapy. This included: allowing clients to choose content to bring to sessions; a slow, unpressured pace that enabled clients to take time to bring forward material and to develop the ability to emotional regulate; offering clients' choice in interventions; when to end therapy, and collaborating on therapy related decisions. Therapists managed the balance between avoidance and exposure purposefully, attuning closely to clients' experiences in the moment and responding accordingly. Some therapists were more directive in accessing trauma memories than others. Empathy and deep acceptance were maintained throughout.

Frequently goals were broad and flexible although they tended to evolve and change over time. Initially clients rarely presented to work through issues of childhood trauma, rather it emerged once the clients trusted and were confident in their therapist. Therapists gave their clients choice in the direction of therapy, whether to participate in specific interventions or not, and in the goals of therapy, although they also often took a leading role. Differences in opinion were negotiated through therapists listening and sharing their own wisdom however, the clients made the final decisions. Clients appreciated being treated with respect and equality, as experts of their own experiences, while also recognising their therapists' professional knowledge and expertise. They noticed and were deterred by subtle or obvious power differentials perceived through therapists' tone of voice, posture and at times use of diagnostic labels. The therapists' authority had the potential to reinforce clients' negative self-perceptions. In this case

trust was often reduced considerably and the clients responded through distancing themselves, withholding information or dropping out of therapy.

Survivors of childhood trauma easily misinterpreted their therapists' intentions and hence recognising and repairing ruptures was found to be paramount. Even with the experienced psychologists' in the present study, misperceptions and inaccurate judgments were made on occasions by the clients that were not always noticed by their therapists, and had the potential to lead to dropout if left unattended. This highlighted both the potential for alliance rupture in a strong established therapeutic relationship, as well as giving support for the use of more formal methods of detecting alliance concerns. When the alliance was strong, repair work was sometimes resolved simply while at other times more extensively. Therapists implemented repair work through an honest, mutual, respectful, empathic method in which therapists took responsibility for a good part of the problem and apologised readily when required, whilst also instilling responsibility in their clients' owning of their contribution. Clients appreciated this approach and rupture repair work was found to be effective when implemented thoroughly.

8.1 Future Research

More qualitative research directly involving long-term survivors of childhood trauma and their experienced psychologists, delivered by researchers trained and practised in complex trauma is warranted. Rather than comparing and contrasting psychotherapeutic interventions it would be beneficial to examine the important common factors in more detail; examining how advanced empathy, deep acceptance, boundaries, power and control, and repair work can be adapted to individual clients.

The concepts of deep caring and genuineness, and the intricate qualities of how to develop deep acceptance of clients and to continue to grow in our own self-awareness as therapists would be beneficial. Furthermore, examining the conditions under which therapists maximise their qualities of empathy and non-judgment, and how burnout or other factors may impede therapists are other areas of importance.

Research related to unpacking the qualities and conditions of therapeutic presence is warranted which, perhaps due to the complexity of the concept and

difficulty in reducing it to symptoms or behavioural features for quantitative research, has been somewhat overshadowed.

Further research is recommended about the impact of diagnostic labelling as well as delineating how to manage the dilemma of diagnostic labelling which was often imposed upon practitioners within government funded organisations, and yet can interfere with the therapeutic process. Clients are frequently required to meet diagnostic criteria to enable access to services and whilst diagnostic labelling can assist therapists in understanding, assessing and guiding treatment, they can also cause problems through clients' perceived judgment and becoming stuck and limited in the mentally unwell role. The use of diagnoses without reinforcing self-perceptions of being dysfunctional, while delivering them tentatively and respectfully as a category rather than as an unchangeable aspect of client selves, needs further investigation.

More studies on how to make decisions related to therapist personal self-disclosure and whether or when this is likely to benefit or inhibit the therapy process would be useful, hence guiding therapists more specifically in their decision to self-disclose. More research may enable increased insights into the potential benefits of therapist self-disclosure when delivered with the appropriate level of detail and timing. Clear markers for therapist withholding self-disclosure would also be useful.

Further research into the powerful effects of forgiveness, differentiating how and when an apology is delivered with survivors of childhood trauma in order to be effective. Further development of the alliance repair process is also warranted to deepen understanding of the process related to different clients, expanding on the current knowledge related to confrontational and withdrawing clients, and extending to differences amongst therapists with natural tendencies to approach or withdraw from conflict.

Lastly, examining advanced empathy, deep acceptance, boundaries, power and control, and repair work across different ethnic and religious orientations would broaden the understanding of the therapeutic relationship across diverse groups, highlighting how it might be adapted for different cultures.

8.2 Limitations

Although the methods used to implement the current qualitative research were of a rigorous nature, and a reasonably large sample of both clients and experienced psychologists was used, it is important to be aware of the limitations of the research. The current study does not predict causality. It was exploratory in nature. The method used required grouping of issues that emerged into themes. Different researchers may have undertaken a study similar to this but interpreted the results differently. Although the researcher was experienced and competent at setting aside existing knowledge to enable objectivity, it is inevitable that the analyses were influenced by the researcher's prior knowledge and understandings to some degree. Hence the researcher's self-observation during the interviews was essential to notice her own judgments and prior knowledge and to focus on remaining present to the client or psychologist in the moment. Furthermore, the interviews captured only information that was conscious and accessible to both clients and psychologists, although given the long-term nature of the clients and the experience of the psychologists, they yielded rich and extensive data.

The psychologists were approached by the researcher through professional connections and leads. They were predominantly Caucasian and all worked experientially, tracking moment by moment client experiences with an advanced emotional empathy, however they differed in their psychotherapeutic orientations. As the therapists in the current study worked more experientially, this may be a necessary component when working with survivors of childhood trauma or this may be as a result of the selection process. That is, the type of psychologists who agreed to participate and who valued the qualitative nature of the current study may not have represented all trauma specialists. Nonetheless psychologists using this orientation appeared to be able to relate and work with complex trauma clients effectively and successfully as indicated by what the clients regarded as important in the current study. These qualities are likely to be essential when working with clients who have experienced this level of trauma, however this research project has not demonstrated that a more conventional approach such as goal directed Cognitive Behavioural Therapy may not also be well received by these clients.

Furthermore, it was possible that the psychologists withheld information during the interviews that was feared to be judged, and that they presented the more positive, acceptable details that depicted themselves in a favourable light (e.g. self-serving bias).

There were however some issues that emerged, sometimes tentatively by psychologists that revealed some negativity related to themselves and their fear of societal judgment.

Clients may also have withheld negative data about their current psychologists due to the tendency to protect the therapeutic relationship or due to idealising their therapist (Levitt & Piazza-Bonin, 2011). Hence, although some examples emerged, it was likely that some were hidden and not revealed.

All of the data may not be generalisable to early alliance as particularly the positive data largely represented long-term, established relationships. Most of the negative experiences depicted by clients applied to previous short-term therapeutic relationships. Many of these relationships did not extend into long-term relationships because the counsellors were unable to establish the trust and safety required for these clients to remain engaged in the therapeutic process.

Although a number of clients who participated in the current study had varied cultural backgrounds, there were likely to be culturally specific issues in the therapeutic relationship that were not found in the current study. Therefore, there may be other factors that needed further investigation into more culturally specific therapy, and the application of the areas that emerged may be different across cultures and indigenous groups. The experienced psychologists seemed to be competent for example with gauging the physical distance between therapist and clients, adjusting eye contact when necessary, and level of engagement with the client. They managed to read the clients' body language and have a level of understanding, however some therapists may need more direction in these areas when learning and beginning counselling with survivors of childhood trauma. They would certainly need to adjust these skills when working multi-culturally.

In addition professional ethics needs to be considered carefully when practising counselling. Some of the examples may have been considered outside usual parameters of professional boards of registration or legal settings. When working therapeutically with survivors of childhood trauma, treatment needs to be guided by empirically based practice, and tailored to the individual clients. If uncertain, caution needs to be exercised. Engaging in supervision can be an effective means to assist practitioners to maintain objectivity and to highlight blind areas in the therapeutic process. It might be that the findings of this investigation will not be appropriate for practitioners who have

insufficient personal insight and awareness or undeveloped professional judgment and intuitive skills. Protecting the clients from retraumatisation and maintaining safety should always be a priority.

8.3 Implications of the Findings to Therapy

What have these findings indicated about how to improve and maintain the therapeutic alliance with survivors of childhood trauma in order to improve outcomes and reduce dropout rates? Regardless of psychotherapeutic orientation, the importance of developing advanced empathy skills and therapists' deep acceptance of and presence to their clients was paramount. This could be implemented through experiential groups with recordings demonstrating highly empathic therapists as role models of advanced empathy. Embodying the warmth, sensitivity and deep acceptance of the highly empathic therapists while viewing the video recordings is likely to enhance therapist's own empathy. Also, micro skills observed and spoken could be documented by training therapists, for example short empathic responses that validate the client's distress, as well as tone of voice and pace of sessions.

Furthermore therapists video recording themselves during sessions would not only expose them to their own uncomfortable feelings but would help develop their own emotional regulation tolerance to increase their therapeutic presence with clients' intense emotional experiences and narratives, and would also be an opportunity to reveal 'blind spots' in the therapists. This would need to be delivered in a highly sensitive, non-judgmental and empathic manner so as to create safety for the therapists and to maximise the opportunity for effective growth and learning. Psychoeducation related to the different cognitive, emotional and behavioural aspects of empathy and how these may be adapted to individual clients has a theoretical and knowledge based component, as well as an insight aspect. Understanding ones' own tendencies to hyperactivate or withdraw in sessions with particular types of clients, while exploring the barriers to remaining present may be useful in groups, supervision or individual counselling.

Focus on a strong therapeutic alliance and regularly checking in with clients was indicated, even when the alliance was strong and established. Therapists needed to be aware of the signs of small changes in their clients that may indicate an alliance problem and to have the courage to bring the matter up with their clients. Knowledge

and practice on knowing how to address these areas effectively in a non-reactive manner was indicated as was taking responsibility as therapist, while also promoting client responsibility. Therapists' awareness of their own tendencies to take on too much or too little responsibility and exploration of potential barriers to apology would be a beneficial reflection.

Mindfulness practice and focusing were found to be means to improve therapists' self-awareness, and to increase recognition of clients and self experiences in the sessions. This was likely to improve therapy by reducing therapists' avoidance patterns and being able to connect more deeply with clients on an emotional level and in the moment.

Developing broad client goals and yet maintaining a flexibility and fluidity with them, in contrast to rigidly abiding by them was important. A willingness to let go of interventions and to adapt to the individuals' needs was a priority in response to client requests, although it needed to follow a collaborative discussion about the matter.

Therapists may benefit from training in the area of firm and flexible boundaries with survivors of childhood trauma through case examples and group discussions, including consideration of ethical issues. Discussion in this area with a supervisor or colleague is also advised, in uncertain cases. Education and training related to instilling responsibility and firmness while also maintaining empathy, particularly with clients who have narcissistic or borderline processes was highlighted as important. This may include managing client confrontation and anger in sessions, as well as client withdrawal.

Therapists' managing of the boundary between self and clients to minimise vicarious traumatisation yet maintaining therapeutic presence was also indicated as important. This included recognising when additional support or personal counselling was required and essential to maintain safety for both clients and therapists. If therapists were not able to be fully accepting and open to their clients with warmth and non-judgment, it was worth considering discussing with the client and deciding together, the option of referring on to another therapist.

Supervision that practices all of the qualities highlighted as important in the current study would be beneficial for therapists. Supervisors should embody; an advanced empathic approach, a therapeutic presence, deep acceptance, empowerment of

the supervisee while also instilling responsibility, and repair work during supervision. In this regard therapists would have the opportunity to experience these factors with theoretical discussion and case examples during supervision.

Finally, therapists having training across a number of modalities has been recommended (Moloney & Andrew, 2016) as different psychotherapeutic approaches may emphasise some areas more strongly than others. For example, EFT emphasised emotional depth while psychodynamic approaches had strength in cognitive understanding. Schema Therapy gave clear guidance in managing responsibility when narcissistic processes were present. DBT, EFT and Schema Therapy elaborated on validation, empathy and acceptance particularly with borderline processes. A broad training in many varied approaches could enable therapists to increase awareness, knowledge and experience in less developed areas of their practice.

8.4 Final Comments

The current research study has yielded important information which deepens our understanding and knowledge of the relationship between client and therapist, when working with survivors of childhood trauma. Real life experiences from both the survivors and their therapists, have been captured with both groups rarely represented in research studies. Therapists embodied common qualities. They had an advanced ability to empathise, emotionally and cognitively when therapy was emotionally intense, when delivery of evocative feedback was required; in managing client avoidance, and in implementing alliance repair work. Therapists remained consistent throughout therapy beginning with the first phone call. They adapted to a wide range of clients, diverse or mainstream, timid or intimidating and were able to deeply and genuinely accept and like each person. Therapists engaged with an openness and non-judgment while flexibly tracking, attuning to and responding to clients moment by moment experiences, sometimes creatively using humour and metaphor. They were knowledgeable and confident with solid wisdom and yet maintained humbleness and engaged in a mutual relationship with a minimisation of power differential.

These key factors can be applied to a variety of psychotherapeutic approaches. They require a committed therapist who is willing to remain in the practice of psychotherapy for the 'long haul', while nurturing their own supports and growth. Therapists need to be able to slow down and be present to their diverse clients with

interest, hope and belief in their potential, rather than being dominated by tasks and interventions. Challenges, fears and uncertainties will need to be managed along the way. Vigilance to the alliance issues is required with the courage and skills to address and repair problems as they arise. If unsure, clients can be questioned and therapists should then be open to hearing negative responses.

Finally, it is a privileged position as a therapist who shares their clients' world sometimes for the first time, and joins them on their journey of discovery, changes and growth. Insights are gained and the psychological growth for therapists continues, when navigating the rich and meaningful path of continuously improving psychotherapy practice.

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Appendix A: Questions for Client Participants

1. What was it about your counselling relationship with (Psychologist) that allowed you to open up, and to tell your full story?
2. Was there a time when a significant positive change occurred in your interactions with (Psychologist)? What happened? How did it come about? What was important for you?
3. Was there a time when a significant negative change occurred in your interactions with (Psychologist)?
4. What was it about the counselling relationship with(Psychologist) that enabled you to stay in counselling during difficult times?
5. To what extent did (Psychologist) include you in the direction of your counselling?
6. Have you experienced counselling before? Was this a positive experience with your previous therapist/s? Why or why not?
7. Do you remember how you felt about (Psychologist) at the beginning of your counselling. How have things changed?

Appendix B: Questions for Participants / Psychologists

1. How did you foster strong engagement with (Client)?
2. What was important when working with (Client)?
3. What worked well with (Client)?
4. What did not work so well?
5. How do you work differently with this complex trauma client compared to working with other client groups? What do you look out for when working with complex trauma clients?
6. What were the most significant events when working with (Client)? What happened? How did this come about?
7. What enabled (Client) to persist in counselling during difficult times?
8. To what extent did you include (Client) in the direction of your counselling?

Appendix C: Information for Participants / Clients

“What is it about the therapeutic alliance that enables trust with adult survivors of childhood abuse?”

Shona Tudge is a psychologist and researcher completing this project as part of a doctoral thesis at Swinburne University. She is being supervised by two counselling psychologists at Swinburne University: Associate Professor Roger Cook and Associate Professor Stephen Theiler.

What is this project about?

This is a voluntary research project that involves asking you some questions related to your counselling relationship with your psychologist. The research project hopes to find out more information about what works well for clients who are working through issues of childhood abuse, and what does not work so well for them. Very little research to date has involved asking clients themselves what they believe is useful. Many clients dropout of counselling due to problems in their counselling relationship with their psychologist, indicating that we need further information to improve in this area.

What is involved?

This project involves interviewing you and your psychologist separately and confidentially about what is important in your counselling relationship. I will be asking questions related directly to what works for you in your counselling relationship through interview. I will not be offering counselling to you, but will be supportive of you during the interview. It will take approximately one hour and will be audio recorded. I will consult with you as to the most comfortable and convenient venue, either at your home, your psychologists' rooms, or at Swinburne University for

interviewing to take place. A copy of the interview questions for yourself and your psychologist are attached.

What happens to the information?

The information that you provide in the interview will be collated with about 30 other participants. Themes and patterns are expected to emerge through analyses yielding important information that will be written up into a doctoral thesis, and may be presented in conferences or research journals. Your information will remain anonymous and confidential at all times. This means that I will not speak to your psychologist about what you say or anyone else, except my two supervisors. All information will be kept securely stored, and deleted or destroyed on completion. Your name will be changed and your identity disguised in written papers, and if your direct words are used I will seek your consent before publishing.

What do you get out of participating?

This is an opportunity for you to spend one hour talking about your counselling relationship with a researcher, which is likely to assist you in continuing to develop your awareness around what works for you in relationships. You will also be assisting future clients dealing with childhood abuse through sharing your knowledge and experience by participating in research.

What happens if I become upset during the interview?

Shona Tudge is a researcher and psychologist experienced in counselling. She will be able to offer basic emotional support to you if this occurs.

Why implement this project?

Shona is a psychologist counselling in private practise who hopes to contribute to the psychology profession generally by expanding knowledge and understanding of

the counselling relationship, when working with clients who are working through childhood abuse issues.

What if I change my mind?

This project is entirely voluntary. You can withdraw from participating in this project at any time.

If you would like to know more information or are willing to participate, please contact:

Shona Tudge (Researcher and Psychologist)

Mobile: 0433 553 689

Email: email: studge@swin.edu.au

Supervisor Associate Professor Roger Cook

Phone: 9214 8358

Email: rcook@swin.edu.au

This project has been approved by or on behalf of Swinburne's Human Research Ethics Committee (SUHREC) in line with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the conduct of this project, you can contact: Research Ethics Officer, Swinburne Research (H68), Swinburne University of Technology, P O Box 218, HAWTHORN VIC 3122. Tel (03) 9214 5218 or +61 3 9214 5218 or resethics@swin.edu.au

Appendix D: Information for Participants / Psychologists

“What is it about the therapeutic alliance that enables trust with adult survivors of childhood abuse?”

What is this project about?

This is a voluntary research project that involves interviewing of experienced psychologists and complex trauma clients regarding the therapeutic alliance. Clients who have been working through issues related to childhood abuse (sexual, physical, emotional, neglect) and psychologists with a minimum of 5 years complex trauma counselling experience are applicable. The research project has been developed in response to renowned high dropout rates with trauma clients (Paivio & Pascual-Leone, 2010; van der Kolk, 2005), and the alliance being shown to be the strongest predictor of success in psychotherapy generally (Wampold, 2001).

Overall there is a reasonable body of research supporting the importance of client subjective experiences in developing the therapeutic alliance, however these studies and alliance literature as a whole largely focus on less severely distressed clients (Fitzgerald, 2009; Horvath & Bedi, 2002). Few studies use experienced practitioners, who may offer greater depth of understanding and insights around what is useful in the therapeutic alliance, particularly with more complex cases.

A qualitative study, examining subjective experiences of survivors of childhood abuse and experienced therapists through semi-structured interview is predicted to gather rich and meaningful data, which cannot be captured through randomised clinical trials predicting causal relationships (Balmforth & Elliot, 2012; Elliot, 2010). We know from alliance research to date that there is more happening to the client in session than the therapist knows about (Rees, Hardy, Barkham, Elliot, Smith & Reynolds, 2001). Furthermore, studies have shown clients to be resistant to giving therapist feedback due to fear of being judged, or due to concern for therapist upset or in protection of the therapeutic relationship (Levitt & Piazza-Bonin, 2011). Hence, the project is likely to yield clinically meaningful and theoretical data related to working with complex trauma

clients, expanding on current alliance theories, and applicable clinically across different psychotherapeutic orientations.

What is involved?

This project involves a one hour semi-structured interview of experienced psychologists and clients working with complex trauma, separately and confidentially, on questions related to the alliance. The interview will take place at a venue and time of your convenience and will be audio recorded to assist data collection. (A copy of the interview questions for both yourself and your clients are attached).

The timing of the interview will occur when your client extends therapy sessions beyond fortnightly visits or ceases therapy. If you agree to participate, you will be asked to give a brief explanation of the project to your client (see attached sheet) and to hand him/her a sealed envelope with research project information inside. The letter asks the client to contact Shona Tudge directly, via email or telephone.

What happens to the interview data?

The information that you and your clients provide during the interview will be collated with about 30 clients and 10 psychologists. Through qualitative analyses, themes and patterns are expected to emerge, that will be written up into a doctoral thesis, and may be presented in conferences or research journals. Participant information will remain anonymous and confidential at all times, shared only with two supervisors at Swinburne University; Associate Professor Roger Cook and Associate Professor Stephen Theiler. All information will be kept securely locked electronically or in filing cabinets, and deleted or destroyed on completion. Your consent will be sought for direct words to be used before publishing.

What do you get out of participating?

This is an opportunity for you to spend one hour with a researcher reflecting on your therapeutic alliance working with complex trauma clients. This is likely to deepen your insights and understanding and contribute to professional development. In

participating in this project, you will be sharing your knowledge and expertise in complex trauma across the psychology profession, and contributing towards advancement of alliance theory and practise.

Who is implementing this project?

Shona Tudge is completing this project as part of a doctoral thesis at Swinburne University. She is also a psychologist counselling in private practise and hopes to contribute to the psychology profession by expanding knowledge and understanding on how the alliance works optimally with complex trauma clients.

What if I change my mind?

This project is entirely voluntary. You can withdraw from participating in this project at any time.

If you would like to know more information or are willing to participate, please contact:

Shona Tudge (Researcher and Psychologist)

Mobile: 0433 553 689

Email: email: studge@swin.edu.au

Supervisor Associate Professor Roger Cook

Phone: 9214 8358

Email: rcook@swin.edu.au

[This project has been approved by or on behalf of Swinburne's Human Research Ethics Committee \(SUHREC\) in line with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the conduct of this project, you can contact: Research Ethics Officer, Swinburne Research \(H68\), Swinburne University of Technology, P O Box 218, HAWTHORN VIC 3122. Tel \(03\) 9214 5218 or +61 3 9214 5218 or \[resethics@swin.edu.au\]\(mailto:resethics@swin.edu.au\)](#)

Appendix E: Informed Consent Form for Client Participants

“What is it about the therapeutic alliance that enables trust with adult survivors of childhood abuse?”

I.....(name) have read and understood the information on the participant/client information sheet and I agree to participate in this research project.

I agree to be interviewed and for the interview to be recorded and kept confidentially, knowing that I can withdraw at any time.

I agree to complete some questionnaires.

I agree that the data collected from this project may be published or presented at a conference with my name remaining anonymous so that I cannot be identified.

Signature.....

Date:

Appendix F: Informed Consent Form for Psychologist Participants

“What is it about the therapeutic alliance that enables trust with adult survivors of childhood abuse?”

I.....(name) have read and understood the information on the participant/experienced psychologist information sheet and I agree to participate in this research project.

I agree to be interviewed and for the interview to be recorded and kept confidentially, knowing that I can withdraw at any time.

I agree to complete a questionnaire on demographic information.

I agree that the data collected from this project may be published or presented at a conference with my name remaining anonymous so that I cannot be identified.

Signature.....

Date:

Appendix G: Information for Psychologists to give to Clients

Shona Tudge is implementing a research project as part of a doctorate at Swinburne University. She is interviewing clients and their psychologists, asking them questions about the counselling relationship. Further information is available inside this envelope, as well as her contact details if you are interested in participating.

Appendix H: Ethical Dilemmas: Questions (Q) and Answers (A)

Questions (Q)

Answers (A)

Q: What does the researcher do if the client/participant requests counselling with you?

A: Advise the client/participant that, as a researcher, I have an obligation to maintain our relationship as participant-researcher. Explain to the client/participant that it would be against the researcher's professional ethical guidelines to see the client/participant for counselling and was therefore unable to occur.

Q: How does the researcher respond if the participant/client asks for an opinion on the competence of their psychologist?

A: Remind the participant/client that you are a researcher and that you are unable to comment. Maintain neutrality and avoid interfering with the participant/client's relationship with their psychologist.

Q: What does the researcher do if the participant/client begins to talk in detail about their childhood trauma experience?

A: Remind the participant/client that you are a researcher and that it was necessary for the interview to be structured around the research questions related to the relationship between the researcher and client.

Q: What does researcher do if participant/client is highly anxious and vulnerable during interview?

A: Empathise with and support the participant/client without intentionally deepening the emotional experience. Give reassurance. Manage the power imbalance between

client/participant and researcher carefully. Do not rely on participant/client speaking up, as they may not be able to. Reassure the participants of voluntary participation.

Q: What does the researcher do if the participant/client becomes upset and emotionally breaks down during the interview?

A: Researcher offers the participant/client emotional support through empathy and holding until the client settles down. The researcher does not deepen the issue with the client. If the problem remains unresolved, the researcher may refer the client/participant back to their psychologist.

Q: What does the researcher do if the client/participant has negative concerns related to their psychologist?

A: The researcher maintains neutrality. The client is encouraged to discuss the matter with their psychologist, with a likely positive outcome in the therapeutic relationship.

Q: What does the researcher do if the client/participant indicates that s/he does not want to continue with the interviewing?

A: The participants have the right to discontinue participation at any stage of the research project.

Appendix I: Demographic Questionnaire for Participants/Clients

“What is it about the therapeutic alliance that enables trust with adult survivors of childhood abuse?”

Thank-you for participating in this research project. Could you please complete the following questionnaire?

Name: _____

Email: _____

Today's Date: _____ (dd/mm/yy)

Date of Birth: _____ (dd/mm/yy)

Sex (circle): Female / Male

Occupation: _____

Completion of schooling to year _____

Tertiary Education _____

Which ethnic group do you belong to or identify with? _____

Have you ever had counselling in the past? _____

Reason for seeking counselling? _____

Do have any medical conditions? _____

Appendix J: Demographic Questionnaire for Participants/Psychologists

“What is it about the therapeutic alliance that enables trust with adult survivors of childhood abuse?”

Thank-you for participating in this research project. Could you please complete the following questionnaire?

Name: _____

Email: _____

Today's Date: _____ (dd/mm/yy)

Date of Birth: _____ (dd/mm/yy)

Sex (circle): Female / Male

Which ethnic group do you belong to or identify with _____

Occupational Title: _____

Tertiary Education _____

Number of years of counselling experience _____

Main theoretical orientation used (circle)

Humanistic (emotion focused therapy / existential / person-centred / gestalt)

Cognitive behavioural therapy

Psychoanalytic

Psychodynamic

Eclectic

Other _____

Number of sessions with this client? _____

Client's main presenting problem _____

Type of abuse, period of time it occurred and frequency (neglect, sexual, physical, emotional)

Appendix K: Swinburne University of Technology Ethics Approval

To: Assoc Prof Roger Cook/Ms Shona Tudge, FLSS

Dear Roger and Shona

SUHREC Project 2013/112 What is it about the therapeutic alliance that enables trust with adult survivors of childhood abuse?

Assoc Prof Roger Cook, FLSS; Ms Shona Tudge, Assoc Prof Stephen Theiler

Approved Duration: 17/07/2013 To 30/06/2017 [Adjusted]

I refer to the ethical review of the protocol for the above project by Swinburne's Human Research Ethics Committee (SUHREC). Your responses to the review were as per your emails of 13 June and 15 July 2013, both with attachments, the latter email superseding the former. The latter email and attachments, including that the consent instruments will use Swinburne letterhead, were put to a SUHREC delegate for consideration.

I am pleased to advise that, as submitted to date, the project has approval to proceed in line with standard on-going ethics clearance requirements here outlined.

- All human research activity undertaken under Swinburne auspices must conform to Swinburne standards and applicable Policies, including external regulatory standards such as the current *National Statement on Ethical Conduct of Human Research* and with respect to secure data use, retention and disposal.
- The named Swinburne Chief Investigator/Supervisor remains responsible for any personnel appointed to or associated with the Swinburne student project being made aware of ethics clearance conditions, including research and consent procedures or instruments approved. Any change in chief investigator/supervisor requires timely notification and appropriate endorsement.
- The above project has been approved as submitted for ethical review by or on behalf of SUHREC. Amendments to approved procedures or instruments ordinarily require

prior ethical appraisal/clearance. SUHREC must be notified immediately or as soon as possible thereafter of (a) any serious or unexpected adverse effects and any redress measures; (b) proposed changes in protocols; and (c) unforeseen events which might affect continued ethical acceptability of the project.

- At a minimum, an annual report on the progress of the project is required as well as at the conclusion (or abandonment) of the project.

- A duly authorised external or internal audit of the project may be undertaken at any time.

Please contact the Research Ethics Office at Swinburne Research if you have any queries about the Swinburne ethical review, citing the SUHREC project number. Copies of clearance emails should be retained as part of project record-keeping.

Best wishes for the project.

Yours sincerely

Keith

Keith Wilkins

Secretary, SUHREC & Research Ethics Officer

Swinburne Research (H68)

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Appendix L: Matching of Clients and Psychologists

Table 2.0

Clients matched with their Psychologists

Psychologists	No of Clients
Psychologist A	5
Psychologist B	5
Psychologist C	3
Psychologist D	3
Psychologist E	3
Psychologist F	2
Psychologist G	2
Psychologist H	2
Psychologist I	1
Psychologist J	1
Psychologist K	1
Psychologist L	1
Psychologist M	1