Fosha and Rogers: Using Client-Centered Therapy and Accelerated Experiential Dynamic Psychotherapy in a School Counselling Setting

by

Caleb D. W. Robinson

A Paper

Presented to the Gordon Albright School of Education

In Partial Fulfillment of the Requirements

For the Degree of Master of Education

EGC 640 School Counselling Project

June, 2023

Fosha and Rogers: Using Client-Centered Therapy and Accelerated Experiential Dynamic Psychotherapy in a School Counselling Setting

APPROVED BY DEANNA C. C. PELUSO, PHD

Dedication and Thanks

This small work is dedicated to all my clients, both official and unofficial, student, colleague, or otherwise. Their longing to live lives of truth and authenticity is a wellspring of inspiration for me. Nevermore than when I am with them am I reminded of the great honour it is to be doing this work, to be fully with another, however long or short. Their bravery in sharing their journeys with me is a gift I will cherish forever.

I would like to thank Lisa Porter for her wisdom and advice and for trusting me with her clients. I could not have asked for a better supervisor.

I would like to thank Dr Carla Alexander for introducing me to Carl Rogers and for her help throughout this entire degree.

I would like to thank Dr Deanna Peluso for her guidance in writing this paper and for her patience with me.

I would like to thank my dear friends, Scott McIndoe, Bridgid Dunning, and Gillian Whitely, the Dream Team, for their constant companionship throughout this degree. The Fellowship has finally come to rest in the sanctuary of Imladris.

I would like to thank Chuck LeBlanc for reminding me of what I already knew.

I would like to thank my dear friends, Alex Sandvoss, Jordan Buffie, Karen Slakov, Adam Gough, Marley Stewart, Heather Gunn, and Zack Gilkison for all their love and support.

I would like to thank Flynn Robinson and Jane Hird for their company during long hours of writing and online classes and for only occasionally sleeping on my keyboard.

I would like to thank my dear brothers and their partners: Sam and Beth, Isaac, Eli and Elise, and Gil – I love you all.

Most of all, I would like to thank my beloved parents, Donald Robinson and Wendy Hird. I love you more than words can say.

Abstract

Working with traumatized students as a school counsellor is an inevitability and we must be equipped to support them. All trauma students experience will necessarily be childhood trauma, which has unique impacts on nervous system function and emotional regulation and can create a persistently negative self-concept and difficulty navigating interpersonal relationships. Client-Centered Therapy and AEDP are presented as possibilities for working with traumatized students given their relational nature. Client-Centered Therapy focuses on building relationship and creating a safe therapeutic environment through empathy and positive regard while AEDP works directly with the attachment relationship and associated affect to facilitate emotional regulation and positive self-image. In this paper, three tiers of recommendations are presented in a Response to Intervention framework, first using Client-Centered Therapy for work with all students, then using aspects of AEDP for regulation and self-image, and finally using intensive interventions to help the client process overwhelming emotion and access the positive, adaptive affect that follows.

Keywords: Trauma, school counselling, Client-Centered Therapy, AEDP, emotional regulation, self-concept, Carl Rogers, Diana Fosha, attachment, Emotion Focused Therapy

Table of Contents

Fosha and Rogers: Using Client-Centered Therapy and Accelerated Experiential Dynamic Psychotherapy in a School Counselling Setting

Chapter 1: Introduction

Introduction

Difficulty and tragedy are universal human experiences and it is a painful fact that many students who go through our school system will have had more than their fair share. It may be tempting for school staff to dismiss their students' traumas as irrelevant to the task of education, but to do so is to misunderstand the impact that traumas have on a youth's ability to function, much less learn. School counsellors would hopefully never dismiss a student's trauma but we must also be equipped both to support students in their difficulties and to educate them as well as other staff members about the potential effects of trauma.

During my clinical internship for this degree, I worked with a student who inspired me to dive deep into the study of trauma. They were wracked with anxiety, prone to extreme emotional dysregulation, struggled with self-harm and substance use, and had a profoundly negative view of themselves. For a few sessions, we worked with some DBT-based emotional regulation strategies, such as box breathing and general mindfulness, but the ghost of Carl Rogers kept tapping me on the shoulder and so we began working more deeply with feelings, meaning, and experience. It was not long before the student bravely shared life-long experiences of emotional trauma and neglect and their underlying fear that they were fundamentally broken. During these middle sessions, they shared one of the most heartbreaking things I have heard from a student: "No adult has really cared about me before." In hindsight, it is clear to me now that the best counsellor I could be for that student was not an expert in brain science or cognitive distortions.

The student needed a safe environment and a relationship with a caring adult who deeply tried to understand them. Tragically, for this student and for many others, having a relationship with a caring, listening adult is a unique experience.

Trauma among high school students is a common topic of discussion and concern, both informally among school staff members and in the literature (Record-Lemon & Buchanan, 2017). Its effects appear wide in scope, ranging from cognitive difficulties to externalizing behaviours, and educators are often encouraged to work within trauma-informed practices. Schools can be an integral part of caring for traumatized youth and school counsellors are key in this undertaking (Record-Lemon & Buchanan, 2017).

The complexity and enormity of trauma can be burdensome, even for educated and trained professionals, and working with traumatized students in a counselling setting presents even greater challenges. This paper aims to offer concrete interventions for school counsellors to use in support of students with trauma with full attention to the significance of these challenges.

Statement of the Problem

An average school counsellor in BC will likely have a dozen or more students with traumatic backgrounds (Heidinger, 2022; McLaughlin et al., 2020). While outside supports such as Child and Youth Mental Health exist, the waiting lists are long (Ministry of Child and Family Development, n.d.) and these students need help in the meantime. The effects of that trauma may make it difficult for that student to be academically and socially successful in a school setting. Finally, current recommendations for treating trauma are often CBT-based. While these therapies are useful and effective, they have certain features that may make them difficult to use in a school setting or with certain students (Gharfoori et al., 2019; LeBeau et al., 2012). Therefore,

school counsellors need to be familiar with other evidence-based treatments to readily engage with the unique needs of their students.

27% of Canadians report experiencing at least one instance of physical or sexual abuse before the age of 15 (Heidinger, 2022). 1 in 6 children exposed to trauma will develop PTSD (McLaughlin et al., 2020). If a school has a population of 1600, there will be approximately 72 students who meet the criteria for PTSD, approximately 18 per counsellor. This number does not include students who experienced traumatic events but do not experience symptoms to the level required for a formal PTSD diagnosis. Pre-traumatic vulnerabilities include lower SES/education levels (American Psychiatric Assocation, 2013; DiGangi et al., 2013) and parental trauma (Marzilli et al., 2021), so it is likely that traumatized students will be clustered into lower income areas within a school district. The author works in Metro Vancouver, which has the highest poverty rate of any metropolitan area in Canada (Statistics Canada, 2022), so it is likely that readers from this or other metropolitan areas will see higher than average numbers. Traumatized students are an eventuality, not simply a possibility, and school counsellors must be equipped to support them.

While outside community supports in BC exist for students with trauma, the waitlists are often several months long; in 2021/2022, the average wait time to access mental health services in BC was 71 days and where the author works, in the South Fraser region, the average wait time was 116 days (Ministry of Children and Family Development, n.d.). School counsellors are likely to have initial appointments with students during a period of acute crisis and while counsellors should refer them to outside agencies if the client consents, they must be ready to work with them in the intervening four-month waiting period.

The impact of trauma on children and youth is unique. It can cause problems with self-regulation, attention, (McLaughlin et al., 2020) self-destructive behaviour, and substance abuse (Straussner & Calnon, 2014). Neurobiologically, it effects memory, disorganizes thinking (Straussner & Calnon, 2014) and reduces ability for abstract thought (Giotakos, 2020). All these effects have implications on the student's ability to function in a school environment, to learn, and to socialize.

Cognitive Behavioural Therapy (CBT) is usually recommended as a treatment for trauma (American Psychological Association, 2017). While CBT is an effective treatment for PTSD, it has higher dropout rates compared to other trauma treatments (Gharfoori et al., 2019) and its effectiveness may be modulated by the client's ability to complete intersession homework (LeBeau et al., 2012). Trauma's unique impacts on linguistic or abstract processes (Giotakos, 2020) and disorganized thinking (Straussner & Calnon, 2014) has implications for a traumatized youth's ability to engage with and complete CBT homework. Student clients also have academic classes with their own assigned homework, so a counsellor adding additional written material to a student's workload may be an additional stressor rather than an alleviation. The success of trauma treatments increases as clients remain in the treatment (Gharfoori et al., 2019), so school counsellors must balance the effectiveness of a particular modality with the likelihood that a student will continue meeting them. When working with traumatized youth and young adults, school counsellors should therefore have familiarity with other evidence-based trauma treatments, of which there are many.

Purpose of the Paper

This capstone aims to offer school counsellors additional resources in order to support students with trauma by drawing from Carl Roger's Client-Centered Therapy (CCT) (Rogers,

1951) and Diana Fosha's Accelerated Experiential Dynamic Psychotherapy (AEDP) (Fosha, 2000). Complex trauma is often relational and so the author has chosen these two psychotherapies for their relational focus. These two approaches work very well together and will build upon one another in three possible approaches, outlined in chapter 3.

Contemporary education often uses the phrase "trauma-informed" to describe its practice and orientation. The intent of this paper is to give school counsellors background knowledge on the causes, effects, and possible presentations of trauma and to recommend some specific strategies from modern trauma therapy to help make a trauma-informed counselling office.

There are no studies on the use of AEDP for youth or in a school setting, so the capstone aims to familiarize the reader with Fosha's suggestions for intervention and to encourage their possible use for students experiencing acute crises related to trauma. While this paper is primarily written for school counsellors, some teachers, administrators, and other school staff may find the material useful and resonant with their philosophy, particularly those who prioritize relationship, empathy, and positive regard for those in their care.

Research Question

This capstone will address the following question: How can school counsellors support students with trauma with an integration of Rogerian Client-Centered Therapy and Fosha's Accelerated Experiential Dynamic Psychotherapy (AEDP)?

Significance of the Study

Due to the number of students on a caseload, a school counsellor must be flexible in their approach and have a variety of "tools in their toolkit" to draw upon depending on the needs of a particular client. Different students need different things and so a school counsellor must be something of a generalist. Client-centered therapy is well established in the literature (Hill &

Nakayama, 2000) and is general in nature, due to its lack of specific interventions. CCT will be offered as the first tool due to its potential harmony with other therapeutic approaches. AEDP recommends specific interventions, so while it is less general than CCT, it is another possible tool for a counsellor.

As with most studies in counselling, the benefit of the recommendations lies primarily with the client. This study is significant insofar as it aims to help struggling students by equipping their counsellors. This paper will benefit counsellors by offering new and concrete ways of supporting their students. The sections on trauma may also benefit other school staff such as administrators and teachers by giving them an understanding of how trauma presents in students as well as its impacts on a student's ability to learn. The sections on CCT may also benefit administrators and teachers by offering a supportive way of being that is not exclusively the realm of counsellors.

Outline of the Remainder of the Paper

In this chapter, I have presented the problem guiding my research, which is the number of traumatized students on a caseload, how that trauma may effect them, the difficulty in accessing outside supports, and the need for additional and alternative approaches for counsellors to support these students. Chapter 2 will review research literature on trauma, on AEDP and its theoretical antecedents, and on CCT and its core conditions. Chapter 3 will present a three-tiered approach to supporting all students and especially students with trauma by targeting emotional regulatory capacity and building a positive self-concept.

Chapter 2: Literature Review

Introduction

The following literature review will explore three major topics. The first section will be on the concept of trauma. It will explore trauma's definitions, causes, manifestations, and impacts on psychosocial and emotional function. It will cover research on PTSD and its cousin, cPTSD, including diagnostic markers, common symptoms, and possible causes. This section will cover research on the neurobiology of trauma, including hormonal factors, neurochemical factors, and synaptic/brain region factor. Finally, because not everyone who experiences a potentially traumatic event will develop trauma, this section will cover the factors contributing to resilience and vulnerability to trauma.

The second section will be on Diana Fosha's Accelerated Experiential Dynamic Psychotherapy (AEDP) (Fosha, 2000). This psychotherapy is based on Attachment Theory and Emotion-Focused Therapy and so these topics will be covered in the first and second sections. Attachment theory has implications for children's ability to identify and regulate their emotions and has three major styles, with suggestions of a somewhat controversial fourth. The subsection on Emotion-Focused Therapy will define its major constructs, namely primary and secondary, defensive emotions, and discuss its clinical effectiveness. The subsection on AEDP will define the psychotherapy, explore its theory of emotion, attachment, psychopathology, and transformation, and discuss AEDP's unique technique, metatherapeutic processing. The final subsection will present clinical support for AEDP.

The third section will be on Carl Rogers' Client-Centered Therapy (CCT). It will define its main concepts of actualizing, congruency vs incongruency, conditions of worth, and the core conditions of therapy, unconditional positive regard, empathy, and genuineness. The second and

third subsections will be for defining unconditional positive regard and empathy respectively, as well as examining their effect on CCT and psychotherapy in general. Finally, the last subsection will be on the clinical effectiveness of CCT.

Review of Research Literature

Trauma

What is Trauma?

The word trauma is etymologically of Greek origin. It comes from the Greek *τραύμα* (trauma), meaning a wound (Kolaitis & Olff, 2017). Later understandings, particularly influenced by Freud, understood this wound as being in the mind and not the body. The trauma of the mind was understood to be principally different from the wound of the body, which is a simple and healable event whereas the trauma was an injury that was unexpected, experienced without any warning, and hidden from one's consciousness, not fully known (Caruth, 2017).

A modern definition of trauma understands it as a response to any kind of stress or stressful event that overwhelms an individual's ability to cope (Straussner & Calnon, 2014). These events can typically be dangerous experiences involving threats of, witness of, or actual experience of death, injury, or sexual violation and is usually accompanied by feelings of intense fear and, crucially, helplessness (McLaughlin et al., 2020; Sherin & Nemeroff, 2011, Straussner & Calnon, 2014). These experiences may affect individuals' psychological processes, significantly altering self-concept, relationship patterns, and belief systems (Schimmenti, 2017). Trauma may make the world seem unpredictable and out of one's control, changing an individual's worldview to distrust other people (Straussner & Calnon, 2014).

A broader definition of trauma is emerging, which recognizes two forms of trauma. "Large-T" traumas are events like natural disasters, human-caused disasters, mass violence, etc,

which can affect more than single individuals. These can also include more complex traumas of prolonged duration or multiple exposures such as interpersonal violence, longterm sexual abuse, wars, and terrorism. “Small-t” traumas are more common, but tend to be under-acknowledged. These are events such as bullying, poverty, childbirth, and discrimination or microaggressions, which still cause psychic pain and may cause lifelong damage. (Straussner & Calnon, 2014). Trauma may also result from how distressing events in one’s life are related and connected to each other (Schimmenti, 2017). However, trauma is also understood to be subjective; reaction to potentially traumatic events is modulated by age, gender, ego strength, previous trauma, chronicity of trauma, family history, life stressors, worldview, social supports, developmental stage, and psychosocial environment (Straussner & Calnon, 2014).

Because trauma is, in part, a maladaptively processed experience, certain sensory inputs co-opt an imbalanced degree of emotional importance in traumatized individuals. This imbalance informs behavioural reactions that are primarily to defend against future trauma in an effort to maintain homeostasis (Sherin & Nemeroff, 2011). Reactions to traumatic events come in three groups: 1) reminders of the exposure in the form of flashbacks, intrusive thoughts, or nightmares, 2) activation or hyperarousal in the form of insomnia, irritability, agitation, impulsivity, or anger, or 3) deactivation or numbing in the form of avoidance, withdrawal, depression, dissociation, or derealization (Sherin & Nemeroff, 2011). Intrusive memories and flashbacks can have somatosensory components, whether visual, olfactory, auditory, kinaesthetic, or visceral (Giotakos, 2020). Hypervigilance is a defense mechanism that seeks to keep an individual safe from their environment and avoid threat (Wilkinson, 2017) whereas dissociation defends from cognitively overwhelming processes by passively disengaging from reality and compartmentalizing the traumatic experience(s) (Schimmenti, 2017).

Trauma exposure, especially in childhood, is considered to be a diagnostic marker for and increases the risk of several forms of psychopathology, including anxiety, depression, substance use disorders, disruptive externalizing behaviours, and Post-Traumatic Stress Disorder (McLaughlin & Lambert, 2017; McLaughlin et al., 2020). 80% of youth that are of high-risk for psychosis have a lifetime history of childhood trauma and victimization (Giotakos, 2020). Traumatic stress tends to cause disorganized thinking, impaired judgement, altered reaction time, and unhelpful coping strategies (Straussner & Calnon, 2014) and can be accompanied by a reduction in associative processes involving linguistic and/or abstract concepts (Giotakos, 2020). Further neurobiological and genetic aspects of trauma will be discussed in a later subsection.

The impact of trauma on children is unique, including possible prenatal impacts on head size, thereby influencing neurocognitive development, and on endocrine and nervous system function (Straussner & Calnon, 2014; van der Kolk, 2003). Childhood trauma is considered to be a very significant transdiagnostic factor and is associated with elevated risk for nearly all commonly occurring forms of psychopathology, both internalizing and externalizing (McLaughlin et al., 2020). Childhood trauma can cause problems with self-regulation, aggression, attention difficulties, physical and somatic problems, and difficulty negotiating fulfilling interpersonal relationships (van der Kolk, 2003; McLaughlin et al., 2020). Traumatized school-age children show more aggression and somatic complaints compared to their peers as well as impaired concentration and difficulties with memory (Straussner & Calnon, 2014). Traumatized adolescents may show more acting-out and self-destructive behaviour, such as substance abuse or re-enactments of violent episodes (Straussner & Calnon, 2014). It is possible, however, that children may not show “classic” trauma symptoms until later in life due to a

delayed expression (Heringa, 2017) and the symptoms of chronically traumatized children may be obscured by other cognitive, affective, social, and/or physical problems (van der Kolk, 2003).

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is a mental health condition that can follow exposure to or threat of death, serious injury, or sexual violence (American Psychiatric Assocation, 2013, Forbes et al., 2011). It can be understood as a combination of an anxiety and memory disorder, characterized by the inability of a person to integrate a traumatic event into their consciousness (Giotakos, 2020). Symptoms of PTSD emerge beginning after the traumatic event occurred and must meet each of the following three criteria to be diagnosed: 1) recurring, involuntary, and distressing re-experiencing of the event and feelings of fear or horror, 2) persistent avoidance of trauma reminders or stimuli associated with the traumatic event, and 3) significant increases in reactivity, hypervigilance, or an enhanced startle response (World Health Organization, 2019; American Psychiatric Association, 2013; Saraiya et al., 2021).

Lanius et al. (2010) suggest a model of PTSD that divides it into two subtypes based on emotional regulation strategies. The more common reexperiencing and hyperarousal subtype is considered to be a result of undermodulating affect whereas the dissociative subtype is the result of overmodulating affect and gaining psychological distance. This dissociative subtype is suggested to appear more when the patient experienced interpersonal trauma during younger, developmental periods (Lanius, Bluhm, & Frewen, 2011). It appears in 12-30% of patients with PTSD (Hansen, Ross, & Armour, 2017).

Women appear to be more susceptible to trauma than men; The ratio of men with PTSD to women with PTSD is 1:3. The mechanism for this is unknown, but may be related to help-

seeking behaviour, neurobiological or hormonal differences, or women's greater exposure to interpersonal and sexual violence as children/young adults (Straussner & Calnon, 2014).

A related, but separate disorder called Complex Post-Traumatic Stress Disorder (cPTSD) has been proposed to describe experiences of prolonged and repeated trauma in which a victim is held captive, under control of the perpetrators, or otherwise unable to escape (Herman, 1992, as cited in Knefel & Lueger-Schuster, 2013). Multiple exposures to trauma have been shown to lead to outcomes that are not simply more severe than single-trauma symptoms, but are categorically different in their effects on affective and interpersonal domains (Cloitre et al., 2009, Knefel & Lueger-Schuster, 2013), and are significantly more impairing than PTSD (Cloitre et al., 2013). It may be that the impact of prolonged trauma is less in the duration or repetition of traumas, but in the multiple, overlapping nature of them (Cloitre et al., 2009). Viewed developmentally, there is a significant relationship between prolonged childhood trauma and symptom complexity in adults, but crucially, not prolonged adult trauma (Cloitre et al., 2009) and those with cPTSD report very high levels of childhood interpersonal violence and abuse, both physical and sexual (Cloitre et al., 2013).

The symptoms of cPTSD have each of the core elements of PTSD with the inclusion of one symptom from each of three domains of self-organization: affective problems, a persistent negative self-concept, and relational disturbances (World Health Organization, 2019; Cloitre et al., 2013; American Psychiatric Association, 2013). In the affective domain, symptoms include emotional dysregulation/reactivity (Cloitre et al., 2014), stress-induced dissociation (Cloitre et al., 2009), and emotional numbing (Lanius, Bluhm, & Frewent, 2011). cPTSD patients exhibit a persistently negative self-concept, particularly beliefs that one is diminished, defeated, or worthless (Cloitre et al., 2014; Cloitre et al., 2013; Lanius, Bluhm, & Frewen, 2011). They are

likely to have interpersonal difficulties, particularly in sustaining close relationships, which causes increased avoidance and a sense of alienation (Cloitre et al., 2014).

The treatment for PTSD should focus on exposure to frightening stimuli and processing the trauma memories that follow (Rothbaum & Schwartz, 2002). However, because many of the traumas that cause cPTSD are interpersonal in nature, it has been suggested that treatment should seek to heal attachment injuries and rehabilitate emotional reactivity and maladaptive interpersonal patterns (Cloitre et al., 2009; Gonzalez, 2018). Finally, cPTSD treatment should work on making a more positive self-concept, reducing avoidance behaviours, and, finally, engaging with the meaning of trauma memories (Cloitre et al., 2014).

Neurobiology of Trauma

Trauma has a neurobiological impact due to three major factors: endocrine factors, neurochemical factors, and brain circuitry factors (Sherin & Nemeroff, 2011). The main endocrine impact is dysregulation and overactivation of the hypothalamic-pituitary-adrenal (HPA) axis (Sherin & Nemeroff, 2011; Giotakos, 2020; van der Kolk, 2003). The HPA axis is inhibited by the hippocampus and prefrontal cortex and stimulated by the amygdala. The HPA axis coordinates hormonal stress responses by producing glucocorticoids, which block the retrieval of emotional memories (Sherin & Nemeroff, 2011).

Neurochemical factors include sustained hyperactivity of the sympathetic nervous system (SNS) producing dopamine (DA) and norepinephrine (NE). NE is a principal mediator of the autonomic nervous system (ANS) stress response by encoding emotional memories, increasing fear conditioning, arousal, and hypervigilance (Sherin & Nemeroff, 2011). It has been suggested that an overabundance of NE accounts for certain classic aspects of PTSD symptoms, including hyperarousal, increased startle, and increased encoding of fear memories (Sherin & Nemeroff,

2011). Glutamate is an excitatory neurotransmitter, activated by glucocorticoids, that binds to NMDA receptors, which are associated with synaptic plasticity and dissociation/derealization. Overexposure to glutamate may contribute to loss of hippocampal and prefrontal cortical neurons in patients with PTSD (Sherin & Nemeroff, 2011; Giotakos, 2020).

The brain circuitry of the hippocampus, the amygdala, and the prefrontal cortex (PFC) are impacted by trauma and PTSD (Sherin & Nemeroff, 2011; Straussner & Calnon, 2014; van der Kolk, 2003). These areas, as well as cortical regions, form a neural circuit that mediates stress adaptations and fear conditioning. Impacts in these areas lead to problems with emotional regulation, heightened reactivity, and weakened emotional resiliency (Straussner & Calnon, 2014). People with trauma and PTSD show reduced volume in the hippocampus and PFC and increased volume in the amygdala (Sherin and Nemeroff, 2011; Giotakos, 2020; Wilkinson, 2017; Straussner & Calnon, 2014; van der Kolk, 2003).

The thalamus, which coordinates a large network of brain regions, shows lowered activity in persons with PTSD, leading to a reduction in associated processes involving words and abstract concepts (Giotakos, 2020). Broca's area, responsible for inner speech, is dark during traumatic image recall, possibly due to weakened associative processes while remembering traumatic events (Giotakos, 2020; van der Kolk, 2003).

The hippocampus controls stress responses and declarative memory (Sherin & Nemeroff, 2011; Giotakos, 2020). Hippocampal damage due to prolonged stress hormone release damages memory, leading to fragmented memories of trauma (Giotakos, 2020; Sherin & Nemeroff, 2011). Early abuse and neglect affect maturation of the hippocampus, leading to difficulty interpreting sensory input as dangerous or threatening (van der Kolk, 2003; Straussner & Calnon, 2014; Giotakos, 2020;

The amygdala is responsible for emotional processing and is critical for acquisition of fear responses. PFC inhibits stress responses and emotional reactivity by downregulating the amygdala (Sherin & Nemeroff, 2011). Traumatized individuals show decreased activation of PFC in response to trauma stimuli and hyperreactivity in the amygdala, both to trauma reminders and non-traumatic emotional stimuli such as emotional faces (Sherin & Nemeroff, 2011; Giotakos, 2020; Lanius, Bluhm, & Frewen, 2011). The amygdala can activate when stressors resemble previous trauma, creating inappropriate defensive responses (van der Kolk, 2003). It has been suggested that the faster maturation of the amygdala relative to PFC contributes to unique impacts of childhood and youth trauma due to lack of balance between the "reasonable" and "impulsive" brain (Giotakos, 2020).

Patients with PTSD show lower activity in the frontal lobe, the anterior cingulate cortex (ACC), and thalamic areas, affecting executive functioning and attention (Giotakos, 2020). This also leads to failures in cognitive integration, leading to self-blame and shame, failures in memory integration, leading to over-consolidated episodic memory and impaired semantic memory, and failures of somatosensory integration, leading to fragmented memories, sensory experiences, and flashbacks (Giotakos, 2020).

As mentioned above, trauma memories are blocked by glucocorticoids, an overabundance of norepinephrine (Sherin & Nemeroff, 2011), fragmented by hippocampal damage (Giotakos, 2020; Sherin & Nemeroff, 2011) and a lack of somatosensory integration (Giotakos, 2020). During trauma memory recall, there is reduced activation in the ventromedial PFC and anterior insula, which may be part of the interoceptive network, leading to dissociation (Lanius,, Bluhm, & Frewen, 2011). Patients with PTSD show similar activity even when recalling sad and/or anxious non-traumatic memories (Lanius, Bluhm, & Frewen, 2011).

Patients with PTSD show marked increase above controls in activation of the right hemisphere compared to the left (Giotakos, 2020; Straussner & Calnon, 2014; van der Kolk, 2003) especially when recalling an upsetting memory vs a neutral one (van der Kolk, 2003). This decreased activation is found especially in the left dorsolateral PFC, mediated by an overactive amygdala, which may contribute to hyperarousal (Giotakos, 2020). Left cortical underdevelopment is responsible for difficulties in perceiving and expressing language, which is consistent with findings that abused patients show verbal deficits (van der Kolk, 2003). The thalamus is thought to contribute critically to the functioning of the corpus callosum, which regulates bilateral neural activity, therefore lower activity in thalamic areas shown above may contribute to altered lateralization between hemispheres (Giotakos, 2020). The middle portion of the corpus callosum has been found to be significantly smaller in children with histories of abuse, especially male children (Straussner & Calnan, 2014; van der Kolk, 2003).

Jaworska-Andryszewska and Rybakowski (2019) show how genetic factors may make children more predisposed to the effects of trauma due to the interaction between several genes. In particular, the most important interactions are between the serotonin transporter gene 5-HTT and the protein binding gene FKBP5, which has an effect on the HPA axis and higher stress hormone levels. Childhood trauma is associated with DNA methylation (van der Kolk, 2003), which can epigenetically increase dysfunctional behavioural patterns and risk for psychopathology. It has been suggested that this is also a possible mechanism for transmission of intergenerational trauma (Jaworska-Andryszewska & Rybakowski, 2019).

Resilience and Vulnerability to Trauma

76% of Canadians have experience at least one traumatic event in their lifetimes, but the prevalence rate of lifetime PTSD is 9.2% (Van Amerigen et al., 2008). The likelihood of an adult

or child developing PTSD from a traumatic event is mediated by vulnerability and resiliency. It is important to think of these two concepts as multi-factorial, as mono-causal theories of either risk or resilience lose sight of the complex nature of human wellbeing (Davydov et al., 2010).

It was previously assumed that trauma abnormalities were acquired after an exposure, but there are pre-traumatic factors that influence vulnerability to PTSD that may be unmasked by stressors (Sherin & Nemeroff, 2011). 3 sets of factors contribute to vulnerability to developing PTSD: 1) Pre-traumatic factors, including previous trauma exposure, prior mental disorders/emotional problems, family dysfunction including parental separation or death, racial/ethnic status, lower SES/education levels, and possible genetic factors, 2) Peritraumatic factors including the severity of the trauma, personal injury, and whether the trauma was interpersonal, especially if it involved a caregiver, and 3) Posttraumatic factors including negative appraisals, inappropriate coping strategies, repeated reminders, and financial or other trauma-related losses. (American Psychiatric Association, 2013; DiGangi et al., 2013)

For children, familial trauma is a strong predictor of a child developing PTSD (Marzilli et al., 2021). Parents with PTSD exhibit a tighter coupling with children, leading to an inability to relax dependence and allow them to develop self-regulation and capacity for resilience (Motsan et al., 2020). Traumatic events can compromise the parent-child relationship, which mediates the development of PTSD (Marzilli et al., 2021; Motsan et al., 2020).

Resilience is a difficult concept to fully and accurately define and studies of it vary substantially in definition and measurement (Davydov et al., 2010). It has been defined as an individual's capacity to utilize external and internal resources in response to stress (Straussner & Calnon, 2014). It has also been defined as having the components of flexible adaptation, managing stress via coordinated action with significant others, and the possibly uniquely human

phenomenon of making meaning (Feldman, 2020). Resilience-as-adaptation may include viewing stress as a challenge to overcome, having a sense of self-efficacy and control, and tolerance for negative emotions (Shebuski, Bowie, & Ashby, 2020). It has been studied as an individual trait, a group trait, an adaptive temperament, having effective coping strategies, having high positive emotions, and having flexibility in using emotional resources; Its determinants are genetic, biological, psychological, familial, community-based, social, and environmental. (Davydov et al., 2010).

External resources an individual may use to resist trauma include social support, which has been shown to be a protective factor both pre- and post-trauma (American Psychological Association, 2013; Wang et al., 2021) and parental resilience, as higher levels of resilience in parents predicted lower trauma distress and lower psychopathology in their children (Marzilli et al., 2021). The attachment bond, which may be considered both an external and an internal resource, is an important mitigating factor against trauma-induced disorganization (van der Kolk, 2003). Internal resources an individual may use to resist trauma include a sense of control and the ability to tolerate negative emotions (Shebuski, Bowie, & Ashby, 2020; Straussner & Calnon, 2014). Self-compassion, shown to be more prevalent in men, is the tendency to treat oneself with kindness during difficult experiences. It is a significant moderator between trauma exposure and psychological distress and predicts lower levels of trauma symptomology. (Shebuski, Bowie, & Ashby, 2020).

Accelerated Experiential Dynamic Psychotherapy (AEDP)

Attachment

Attachment theory is an evolutionary theory developed by John Bowlby (1982), and later further developed by Mary Ainsworth (1985), that explains predispositions in an individual's

engagement with important others in the search for safety and survival. (Simpson et al., 2020). It posits that humans have innate wiring geared towards forming connections with primary caregivers (Wilkinson, 2017). This attachment with primary caregivers is suggested to play a key role in emotional awareness (Lanius, Bluhm, & Frewen, 2011) Caregivers protect children from the effects of stressful situations by helping them to regulate their emotions, thereby helping the infant to develop the necessary structures and behaviours to deal with future stressors (van der Kolk, 2003).

Attachment networks that are developed in infancy and childhood are internalized as an individual grows and develops, creating a working model of self and others from which they develop adult attachment orientations (Simpson et al., 2020; Wilkinson, 2017; Sutton, 2018). The affiliative orientation of the human brain that develops in early life is what enables the formation of close relationships, both platonic and romantic, and later in life, parental (Feldman, 2020).

Ainsworth (1985) theorized that children organize their behaviour into three distinct styles, relative to their caregivers: secure, anxious-avoidant, or anxious-ambivalent. The latter two styles are sometimes grouped together and called insecure attachment. In a study of infants separated from mothers in a “Strange Situation,” Ainsworth observed that: 1) Group A (anxious-avoidant) were unperturbed by separation from the mother and avoided her when she returned, 2) Group C (anxious-ambivalent) were very wary of the stranger-researcher, were intensely upset by separation, and upon the mother’s return, wanted closeness, but were inconsolable in their anger, and 3) Group B (secure) explored the strange environment readily with the mother present, explored less when she was absent, and sought closeness or positive interaction upon her return (Ainsworth, 1985).

From an attachment perspective, caregivers must actively help an infant to modulate their stress and physiological arousal; if a child does not get relief from their external environment, they will not develop ways to organize their experiences coherently (van der Kolk, 2003, Simpson et al., 2020). The attachment relationship is thought to facilitate emotional and self-regulation by seeking to be close, either physically or emotionally, to a secure figure, who is a safe place from which to regulate and a secure base from which to explore the world and develop autonomy (Simpson et al., 2020). The attachment relationship has been shown to be physiological as well as psychological, suggested by how the heart rates of parents and infants parallel each other when interacting (van der Kolk, 2003). This biobehavioural synchrony is thought to be how attachment bonds become dyad-specific and long-lasting (Motsan et al., 2020).

Marshal and Frazier (2019) show how attachment orientations can be mapped onto two continuums of attachment anxiety and attachment avoidance. Securely attached individuals, low in both anxiety and avoidance, seek engagement which results in the necessary support, security, and amelioration of distress through emotional co-regulation. Insecurely attached individuals must rely on secondary strategies because they are unable to gather the support and security they need from the environment. Anxious-ambivalent individuals, high in anxiety, have learned that caregivers are unpredictable and so use hyperactive strategies to attain the support they desire, potentially by exaggerating the seriousness of distress. Anxious-avoidant individuals, high in avoidance, have learned that caregivers reject their emotional needs and use downplaying strategies by denying need for support and suppressing the seriousness of distress (Marshal and Frazier, 2019).

A fourth style of attachment orientation, disorganized/disoriented, has been suggested (Main, 1995), which is characterized by the attachment figure being frightened and frightening, both a source of fear and the safe haven to which the child longs to retreat (Main, 1995). The behaviours associated with disorganized attachment were viewed as lacking a readily observable goal, clear intention, or explanation and were often observed to be contradictory from one moment to the next (Main, 1995). While all insecure attachment styles are associated with externalizing behaviours, children who are disorganized in their attachment show elevated risks of externalizing behaviours (Fearon et al., 2010). Disorganized attachment has been associated as a risk factor for ODD through detrimental effects on socio-emotional competencies (Forslund, Peltola, & Brocki, 2019).

This classification is not without criticism, however. Duschinsky (2015) claims that practitioners are misunderstanding Main and Solomon's original research when they work under the assumption that disorganized attachment 1) is undifferentiated and illogical internal chaos and 2) completes the formerly tripartite Ainsworth classification, making an exhaustive typology for all behaviours. Duschinsky claims that the classification was not meant to capture all outlier behaviour and was instead meant to be used as a scale to describe dysregulation in the attachment system. Reisz, Duschinsky, and Seigel (2018) claim that the misunderstanding stems from the original authors using the term "pattern," invoking the Ainsworth classification system, which the authors did not intend and that unpublished manuscripts show that Main thought that trauma caused disorganization in the attachment system and does not create a new category. Indeed, it has been shown that when parental figures are unable or unwilling to aid a child in co-regulation in the face of intense trauma or when they themselves are its source, the children are

left alone with overwhelming emotions, leaving them to cope via dissociation (Schimmenti, 2017).

Attachment style is associated with differences in emotional regulation and recognition. Anxiously attached individuals show more regulatory difficulties than securely attached individuals, with a higher use of rumination, self-blame, and catastrophization, whereas avoidant individuals show difficulties in identifying emotions and use more deactivating strategies (Henschel, Nandrino, & Doba, 2020). Clinical interventions for those with attachment difficulties should focus on affect regulation within the context of a secure relationship with the therapist, however, due to defensive and/or fearful stances that clients bring, that trusting relationship should be built first before the dyad attempts to work with distressed or negative feelings (Wilkinson, 2017).

Emotion-Focused Therapy

Emotion Focused Therapy (EFT; Greenberg, 2004) is an experiential psychotherapy that views emotions as foundational to human self-structure and a key component of our self organization. EFT views emotions as adaptive experiences that help individuals appraise a situation around goals, concerns, or needs and that the biological and cultural process of making meaning of one's emotions involves explicating one's emotional experience and integrating reason with emotion. EFT conceptualizes emotions as either primary emotions, which are fundamental, initial reactions to a situation, and secondary emotions, which are responses to prior thoughts and feelings and may be avoidant defenses against primary emotions (Greenberg, 2004).

The EFT therapist usually conceptualizes cases in this process: a client comes with undifferentiated emotions or *global distress* and together the dyad work through secondary

emotions and avoidance strategies by fully experiencing and validating them until primary emotions emerge in the form of core pain and/or unmet needs. By fully experiencing the primary emotions, new adaptive emotions emerge (Timulak & Pascual-Leone, 2015). The primary focus of EFT is not on symptoms such as worry or anxiety, but rather on building capacity to tolerate difficult emotions and overcoming avoidance strategies so as to generate primary adaptive emotions such as self-compassion or protective anger (Timulak et al., 2022). However, as a process-oriented psychotherapy, EFT should have no predetermined treatment plan and is instead planned collaboratively with the client, creating a focus in early stages of treatment (Goldman & Goldstein, 2022). Focusing on what parts of the process clients find difficult in early stages will lead to better treatment outcomes and relying on initial strengths of the dyad and ignoring shortcomings may not be optimal (Harrington et al., 2021).

The therapeutic relationship is a key part of EFT as it theorizes that emotional triggers resemble developmental injuries in which certain emotions in the client's past were neither externally accepted nor validated, resulting in emotional or behavioural avoidance (Timulak & Pascual-Leone, 2015). An accepting, empathetic relationship provides safety and openness to sort out feelings, develop self-empathy, and access resiliency through emotional regulation (Joseph, 2004). As a trauma therapy, EFT places importance on relationship building before exposure-based or experiential work begins, as exposure without emotional regulation is not as effective (Murphy, Elliott, & Carrick, 2019; Shahar, Bark-Kalifa, & Alon, 2017).

As mentioned above, although EFT does not focus on symptoms (Timulak et al., 2022), it has been shown to be a very effective treatment for PTSD, cPTSD (Paivio et al., 2010) and trauma symptoms, especially anxiety. Shahar, Bar-Kalifa, & Alon (2017) found EFT very effective in a small sample for social anxiety disorder and clients showed lasting improvements

in self-criticism. O'Connell et al. (2021) showed that a brief version of EFT for students with generalized anxiety showed large effect sizes including decreased anxiety, increased self-understanding, resilience, self-compassion, and assertiveness. Timulak et al (2022) found in small trials that EFT's effectiveness for treating anxiety showed no difference to parallel CBT trials.

What is AEDP?

Accelerated Experiential Dynamic Psychotherapy (AEDP) is a therapeutic modality developed by Diana Fosha (2000). It is an integration of emotion-focused therapy (Markin et al., 2018), affective neuroscience (Lipton & Fosha, 2011; Fosha, Thoma, & Yeung, 2019; Fosha & Thoma, 2020), and attachment theory (Fosha, 2000; Lipton & Fosha, 2011; Harrison, 2020; McBride et al., 2020). AEDP views much of psychopathology as the result of unwilled and unwanted aloneness in the face of overwhelming emotion (Fosha, 2009; Fosha, Thoma, & Yeung, 2019; Fosha and Thoma, 2020; Harrison, 2020). In other words, symptoms are viewed as manifestations of internalized, insecure attachment (Markin et al., 2018) and the AEDP therapist seeks to provide a corrective experience by undoing aloneness in the context of secure attachment. (Lipton & Fosha, 2011; McBride et al., 2020). AEDP views humans as having neurobiologically wired strivings towards healing and self-righting (Lipton & Fosha, 2011; Fosha, Thoma, and Yeung, 2019) that are activated within a real, genuine, collaborative, and secure relationship to experience and process emotions that were previously too distressing or threatening. (Markin et al., 2018; McBride et al., 2020). AEDP also views the securely attached relationship to be therapeutic in and of itself as a reparative experience to past traumatic relationships (Markin et al., 2018) by disconfirming the patient's attachment-based experiences (Harrison, 2020).

AEDP is also a theory of emotion and a critique of previous psychotherapies in general. Previous trends in psychotherapy have focused on relieving suffering and ignored emotional flourishing as a goal (Fosha & Thoma, 2020). AEDP considers itself a positive psychology because its goal is to focus on the positive emotions that emerge during the work of experiencing and processing the negative emotions that are associated with trauma and suffering (Fosha, Thoma, & Yeung, 2019; Harrison, 2020). It presents a new framework for understanding mental health by incorporating the current dimension of presence vs absence of symptoms and adding an additional dimension of languishing vs flourishing (Fosha & Thoma, 2020). In this view, it is possible to flourish despite the presence of symptoms and to languish despite their absence (Fosha & Thoma, 2020).

Rather than simply processing negative emotions to completion, AEDP focuses on and fosters positive emotions that naturally come from working with negative emotions (Fosha, Thoma, & Yeung, 2019). In this framework, negative emotions are defenses that block natural adaptive tendencies and positive emotions are healthy, adaptive expressions that feel "right" (Markin et al., 2018). For example, sadness and crying may be a positive emotion that feels "right" to a client who has not been able to grieve before.

AEDP uses metatherapeutic processing, sometimes called metaprocessing, to work with positive emotions. Metaprocessing is when the client and therapist join to collaboratively reflect on the process of change within the therapeutic dyad (Fosha, 2000) thereby undoing the client's aloneness relationally (Fosha & Thoma, 2020). Together, they experientially process the positive emotions that come from therapeutic change (Fosha & Thoma, 2020; Harrison, 2020) by diving deep into the moment-to-moment experience of difficult emotions and their adaptive experience (Fosha, Thoma, & Yeung, 2019). By continuously asking "What is that like?" the client/therapist

dyad moves through stress/distress/symptoms, into core affective experiences, to transformational experiences of joy, pride, vulnerability, gratitude, tenderness, etc, and finally reaches a core state which is a feeling of calm, clarity, ease, and self-confidence (Fosha, Thoma, & Yeung, 2019; Fosha & Thoma, 2020; Harrison, 2020). A hallmark of AEDP is treating metatherapeutic processing as a recursive process of experiencing and processing the positive effects, the therapist's empathy, and the feeling of transformation at each stage towards core state (Fosha & Thoma, 2020). By reaching core state over many sessions, the clients gain confidence in being able to handle previously unbearable emotions (Lipton and Fosha, 2011).

Clinical Effectiveness of AEDP

AEDP is a relatively young psychotherapy and has only a handful of studies dedicated to showing its effectiveness. However, components of AEDP's framework and theory of change have robust clinical support (Harrison, 2020). The quality of the therapy relationship has been shown to be a strong and consistent predictor of psychotherapy outcomes and is as much a factor in the outcome as the choice of particular treatment modality (Norcross & Wampold, 2011). The reverse is also true; lack of empathy, positive regard, resistance to client feedback, and ignoring relational ruptures makes a practitioner ineffective (Norcross & Wampold, 2011). It has been shown that increased security in the therapeutic relationship has significant positive impacts on client attachment style, moving from insecure to secure attachment (Travis et al., 2001). The attachment style was also shown to have a significant relationship with symptom levels (Travis et al., 2001). Harrist et al. (1994) demonstrated that patients internalize positive aspects of the therapeutic relationship and their internal, intrapsychic functioning becomes similar to the interpersonal functioning of the client-therapist dyad. Finally, Castonguay and Beutler (2006)

identify that working with aroused emotions and helping clients accept, tolerate, and experience these emotions has a more positive effect than just a therapeutic alliance.

AEDP has been shown, in small sample sizes, to have a positive effect on symptoms of anxiety (Markin et al., 2018; Gonzalez, 2018). Change in AEDP is not linear and an ebb and flow of symptoms is to be expected although change can also be rapid, sudden, and seemingly by leaps (Markin et al., 2018). However, AEDP patients show reliable decline in symptoms within this ebb and flow (Markin et al., 2018). It has been shown to improve capacity to access, experience, and process emotion and was associated with lowered avoidance behaviour and higher emotional regulation (Iwakabe et al., 2020). Larger positive effect sizes were found within clinical patients, with complex problems when compared to subclinical patients, which hints at the strength of AEDP in working with complicated cases, although the subclinical group exceeded the population mean in many positive capacities (Iwakabe et al., 2020). AEDP patients have also been shown to have persistent gains in both symptoms and interpersonal functioning after 6 month and 18 months follow ups, which is notably comparable to the long-term effectiveness of Cognitive Behavioural Therapy (Iwakabe et al., 2022). AEDP's goal of providing new attachment experiences from which the client reaches new understandings of emotion has shown to have positive effects on depression, symptoms of trauma, and symptoms of anxiety and stress (Gonzalez, 2018). Finally, it has been suggested that AEDP is uniquely helpful at the end of the therapeutic relationship to help a client with attachment difficulties learn how to say goodbye (Harrison, 2020).

The explicitly short-term framework of AEDP is focused on the immediate, here-and-now, disconfirming, and corrective relational experience (Iwakabe et al., 2020), therefore, the client-therapist relationship is a key indicator for the success of AEDP treatment (Iwakabe et al.,

2022; Markin et al., 2018). For treatment to be effective, the therapist must be authentic and genuine and, crucially, the client must experience them as such (Iwakabe et al., 2022). The experience of feeling "known" by the therapist is thought to facilitate the affective work of therapy and to bring about positive outcomes (Markin et al., 2018).

Rogerian Client-Centered Theory

What is Client-Centered Therapy?

Client-Centered Therapy (CCT; later called Person-Centered Therapy (PCT) although the terms may be used interchangeably) is a psychotherapy developed by Carl Rogers (1951). Rogers considered his system to be a set of attitudes rather than a set of techniques and methods because any technique a therapist uses that is not in line with their own attitudes will be unsuccessful (Rogers, 1951). The guiding principle of CCT is that all organisms have an inherent tendency towards growth, development, and flourishing (Patterson & Joseph, 2007) that Rogers called the actualizing tendency (Rogers, 1959). Whereas the actualizing tendency is common to all organisms, humans, as creatures with selves, also self-actualize, which is a related branch of actualizing in which the self strives to maintain and realise its characteristics (Ford, 1991). A person is said to be *congruent* when these two tendencies are working together and to be *incongruent* when they are at cross purposes or antagonistic to one another (Rogers, 1957).

Congruency and incongruency, for Rogers (1964), are about the development of values; For infants, values are internal, but the developing need and want for love alters their behaviour as they grow to bring the repetition of the wanted experience, positive regard. Therefore, they learn a basic distrust of their own experiences as a guide for behaviour and instead adopt outside values, moving from an internal locus of evaluation to an external one (Patterson & Joseph, 2007). CCT says that unfavourable social and environmental conditions cause this discrepancy

and incongruence within the organism, thwarting the actualizing tendency. This environment is dominated by *conditions of worth*, which are values internalized by the child in order to gain conditional positive regard from significant others in their life (Patterson & Joseph, 2007). These conditions of worth also create conditionality on the client's sense of self-regard (Ford, 1991) because of the natural attunement children have towards their parent's perspectives and attitudes and how the legitimacy of the child's thoughts, feelings, and behaviours is evaluated from the perspective of the other; put simply, a child tends to view themselves in the way their parents view them (Rogers, 1959).

CCT posits that there are six conditions that must be met and continue overtime for constructive personality change to occur: (1) The client, in a state of incongruence, (2) comes into psychological contact with (3) the therapist, who is in a state of congruence. The therapist must have (4) unconditional positive regard for the client and (5) an empathetic understanding of their internal frame, (6) both of which must be communicated to the client to at least a minimal degree (Rogers 1957; Rogers 1959; Rogers, 1951). These conditions are meant to exist on continuua and are not all-or-nothing statements (Rogers, 1959). Unconditional positive regard empathy, and therapist genuineness are considered to be the core conditions of client-centered therapy (Patterson & Joseph, 2007; Bozarth, 2002). The goal of CCT is to create positive social and environmental conditions within the therapy relationship from which a person can evaluate their experiences and values organismically, rather than from the internalized conditions of worth (Patterson & Joseph, 2007).

Rogers (1964) believed that as a client senses they are being prized as a person by the therapist, they slowly begin to value different aspects of themselves and their full experience becomes open to them again. Furthermore, he suggests that as in their environment, their values

would shift and mature to become more flexible, less rigid, considering both past and future, and, crucially, from an internal locus of evaluation. The end goal of such a "fully functioning person" is to move towards the value-directions of sensitivity to others, a valuing of deep relationships, realness, self-direction and an openness to all inner and outer experience and away from people-pleasing and a denial of the self.

Unconditional Positive Regard

Unconditional positive regard (UPR) is a key construct of Rogers' theory. In several writings, he used the verb "to prize" to describe this phenomenon (Rogers, 1957; Rogers, 1959). In this way, the therapist places no conditions of acceptance upon the client and values them as a whole person, irrespective of the differing values one might put on specific client behaviours (Rogers, 1959; Rogers, 1957; Lange, 2020). This notion is embodied by, and flows from, two fundamental questions he posed: "Do we tend to treat individuals as persons of worth, or do we subtly devalue them by our attitudes and behavior? Is our philosophy one in which respect for the individual is uppermost?" (Rogers, 1951, p. 20). Rogers stresses that this caring is for the client as a separate person and not possessively or to fulfill the therapist's needs (Rogers, 1957). Conditions of worth, when an experience or set of experiences is either avoided or sought after because the person deems them as being more or less worthy of self-regard, are challenged in this environment of UPR, because they developed in an environment when feelings of regard from significant other(s) was conditional (Rogers, 1959).

While UPR was developed in the context of CCT, it is considered to be relevant to all psychotherapies that place importance on acceptance and empathy as a necessary, if not sufficient, condition for effective treatment (Frankel, Rachlin, & Yip-Bannicq, 2012; Farber, Suzuki, & Lynch, 2019). The client's experience of UPR is key to its effectiveness; however

open-minded the therapist may be, if the client does not experience their regard, the therapy will not be successful (Wilkins, 2000). However, if they do experience UPR, the belief that the therapist cares about them is critical during times of stress (Farber, Suzuki, & Lynch, 2019).

UPR may be especially useful in work with diverse populations, however the power of UPR lies in prizing the client as a unique individual, not simply as a representative of a group (Enache, 2015). In situations where a non-minority counsellor is working with a client from a racial or ethnic minority, the positive effect of UPR on the relationship increases (Farber, Suzuki, & Lynch, 2019). Clients who identify as gender-diverse may be suspicious of empathetic expressions from a non-minority counsellor due to histories of invalidation and/or internalized stigma. It has been shown that UPR is an important pairing with empathy when working with gender-diverse populations (Lange, 2020).

Although UPR and empathy are both considered separate core conditions of therapy (Patterson & Joseph, 2007; Bozarth, 2002), it is neither possible nor desirable to isolate them in the therapeutic context. UPR and empathy cannot be isolated because acceptance is only valuable when empathetic understanding accompanies it (Frankel, Rachlin, & Yip-Bannicq, 2012) and congruence and empathy both merely provide a vehicle by which UPR is credible to the client (Wilkins, 2000).

One goal of UPR is for the therapist's regard to be internalized by the client as unconditional positive self-regard (UPSR) (Rogers, 1957; Rogers, 1959). For the therapist to offer UPR to the client, they must hold UPSR within themselves (Wilkins, 2000). UPSR within clients is associated with positive posttraumatic growth (Falnagan et al., 2015).

Some critics (Schmitt, 1980) of CCT identify a paradox implicit in UPR, which some practitioners (Wilkins, 2000) of CCT identify as well. The paradox is thus: how does the

therapist offer UPR to a person whose behaviour or attitudes are repulsive and repugnant to them (Wilkins, 2000), as in cases of bigotry or threats of violence/terrorism? Critics say that it is impossible to respond unconditionally to the self, but conditionally to the behavior and even suggest that UPR itself is untenable as it encourages helplessness within the client due to their inability to manipulate the situation (Schmitt, 1980). CCT practitioners offer that the therapist must connect to the person beyond these behaviours and attitudes without condoning the harmful behaviour, but also not colluding with it. They acknowledge the inherent tensions and suggest that they can only be resolved on a case-by-case basis (Wilkins, 2000).

Empathy

Empathy is a difficult concept to fully capture in a single definition. Operational empathy is thought to be expressed in three modes: 1) *empathetic rapport*, where the therapist exhibits a compassionate attitude toward the client, 2) *communicative attunement*, where the therapist engages in an active, ongoing effort to stay attuned to the client's communications from moment to moment and to communicate this engagement, and 3) *person empathy*, which is to experience a near-understanding of the client's world and undergo sustained effort to develop this understanding (Elliot et al., 2011). Neuroscience provides useful clarifications to help define empathy. In this framework, empathy is 1) an automatic and intuitive emotional simulation that mirrors brain states of another, 2) a deliberate, conceptual perspective-taking process, and 3) an emotional-regulation process to soothe personal distress at experiencing another's emotions in order to mobilize compassion and helping behaviours (Elliot et al., 2018). Finally, Carl Rogers (1957; 1959) offers a definition of empathy as a therapist quality of sensing another's internal state *as if it* were your own, but never losing the "as if" and confusing their state for one's own. He believed that empathy is about perceiving, with accuracy, the emotional components and

attached meanings of client experiences and that empathic understanding must be expressed verbally in addition to being non-verbally experienced by the client (Rogers, 1959).

It has been widely shown that the client's perception of their therapist's empathy is one of the best predictors for session quality and treatment outcome (Elliott et al. 2018; Chui, Li, & Luk, 2022; Watson et al., 2019), across different therapeutic modalities, formats (individual vs group) and severity of client problem (Elliot et al., 2019). Similar to Rogers' "feeling as if," it has been shown that the best session outcomes are when the therapist and client become closer in emotions from pre- to post-session (Chui, Li, & Luk, 2022). Client perception and experience of therapist empathy predicts changes in emotional regulatory capacities, as well as levels of depression, interpersonal problems, and negative self-concept, although this impact is modulated by client attachment style (Watson et al., 2019). Empathy has been suggested as an antidote for loneliness, which has significant risk factors for mortality (Wampold, 2015). Finally, it has been suggested that empathy is an important factor in work with clients who, in extreme states, perceive the world differently than others (psychosis, delusions, or expressing disturbing ideas), even though such differences in perception may challenge therapist empathic capacities (Lakeman, 2019).

In order to offer empathy, the therapist's attunement must be towards meaning and feeling, not simply words or content (Elliot et al., 2018). Genuine empathy does not bring any new meaning to the client, but instead, as accurately as possible, captures what is already there (Frankel, Rachlin, & Yip-Bannicq, 2012). As mentioned in an above section, empathy cannot be separated from other relational conditions (Elliot et al., 2019); Client perceptions of empathy are not clearly differentiated from perceptions of other factors such as positive regard or therapist genuineness (Elliot et al., 2018). Finally, therapists should understand empathy less as a

construct they "provide," but as a relational quality that is co-created through the client trying to be understood and the therapist striving to understand (Elliot et al., 2018). Therefore, genuine empathy must be individualized for particular clients as the therapist empathetically attunes to the client's experience of empathy; Fragile clients may find it intrusive, hostile clients may find it too direct, and others may find the focus on feelings to be foreign. The optimal therapeutic distance must be negotiated with respect to client boundaries (Elliot et al., 2011).

Clinical Effectiveness of Client Centered Therapy

Client Centered Therapy has been shown to have positive effects on client outcomes compared to controls and that these outcomes have persisted for up to a year post-therapy (Elliott et al., 2020). It has been shown to produce significant reductions in PTSD symptoms (Capaldi et al., 2016) especially with regards to internalizing behaviours such as anxiety, depression, and somatic complaints (Zandberg et al., 2016; Elliott et al., 2020).

Because Rogers lived and wrote before the term PTSD existed, CCT does not have anything explicit to say about trauma or trauma treatment (Rogers, 1951; Rogers, 1957). Joseph (2004) has defended it as a trauma therapy, arguing that Rogers worked with veterans of World War II and would have been familiar with military trauma. He goes on to say that many concepts from CCT are consistent with PTSD research, in particular how the breakdown of the self-structure and the inability to incorporate trauma into an existing schema is consistent with modern trauma literature.

The American Psychological Association (2017) recommends Cognitive Behavioural Therapy (CBT), Prolonged Exposure Therapy (PET), and other cognitive therapies for the treatment of PTSD, so CCT's effectiveness in treating trauma is often measured against the effectiveness of CBT. The results are mixed, although they generally favour CBT; While CCT

shows significant pre-post treatment effects for symptoms of trauma, in several studies, the effects are not as high as the parallel CBT trials (Elliott et al., 2020) or PET trials (Zandberg et al., 2016; Capaldi et al., 2016). However, Ghafoori et al., (2019) report that CCT showed comparable symptom improvement to CBT.

Certain aspects of CCT may be helpful in treating trauma, in particular, by creating the therapeutic alliance, which has been shown to be very important, although potentially not sufficient, for treating PTSD symptoms (Capaldi et al., 2016). It may be helpful in making the client feel listened to, understood, supported, able to be vulnerable, and crucially, in control of the process (Elliott et al., 2020). Finally, CCT has a much lower drop-out rate when compared to CBT and other trauma treatments (Ghafoori et al., 2019).

Joseph (2004) acknowledges that many modern client-centered therapists are finding it appropriate to be more directive in their work with traumatized individuals and are using ideas and ways of working borrowed from other orientations. Classical CCT works as hard as possible to be non-direct in its approach, so this change represents a major theoretical break from older CCT and admits the possibility of syncretism with other approaches and the need for psychoeducation about trauma for the client. Joseph (2004) ends by suggesting that it is still important to give the client an internal locus of control and for the therapist to approach every client as a new, unique person and not to generalize their traumatized patients.

Summary

Trauma is any psychically painful event(s) or experience(s) that overwhelms an individual's ability to cope (McLaughlin et al., 2020; Sherin & Nemeroff, 2022, Straussner & Calnon, 2014). Reactions to trauma include triggers, hyperarousal, and numbing/dissociation (Sherin & Nemeroff, 2022). Childhood trauma can cause the condition, cPTSD, which can affect

self-regulation and the ability to build interpersonal relationships, due to the often interpersonal nature of the trauma (McLaughlin et al, 2020; van der Kolk, 2003; Cloitre et al., 2009). cPTSD causes affective problems (Cloitre et al., 2013) and a persistent negative self-concept (Cloitre et al., 2014). Treatment for PTSD involves processing trauma memories (Rothbaum & Schwartz, 2002) and cPTSD treatment should seek to heal attachment wounds, develop emotional regulation skills, alter maladaptive relational patterns (Cloitre et al., 2009), create a positive self-concept, and reduce avoidance behaviours (Cloitre et al., 2014).

AEDP works with the attachment relationship, which is thought to facilitate emotional and self-regulation (Simpson et al., 2020), and EFT, which seeks to build tolerance for previously intolerable emotional states and to develop self-compassion (Timulak et al., 2022). AEDP uses metatherapeutic processing to collaboratively and explicitly reflect upon the client's process of change to experience positive, adaptive emotions (Fosha, 2000). AEDP is an effective trauma treatment for anxiety and emotional regulation (Iwakabe et al., 2020). CCT is primarily relational and considers unconditional positive regard, deep empathy, and therapist genuineness to be core conditions (Patterson & Joseph, 2007; Bozarth, 2002). These conditions are considered to be relevant to all psychotherapies (Frankel, Rachlin, & Yip-Bannicq, 2012; Farber, Suzuki, & Lynch, 2019) and are some of the best predictors of session quality and treatment outcome (Elliott et al. 2018; Chui, Li, & Luk, 2022; Watson et al., 2019).

Chapter 3: Summary, Recommendations and Conclusions

Summary

The aim of this capstone has been to investigate how a school counsellor can use Client-Centered Therapy and Accelerated Experiential Dynamic Psychotherapy to assist their students, especially those students with trauma.The following section will first highlight some of the key points presented throughout this study and then will present recommendations on a three-tiered approach for school counsellors to address the unique challenges of working with clients who have experienced trauma.

School counsellors are necessarily going to be working with children, youth, and young adults, meaning any trauma that their student clients have sustained will be childhood trauma, which has unique impacts on nervous system function (Straussner & Calnon, 2014) and on self- and emotional regulation (McLaughlin et al., 2020). Prolonged childhood trauma, especially familial trauma (Marzilli et al., 2021), is a strong predictor of developing cPTSD (Cloitre et al., 2009), which creates a persistent negative self-concept and difficulty with interpersonal relationships (Cloitre et al., 2014).

Memories of prolonged trauma may be difficult to access, due to hippocampal damage (Giotakos, 2020) or patterns of rapid dissociation (Lanius, Bluhm, & Frewen, 2011). Therefore, the traditional exposure therapy treatment for PTSD (Rothbaum & Schwartz, 2002) may not be universally applicable in school counselling and school counsellors should instead focus on attachment injuries, emotional reactivity (Cloitre et al., 2009), self-concept, and avoidant behaviours (Cloitre et al., 2014).

Attachment bonds are connected to the ability for emotional and self-regulation (Simpson et al., 2020) and it is suggested that the trusting relationship should come before any work with

distressing feelings (Wilkinson, 2017). Client-centered therapy is relational in nature and is an ideal base from which to build a therapeutic relationship. Counsellors should be client-centered in all their interactions with students, but particularly for students with trauma. Students with disorganized attachment, whether it is a true category or rather an addendum to an insecure style, need an attachment figure who is clearly and consistently safe (Main, 1995). CCT's focus on genuineness, regard, and empathy are a basis for which this safe environment can be created. These conditions are also useful in working with non-traumatized students (Elliot et al,. 2010; Frankel, Rachlin, & Yip-Bannicq, 2012) or students with other attachment styles, who need a caregiver who is emotionally available and responsive to their needs (Marshal and Frazier, 2019).

AEDP is particularly suitable as a trauma therapy because of its focus on attachment, emotion, and self-concept (Lipton & Fosha, 2011). It does not directly focus on trauma memories, but rather on learning to fully experience emotions within the context of secure attachment, thereby gaining self-confidence in one's ability to tolerate distressing emotions (Lipton & Fosha, 2011).

Recommendations

The recommendations from this study will be three-tiered and may be thought of as mirroring the Response to Intervention Framework (RTI) (McIntosh et al., 2011). The first response, Universal, will be to incorporate the relational, core-conditions of Client Centered Therapy into the everyday work of the school counsellor. Universal interventions are for all students and may even be extended to staff members, as the school counsellor must also have good working relationships with other adults in the building. The second response, Targeted, will be for students who have difficulties with emotional regulation or negative self-concept. Many

counsellors work in a somewhat eclectic format, drawing wisdom from many modalities, and this response will offer some aspects of AEDP that may be absorbed into an otherwise highly varied style of counselling. The third response, Intensive, will be for a small number of students with whom the school counsellor can fully use AEDP to help foster flourishing in the midst of trauma. As with the traditional Response to Intervention Framework, the supports from previous tiers are brought into subsequent tiers, meaning the relational, rapport building aspects of CCT, unconditional positive regard and an empathetic presence, will persist into the work of AEDP.

Universal Supports: Using CCT to build rapport, relationship, and community

> "It is said that when Carl Rogers was once asked for his thoughts on short-term psychotherapy, he replied that whenever you come into contact with another person that it may be for the last time...he thought it essential to make the most meaning out of every relational encounter with a patient." – (Markin et al., 2018, p. 213-214)

It is a relatively uncontroversial statement that counsellors should offer UPR and empathy to their clients in session (Frankel, Rachlin, & Yip-Bannicq, 2012; Farber, Suzuki, & Lynch, 2019). A school counsellor differs from a private counsellor in that they work in a community of students and have caseloads of several hundred clients, so rather than providing recommendations for in-session work, this tier of support will recommend Rogerian concepts outside of the counselling office. The hope is that if a counsellor is perceived by the community as a safe, supportive person, the work of building a relationship in the counselling office will already have begun even before the student enters the room.

i) Prizing

Counsellors meet students in many formats around the school. While much of their work will take place in a counselling office, they also meet students in the hallways, in conversations with teachers, in classrooms, in music rooms, drama studios, and after-school basketball

practices. They are also involved in career counselling and course planning, connecting them to students who do not seek social-emotional support and therefore would not otherwise meet their counsellor. All of these encounters, whether long-term or short-term, are opportunities for the school counsellor to prize the students around them. It may be tempting to see students as an undifferentiated group, but to extend unconditional positive regard to individuals is to care for them as distinct, separate people (Rogers, 1957; Enache, 2015).

Regard for students can also be extended into valuing what they value. A school counsellor can demonstrate positive regard by supporting activities and micro-cultures within a community, implicitly showing that they value what students *do* as well as who they are. This can include attending dance performances, viewing art showcases, attending club fairs, watching sports tournaments, etc. While this represents a potentially significant time commitment, it can also demonstrate the broad regard a counsellor has for their students.

UPR may be useful in two specific realms: Working with students with minority identities and working with students with behavioural challenges. UPR is crucial in working with gender-diverse populations (Lange, 2020) and with clients from racial or ethnic minorities (Farber & Doolin, 2010). For students who may face daily microaggressions (or macroagressions), a school counsellor learning how to correctly say their name or using their correct pronouns, even in passing interactions, signals to them that you value and accept their wholeness when others may not. For students who are consistently experiencing the punitive/punishment side of a school, positive regard of any kind from a staff member may be a rare experience. A school counsellor's unconditional regard, despite behavioural challenges, may be key to developing rapport and relationship with a set of students that need positive adult connections. Even a greeting as simple as "Good morning, _____, it's good to see you today"

could be the first positive thing an adult has said to them recently. Regarding the student positively, but not condoning destructive behaviour is an undeniable tension (Wilkins, 2000) and may not have a universally applicable resolution.

ii) Empathy

Similar to UPR, all encounters a school counsellor has with students are opportunities to offer empathy. Offering empathy for disappointment over a poor grade on a project, anxiety over a performance, or satisfaction over hard work paying off is still a meaningful connection with that student, however brief. Empathy pairs with UPR in this way to signal to students that they are important, unique individuals. From an attachment perspective

Therapeutic empathy is usually described as a dyadic phenomenon in which one senses another's emotional states and associated meaning (Elliott et al., 2019; Elliott et al., 2011; Rogers, 1959). This description assumes two individuals are meeting with no one else around. Empathy for groups is also possible and may be part of modeling interpersonal dynamics for a community. Group of individuals having similar experiences may assign similar meaning to those experiences and therefore feel similar emotions. For example, a loss for a school soccer team may be felt by all as disappointment, loss, frustration, etc. However, it is also likely that individuals within groups assign different meanings and have different emotions. Players within the soccer team may be ambivalent because they play for enjoyment more than competition or they may feel accomplishment at an individual level for passing well or blocking a number of shots. Offering empathy for individuals within groups can model attunement to others' feelings, helping the disappointed player to notice their teammate's personal accomplishments and helping the ambivalent player to notice their teammate's grief over the loss. Modeling empathy within a group of adults, for example in a staff meeting, may accomplish the same goal and help

increase intra-group functioning, by making people feel understood and encouraging perspective-taking.

Empathy is also not simply the state of being attuned to feelings and meaning, but it is also a sustained effort to understand the world of another, that is, to be engaged in a deliberate perspective-taking process. Students in British Columbia are assigned a school counsellor, either by graduation year, by alpha, or by some other system and as far as the author is aware, students do not usually get a choice in who their counsellor is. Therefore, school counsellors have an obligation to promote social justice and to understand the communities in which they work because their unchosen clients live within those communities as well. To offer empathy on a broad scale, it would be advisable for the counsellor to educate themselves on social issues from the perspective of those for whom these social issues are daily experiences. For example, if the counsellor is straight, they should seek the perspectives of queer authors, filmmakers, podcasters, etc, in order to help understand, if only in small ways, the experience of their lesbian, gay, bisexual, or otherwise queer students. Similarly, if the counsellor is white, they should seek the perspectives of BIPOC educators in order to help understand, if only in small ways, the experience of their BIPOC students. This self-education should always be done with the knowledge that students are individuals and communities and identities are not monoliths.

iii) Be a safe presence

Empathy and UPR are not easily separated into distinct phenomena (Elliot et al., 2010) and, when combined with a genuineness or *congruence* (Rogers, 1957) on the part of the counsellor, they create a warm, therapeutic presence. This presence is particularly important in clinical settings (Farber & Doolin, 2010; Chui, Li, & Luk, 2022) but is also applicable in all of the counsellor's interactions. Roger's shift later in his life from calling his practice "client-

centered" to "person-centered" came from the recognition that regard, acceptance, genuineness, and empathy are not just for our clients, but are a whole way of being (Rogers, 1980). While it is impossible to be this way at all times and in all relationships, it should be a goal to offer these conditions to students, colleagues, and most importantly, to oneself.

The nature of school counselling is that appointments or sessions are often time-bound; Most appointments will take place during class time and it is often expected that school counsellors will act in such a way so as to maximize instructional time. Cultivating a therapeutic presence outside of the counselling office and within the school community may contribute to students' opinions of you. If you are already known and experienced as a trusted adult in and around the school, students seeking counselling support for the first time may need less time to build a therapeutic relationship.

A counsellor is also a member of staff in a school and will need to have relationships with most, if not all, adults in the building. They will liaise with teachers about their clients, go to bat for their clients, and plan collaboratively with their colleagues in the client's best interests. This aspect of school counselling will be eased and enhanced if the counsellor approaches each interaction with colleagues in the same way as with students. Before any plans are made with a teacher, it is important that that teacher feels valued by the counsellor and that their perspective is truly being respected. It is also important for the counsellor to share and empathize with their colleague in the daily frustrations and joys of working in the school system. If the relationship comes first, it is more likely that whatever follows will work well.

Self-regard is a key component of a counsellor offering UPR (Rogers, 1957; Rogers, 1959) and empathy is also an emotional-regulatory process in order to soothe oneself when experiencing another's emotions (Elliott et al., 2019). These qualities have implications for the

counsellor's own wellness and mental state. It is much harder to be accepting, empathetic, and congruent when one is burned out. All those in helping professions can resist burnout by seeking wellness in a supportive community, in significant relationships, in physical movement, in family, in rest, in spiritual or religious practice, in mindfulness and meditation, and in one's own therapeutic journey.

The next section will be recommending the specific use of AEDP in work with clients. However, as Rogers (1951) says, any technique that is not in line with the counsellor's attitudes will not be successful. The reader, for whatever reason, may not wish to use AEDP in their practice and instead use another modality that better aligns with their attitudes and strengths, whether that is DBT, CBT, exposure-based work, gestalt, etc, whether in individual or group settings. In this case, it is the author's hope that the recommendations from the previous section will encourage those other modalities to be mindful of the therapy relationship (Norcross & Wampold, 2011) and how to help students recognize the counsellor as a safe, secure environment from which positive, constructive work can be done.

Targeted Support: Using aspects of AEDP in an otherwise eclectic setting

"Nothing that feels bad is ever the last step." (Fosha, 2004, p. 30)

As far as the author has been able to discern, there are no studies about the use of AEDP with youth and young adults and so the following two sections will provide suggestions for the incorporation of AEDP into school counselling. The section immediately following will provide five aspects of AEDP that may be very harmonious with other psychotherapeutic modalities. These five suggestions are the second tier of intervention and so it is assumed that when using these the counsellor will already be meeting the core conditions discussed in the previous section. Because AEDP is attachment-focused, it is critical that the client feel prized by the

counsellor, experience them as a safe presence, and are receptive to their empathy. Because childhood trauma is connected to difficulty with emotional regulation (Sherin & Nemeroff, 2011; Lanius, Bluhm, & Frewen, 2011) and negative self-concept (Giotakos, 2020; Cloitre et al, 2014), the next section will be aimed at treating those conditions.

i) Healing is close at hand

AEDP is a healing-oriented psychotherapy in opposition to pathology-oriented psychotherapies (Fosha, 2000). It assumes that humans have a wired-in striving for healing, for growth, and for flourishing. This wired-in striving is similar to Roger's (1959) concept of the actualizing tendency, a similarity that Fosha acknowledges (Vaz, 2016). Students who struggle with emotional regulation and negative self-concept may see themselves as fundamentally broken or incapable of healing and change. In whatever modality a counsellor and student are working in, AEDP suggests fostering hope in the ability to change is a key force for change itself.

The possibility for healing is always nearby, ready to be activated. Both Fosha (2000) and Rogers (1959) view the experience of safety within the therapeutic relationship to be fundamental to the transformative process and if the relationship is experienced by the client as sufficiently safe, the wired-in capacity for growth and self-righting will emerge. School counsellors wishing to incorporate AEDP into their practice can do so firstly by approaching case conceptualization with this healing-oriented framework. Viewing clients as having capacity for healing within a safe environment will permeate all the in-session minutiae with clients.

One of AEDP's goals is to make the implicit explicit (Fosha, 2006), so secondly, the school counsellor can make this orientation explicit to the client in the early stages of therapeutic work. Sharing with clients about their wired-in capacity and the counsellor's implicit view of

them may be a hopeful revelation for students who have experienced trauma, who despair over their symptoms, and whose self-image is primarily negative.

ii) Noticing the positive

One of AEDP's unique contributions to counselling is plotting clients not only on a continuum of "symptoms — no symptoms", but to include a perpendicular continuum of "languishing — flourishing" (Fosha & Thoma, 2020). It is possible for a person to languish in the absence of symptoms and, conversely, it is possible for a person to flourish in the midst of symptoms. A school counsellor can use these continua to notice positive changes in students and glimpses of flourishing despite of the ebb and flow of their symptoms. It is possible for a client to be greatly flourishing, to be making fulfilling connections with others, and to be living meaningfully while they are also experiencing high levels of symptoms. Whether they are large or small, these moments of flourishing are evidence of the closeness of healing and they deserve as much notice from the counsellor as moments of relief from symptomology.

The counsellor should make their implicit noticing explicit for the client by pointing out the glimmers of flourishing and change that they see. Clients with poor self-image may pass by moment of healing as they are telling a story or describing an experience because their view of themself makes it difficult to notice, so it is the counsellor's responsibility to slow the session down and focus on that glimpse of transformation.

iii) Exploring defenses and appreciating them

AEDP's takes its conception of emotions from Emotion-Focused Therapy. In EFT, emotions are adaptive experiences towards a goal or need and are either secondary, defensive emotions or primary, core emotions. EFT's primary goal is not about treating symptoms, but creating emotional regulatory capacity by building tolerance for difficult emotions (Greenberg,

2004). In the context of an empathetic relationship, there is safety for a client to fully experience their emotions and learn to regulate them with the counsellor's help (Joseph, 2004).

School counsellors wishing to incorporate AEDP can do so by empathically validating all the emotions that a client experiences with the knowledge that each feeling may only be one of a complicated milieu. By correctly tracking each emotion as it emerges, helping the client experience it fully, and process it to completion, the counsellor can facilitate the emergence of positive, adaptive emotions, often of self-empathy or defensive anger. Both these positive affects can contribute to bettering a client's self-concept (Timulak & Pascual-Leone, 2015).

To make the implicit explicit, the counsellor can provide psychoeducation to the client about primary and secondary emotions and how they work to defend us and help us to adapt to new situations. It may be helpful to clients who struggle with emotional regulation to see their emotions as communicating something to them rather than overwhelming experiences that must be avoided. For EFT, defenses and triggers are developmental and come from emotions not being accepted or validated by a caregiver (Timulak & Pascual-Leone, 2015). The end goal of EFT is for the client to develop self-empathy (Timulak et al., 2022) and the explicit framework of adaptive defenses can help them appreciate their defensive emotions for how they kept them safe in the past and how they can begin to let them go.

iv) "What is that like?"

In AEDP, every aspect of a client's experience is fertile ground for the counsellor to explore with the metatherapeutic question "What is that like?" Doing so not only slows the client down to reflect upon their here-and-now experience, but also gives the counsellor a window into the client's world. AEDP believes that emotional regulation comes from building tolerance for

difficult emotions and metatherapeutic processing allows the client to be present with their feelings and develop capacity to manage them rather than defensively retreating.

Metaprocessing questions can also be used to examine the therapeutic relationship. Given that the relationship is one of the primary markers of clinical success (Elliott et al. 2018; Chui, Li, & Luk, 2022; Watson et al., 2019) and given that trauma in youth and young adults often manifests in attachment difficulties (van der Kolk, 2003; McLaughlin et al., 2020), the dyad should be explicitly discussed and the client's experience of the counsellor should be brought into the experiential foreground. For example, if the counsellor empathetically reflects the client's experience such that they exclaim "yes, that's exactly it!" the counsellor can immediately move on to the question "What is it like to have me really understand what you're feeling?" The student may not have thought of their experience of the relationship before and it can lead to their experiences of other significant attachment relationships.

When defensive emotions are validated, experienced, and processed, AEDP's phenomenology predicts that positive, adaptive emotions will follow (Fosha, Thoma, & Yeung, 2019). Similar to noticing the positive, metaprocessing adaptive emotions such as curiosity, sensitivity, joy, zest, etc will bring them into the client's experiential focus, showing capacity for flourishing and positive affect and working against negative self-image. For example, a student may deeply sigh and announce that they feel good. AEDP does not see this statement as an end, but as another beginning for a round of metaprocessing with a question like "What is it like for you to feel good?" or "What does feeling good mean?"

Metaprocessing may also be used with any of the other recommendations in this chapter to deepen the client's experience. For example, the counsellor may share their implicit, healing-oriented framework with the student and this framework may be surprising to them. The

counsellor can then invite the client to share their experience of being told that healing is possible and even close by.

v) Saying goodbye

One of the unique qualities of school counselling is that there is a hard deadline that does not exist in many private clinical counselling relationships. The student-counsellor dyad will end either when a student moves schools or when they graduate. Endings may be particularly difficult for students with attachment trauma because previous endings may have been very distressing. AEDP offers a way of saying goodbye through exploration, affirmation, and transformation of feelings, as well as celebration and expressing trust in the client's journey ahead (Harrison, 2020).

Not all positive emotions are happy. Instead, AEDP views positive emotions as ones that feel "right" (Markin et al., 2018). Grief and sadness at a changing point in the relationship are completely appropriate and not necessarily defensive. A school counsellor can use AEDP's theory of emotion and metaprocessing to help the student fully experience and process their feelings and affirm defenses that may emerge. Metaprocessing can continue this experience to explore any change-for-the-better that the student sees in themselves and the counsellor can work with the student to incorporate that experience into their self-concept.

To make the implicit explicit, the counsellor can be both wise and brave in their self-disclosure by sharing their experience of the relationship as well as any emotions that emerge for them. They may express pride in the client, sadness at their leaving, gratitude for the relationship, and, crucially, confidence in their transformation as an ongoing process. Although the relationship is ending, the counsellor will still care for the client and the client will continue to grow and change. It is important to give students a new, secure attachment experience in

contrast to previous attachment expectations so they can revise working models and feel confident in their ability to move into and thrive in the future.

Intensive Support: Full AEDP

> *"The emotional atmosphere should be one in which the patient feels safe and the therapist brave." (Fosha, 2000, p. 213)*

This final section will briefly describe how a school counsellor can use AEDP in more of its entirety to intensively support a small subsection of their student clients, those who have experienced sustained trauma. As intensive support is the highest tier of support, it is assumed that all previous universal conditions of empathy, prizing, and genuineness are present and that targeted interventions incorporating AEDP principles are present as well.

AEDP views psychopathology as unwanted and unwilled aloneness in the face of overwhelming emotional experiences (Fosha, Thoma, & Yeung, 2019) and so its two main goals are to process emotions in a secure relationship (McBride et al., 2020) and to help the client reliably access the positive, adaptive tendencies that naturally arise (Fosha, 2000).

AEDP gives three broad strategies for intervention: relational, restructuring, and experiential (Fosha, 2000; Fosha & Slowiaczek, 1997). Each is to be used for different clients, but each has the goal of access to core affective experiences which are emotional responses that are not masked, numbed, avoided, or defended against. It is crucial to note that for Fosha (2000), the smallest unit of intervention is not what the counsellor does, but rather what the counsellor does and how the client experiences it; The client's experience of the counsellor is key.

i) Relational Interventions

Relational interventions are focused on fostering the two-way affective bond within the client-counsellor dyad to help the client experience relational safety and to render their defenses unnecessary. These interventions should be used with clients for whom accepting empathy,

affirmation, and support is difficult (Fosha, 2000). The goal of these interventions is to be focused on both the relational experience of both the client and the counsellor and to communicate that feelings can and should come up in the dyad and that they should be discussed (Fosha & Slowiaczek, 1997).

As with previous recommendations, the AEDP counsellor should make their implicit relational goals explicit. This could include tracking the closeness or distance the counsellor feels from the client (Fosha & Slowiaczek, 1997; Ronen-Setter & Cohen, 2020), communicating their experience of the relationship, and asking what the student's perspective of the dyad is. The counsellor can make their regard of the student explicit by expressing support for them, affirming positive qualities, or offering encouragement (McBride et al., 2020; Fosha & Slowiaczek, 1997; Ronen-Setter & Cohen, 2020). This can be done especially to acknowledge and affirm healthy responses, including self-empathy and self-care. The counsellor may judiciously share their own experience either of the dyad itself or of similar experiences to what the student is experiencing (McBride et al., 2020). In particular, this can counteract the appearance of omnipotence on the part of the counsellor and reaffirm their connection with the student rather than reinforcing clinical authority over them (Fosha, 2000).

Interventions are only useful insofar as the client experiences them as such. These explicit affirmations, communications, trackings, and disclosures should be metaprocessed to bring them into the experiential realm (McBride et al., 2020; Ronen-Setter & Cohen, 2020). For example, “what is it like to feel supported and to have your feelings affirmed?” For some clients with relational trauma, feelings of closeness may be unfamiliar and distressing. In this case, the counsellor may explore the client’s reaction to their explicit support and their attempts to build relationship and the cycle of affirmation, processing, and metaprocessing begins again.

The best relationship is one of collaboration and no one knows the client better than they know themselves. Collaboration with the client can be considered a relational intervention in and of itself as it expresses the counsellor's respect and care for the client, their experience, and their wisdom. The AEDP counsellor should be explicitly collaborative in their relational work with their clients and invite them to "compare notes" with their counsellor (Fosha & Slowiaczek, 1997). This may be particularly helpful in instances where the counsellor is unsure of how to proceed, in which case, they can explain the dilemma and ask the client for advice (Fosha, 2000).

ii) Restructuring Interventions

Restructuring interventions are significantly more forthright and are useful for when relational and/or experiential interventions are not effective on lowering client's defenses (Fosha, 2000). They are aimed at addressing the client's awareness and understanding of their emotions, especially their emotional defenses, in order for them to empathize with their defenses as previously necessary and adaptive within previous relationships (Fosha & Slowiaczek, 1997).

The first restructuring interventions would be to identify and clarify the counsellor's experience of the patient's defenses (Fosha, 2000). For example, the counsellor may notice the client quickly shifts into self-criticism after feelings of pride or happiness. A restructuring intervention would be to explicitly say "I'm noticing that when you start to feel happy about yourself, you start tearing yourself down." As always, the counsellor must be empathetic and non-judgmental as clients may already feel shame and guilt about their defenses. In order to work with the defenses, the counsellor should appreciatively reframe them as previously necessary, not as defects. For example, "From what you've told me about your father, it sounds everything needed to be about him, so you started criticizing yourself to stay out of the spotlight and keep yourself safe." This can help the client develop self-empathy and positive self-concept

through reframing their defenses as adaptations (McBride et al., 2020). Because AEDP has an attachment focus, a restructuring intervention that would logically flow from this would be to explore relational patterns with the client. The counsellor may explore how early attachment patterns contribute to current defenses and are reflected in the client's current relationships, including the counselling relationship itself. It is important to remind clients that defenses have been necessary in the past to protect from overwhelming experience, but that the therapeutic relationship can offer them a space to safely process emotions without defenses (McBride et al., 2020).

Restructuring interventions are also about increasing the client's emotional awareness and understanding. As defensive reactions to core emotions emerge, such as anxiety, guilt, shame, or helplessness, the counsellor can explicitly and verbally track the student's experience to show that they are not alone in their feelings (Fosha & Slowiaczek, 1997). The same is true for any positive affect that emerges such as hope, joy, or openness; the counsellor can explicitly and verbally track the student's experience to increase their awareness of their emotions (Fosha, 2000). These interventions will be enhanced by metatherapeutic processing. For example, "what is it anxiety like for you?" or "what does joy feel like for you?" These questions serve the restructuring goal of increasing emotional awareness.

Finally, restructuring interventions can be used to explore how the client makes meaning of their emotions, either positive or defensive (Fosha, 2000). Through affirming and reframing defenses and examining their relational patterns, the student can come to view themselves and their experience with more understanding and self-compassion. This gives the opportunity for them to author new narratives, leaving behind narratives of brokenness or helplessness and creating new ones of process and transformation. Re-authoring may be particularly useful at the

end of a session and especially useful as the counselling relationship is coming to a close. This intervention would be very synergistic with counsellors who practice narrative therapy.

iii) Experiential Interventions

Experiential interventions are for when emotions are already emerging in the client and are focused on helping them deeply feel the affective experience and bypassing cognitive intellectualizing defenses (Fosha, 2000). Adaptive tendencies that arise from core affective experiences can emerge more readily when the affect is lived and relived in vivid thought, textured detail, or even pure fantasy. These interventions are meant to allow the client to truly experience feelings free of defenses (Fosha & Slowaiczek, 1997). Of all three categories of intervention, experiential interventions have received the most support in clinical trials (Iwakabe et al., 2022).

The first experiential interventions would be for the counsellor to direct the client's focus on their affective experience (Fosha, 2000). Students who struggle with emotional regulation may be unaccustomed to focusing on distressing feelings and instead will deflect or defend against them. The counsellor can encourage them to "stay with it" to help them build tolerance for negative emotions (Ronen-Setter & Cohen, 2020). Because AEDP's view of psychopathology is based around client aloneness, the counsellor should actively counteract that loneliness by empathically mirroring the client's affect (Fosha, 2000; McBride et al., 2020). In this way, the counsellor disconfirms attachment expectations by being attuned to the client's emotional state. Through explicitly and verbally tracking the client's experience, the counsellor also models emotional self-awareness for them. For example, "When I see the pain on your face and the tears in your eyes and when I hear the story you are telling me, I feel so sad that you have had to experience that."

A second experiential intervention would be to have the client name their affective experience, with as much specificity and detail as possible (Fosha, 2000; Fosha & Slowiaczek, 1997). This practice brings the experience of emotion into the linguistic realm, moving the awareness from the amygdala to the pre-frontal cortex. Traumatized students may have a heightened amygdala response and a lowered access to their PFC which would make this intervention helpful, albeit difficult. Communicating affect in words can help the client parse a generalized distress or wave of feeling into its constituent parts. Certain students may find this task nearly impossible, especially if they have long histories of numbing and avoiding emotion. In this case, the counsellor may consider incorporating body-based or somatic work to help the student physically experience their emotional state (McBride et al., 2020; Fosha, 2000). The counsellor may also consider this an opportunity for psychodrama (Fosha & Slowiaczek, 1997; McBride et al., 2020); the client can imagine themselves in an emotionally charged situation and act out in their mind their ideal response with the counsellor closely tracking the feelings that emerge. Psychodrama should be used with extreme caution with youth and young adults especially in fantasies of anger or revenge. These imaginings should not be manifested outside the counselling office.

School counsellors work in a school setting and their clients are youth and young adults who will return to the school community once they leave the counselling office. Given that experiential interventions are aimed at deepening the existing experience of affect, the counsellor should be mindful of the state in which their client is exiting. There should be explicit discussion about what constitutes appropriate emotional expression outside of the counselling office. While this intervention is not experiential per se, it may bring the client pre-emptive emotional regulation by helping them recognize and name their experience as well as giving them a sense

of control by examining different choices they have when they experience different internal states.

According to Fosha (2000), interventions are only useful insofar as the client experiences them as such; the smallest unit of intervention is both what the counsellor does and how the client experiences it. AEDP's explicit examination of the therapeutic dyad is a core component of its techniques and its theory of change. Therefore, a school counsellor wishing to use any of the interventions and recommendations in this chapter, whether they are based in CCT or AEDP, should discuss their usage and their effect with the client. A counsellor should be as warm, as empathetic, and as full of regard as they can be and they should also check throughout the therapeutic process to see if the client experiences them this way.

Conclusions

School counsellors will likely meet with a significant number of students who have had traumatic experiences. Community supports exist and should be accessed, but in the intervening time, school counsellors have a responsibility to work with these students. Trauma has unique impacts on academic and cognitive function as well as social-emotional functioning. The recommendations laid out in this paper should provide an effective approach to treating emotional regulatory difficulties and negative self-image, both of which are hallmarks of complex trauma.

This capstone is entirely theoretical and its recommendations should be seen as potentials rather than prescriptions. Its first focus is to suggest how a school counsellor can use Rogerian Client-Centered Therapy to create a safe therapeutic presence for their students and colleagues using Rogers' core conditions of empathy, congruence, and unconditional positive regard. This presence will be necessary when the counsellor works with traumatized students who may never

have experienced safety with an adult before. The counsellor should work to build secure attachment by being empathetically attuned with and supportive of the student. These conditions are not only for traumatized students, but for all clients and colleagues. The second focus of the capstone is to suggest how a school counsellor can adopt aspects of Fosha's AEDP, either in part or as a whole, to work with traumatized student clients. AEDP's theory of emotional regulation and positive self-concept through secure attachment experiences and metaprocessing can be used with clients who experience their emotions as unbearable and experience themselves as broken. While these recommendations are narrowly focused on traumatized students who struggle with emotional regulation and negative self-image, they may be useful for working with students who have no record of trauma or do not sufficiently meet criteria for a PTSD or cPTSD diagnosis.

The suggested approaches have limitations: It is possible that symptoms of trauma may be masked by other social, academic, cognitive, or emotional difficulties or that the symptoms may not be expressed until later in life, leading the school counsellor to miss cues or opportunities. The ebb and flow of the healing process is long-term and the fixed time limit on both session length and relationship length in school counselling may make AEDP unsuitable in some cases. Finally, the metacognitive and self-referential nature of AEDP may be less accessible for younger students and for those who have less developed self-awareness.

References

Ainsworth M. D. (1985). Patterns of infant-mother attachments: antecedents and effects on development. *Bulletin of the New York Academy of Medicine*, *61*(9), 771–791.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2017, February 24) *Clinical Practice Guideline For the Treatment of PTSD. https://www.apa.org/ptsd-guideline/ptsd.pdf*

Bowlby, J. (1982). Attachment and loss: retrospect and prospect. *American journal of Orthopsychiatry*, *52*(4), 664.

Bozarth, J. D. (2002). Nondirectivity in the person-centered approach: Critique of Kahn's critique. *Journal of Humanistic Psychology*, *42*(2), 78–83. https://doi.org/10.1177/0022167802422007

Capaldi, S., Asnaani, A., Zandberg, L. J., Carpenter, J. K., & Foa, E. B. (2016). Therapeutic Alliance during Prolonged Exposure Versus Client-Centered Therapy for Adolescent Posttraumatic Stress Disorder. In *Journal of clinical psychology, 72*(10), 1026-1036 https://doi.org/10.1002%2Fjclp.22303

Caruth, C. (2016). Introduction: The Wound and the Voice. In *Unclaimed experience: Trauma, narrative, and history* (pp. 1–10). Johns Hopkins University Press.

Castonguay, L. G., & Beutler, L. E. (2006). Common and unique principles of therapeutic change: What do we know and what do we need to know? In L. G. Castonguay & L. E. Beutler (Eds.), *Principles of therapeutic change that work* (pp. 353–370). New York, NY: Oxford University Press.

Chui, H., Li, X., & Luk, S. (2022). Therapist emotion and emotional change with clients: Effects on perceived empathy and session quality. *Psychotherapy, 59*(4), 594–605. https://doi.org/10.1037/pst0000442

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: a latent profile analysis. *European Journal of Psychotraumatology, 4*(1), Article: 20706 https://doi.org/10.3402/ejpt.v4i0.20706

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis. *European Journal of Psychotraumatology, 5*(1) Article: 25097 https://doi.org/10.3402/ejpt.v5.25097

Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, *22*(5), 399–408. https://doi.org/10.1002/JTS.20444

Davydov, D. M., Stewart, R., Ritchie, K., & Chaudieu, I. (2010). Resilience and mental health. *Clinical Psychology Review*, *30*(5), 479–495. https://doi.org/10.1016/J.CPR.2010.03.003

DiGangi, J. A., Gomez, D., Mendoza, L., Jason, L. A., Keys, C. B., & Koenen, K. C. (2013). Pretrauma risk factors for posttraumatic stress disorder: A systematic review of the literature. *Clinical Psychology Review 33*(6), 728-744 https://doi.org/10.1016/j.cpr.2013.05.002

Duschinsky, R. (2015). The emergence of the disorganized/disoriented (D) attachment classification, 1979–1982. *History of Psychology, 18*(1), 32–46. https://doi.org/10.1037/a0038524

Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*(1), 43–49. https://doi.org/10.1037/a0022187

Elliott, R., Bohart, A. C., Watson, J. C., & Murphy, D. (2018). Therapist empathy and client outcome: An updated meta-analysis. *Psychotherapy, 55*(4), 399–410. https://doi.org/10.1037/pst0000175

Elliott, R., Murphy, D., Watson, J. C., & Bohart, A. C. (2019) Empathy. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work* (3rd ed., Vol. 1, pp. 245-287). Oxford University Press

Farber, B. A., Suzuki, J. Y., & Lynch, D. A. (2019) Positive Regard and Affirmation. In J. C. Norcross & M. J. Lambert (Eds.), *Psychotherapy relationships that work* (3rd ed., Vol. 1, pp. 288-321). Oxford University Press

Fearon, R.P., Bakermans-Kranenburg, M.J., Van IJzendoorn, M.H., Lapsley, A.-M. and Roisman, G.I. (2010), The Significance of Insecure Attachment and Disorganization in the Development of Children's Externalizing Behavior: A Meta-Analytic Study. *Child Development, 81*(2), 435-456. https://doi.org/10.1111/j.1467-8624.2009.01405.x

Feldman, R. (2020). What is resilience: an affiliative neuroscience approach. *World Psychiatry, 19*(2), 132-150. https://doi.org/10.1002/wps.20729

Flanagan, S., Patterson, T. G., Hume, I. R., & Joseph, S. (2015). A longitudinal investigation of the relationship between unconditional positive self-regard and posttraumatic growth. *Person-Centered and Experiential Psychotherapies, 14*(3), 191–200. https://doi.org/10.1080/14779757.2015.1047960

Forbes, D., Lockwood, E., Elhai, J. D., Creamer, M., O'Donnell, M., Bryant, R., McFarlane, A., & Silove, D. (2011). An examination of the structure of posttraumatic stress disorder in

relation to the anxiety and depressive disorders. *Journal of Affective Disorders, 132*(1-2), 165-172. https://doi.org/10.1016/j.jad.2011.02.011

Ford, J. G. (1991). Rogerian self-actualization: A Clarification of Meaning. *Journal of Humanistic Psychology*, *31*(2), 101–111. https://doi.org/10.1177/0022167891312011

Forslund, T., Peltola, M. J., & Brocki, K. C. (2019). Disorganized attachment representations, externalizing behavior problems, and socioemotional competences in early school-age. *Attachment & Human Development*, *22*(4), 448–473. https://doi.org/10.1080/14616734.2019.1664603

Fosha, D. (2004). 'Nothing that feels bad is ever the last step:' the role of positive emotions in experiential work with difficult emotional experiences. *Clinical Psychology & Psychotherapy, 11*(1), 30-43. https://doi.org/10.1002/cpp.390

Fosha, D. (2006). Quantum transformation in trauma and treatment: Traversing the crisis of healing change. *Journal of Clinical Psychology, 62*(5), 569-583. https://doi.org/10.1002/jclp.20249

Fosha, D. (2000). *The Transforming Power of Affect: A Model for Accelerated Change*. Basic Books.

Fosha, D., & Thoma, N. (2020). Metatherapeutic Processing Supports the Emergence of Flourishing in Psychotherapy. *Psychotherapy, 57*(3), 323-339. https://doi.org/10.1037/pst0000289

Fosha, D., Thoma, N., & Yeung, D. (2019). Transforming emotional suffering into flourishing: metatherapeutic processing of positive affect as a trans-theoretical vehicle for change. *Counselling Psychology Quarterly. 32*(3–4), 563–593. https://doi.org/10.1080/09515070.2019.1642852

Frankel, M., Rachlin, H., & Yip-Bannicq, M. (2012). How nondirective therapy directs: The power of empathy in the context of unconditional positive regard. *Person-Centered & Experiential Psychotherapies*, *11*(3), 205–214. https://doi.org/10.1080/14779757.2012.695292

Ghafoori, B., Wolf, M. G., Nylund-Gibson, K., & Felix, E. D. (2019). A naturalistic study exploring mental health outcomes following trauma-focused treatment among diverse survivors of crime and violence. *Journal of Affective Disorders*, *245*, 617–625. https://doi.org/10.1016/J.JAD.2018.11.060

Giotakos, O. (2020). Neurobiology of emotional trauma. *Psychiatriki*, *31*(2), 162-171. https://doi.org/10.22365/jpsych.2020.312.162

Goldman, R., & Goldstein, Z. (2022). Case formulation in emotion-focused therapy. *Journal of clinical psychology, 78*(3), 436-453. https://doi.org/10.1002%2Fjclp.23321

Gonzalez, N. V. (2018). The Merits of Integrating Accelerated Experiential Dynamic Psychotherapy and Cultural Competence Strategies in the Treatment of Relational Trauma: The Case of "Rosa." *Pragmatic Case Studies in Psychotherapy*, *14*(1), 1–57. https://doi.org/10.14713/PCSP.V14I1.2032

Greenberg, L. S. (2004). Emotion-focused therapy. *Clinical psychology and psychotherapy, 11*(1), 3-16. https://doi.org/10.1002%2Fcpp.388

Hansen, M., Ross, J., & Armour, C. (2017). Evidence of the dissociative PTSD subtype: A systematic literature review of latent class and profile analytic studies of PTSD. *Journal of Affective Disorders, 213*, 59-69. https://doi.org/10.1016/j.jad.2017.02.004

Harrington, S., Pascual-Leone, A., Paivio, S., Edmondstone, C., & Baher, T. (2021). Depth of experiencing and therapeutic alliance: What predicts outcome for whom in emotion-

focused therapy for trauma? *Psychology and Psychotherapy: Theory, Research and Practice*, *94*(4), 895–914. https://doi.org/10.1111/PAPT.12342

Harrison, R. L. (2020). Termination in 16-session accelerated experiential dynamic psychotherapy (AEDP): Together in how we say goodbye. *Psychotherapy*, *57*(4), 531–547. https://doi.org/10.1037/PST0000343

Harrist, R. S., Quintana, S. M., Strupp, H. H., & Henry, W. P. (1994). Internalization of interpersonal process in time-limited dynamic psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 31*(1), 49–57. https://doi.org/10.1037/0033-3204.31.1.49

Heidinger, L. (2022, December 12). *Profile of Canadians who experienced victimization during childhood, 2018*. Statistics Canada. https://www150.statcan.gc.ca/n1/pub/85-002-x/2022001/article/00016-eng.htm

Henschel, S., Nandrino, J. L., & Doba, K. (2020). Emotion regulation and empathic abilities in young adults: The role of attachment styles. *Personality and Individual Differences*, *156*, 109763. https://doi.org/10.1016/J.PAID.2019.109763

Herringa, R. J. (2017). Trauma, PTSD, and the Developing Brain. *Current Psychiatry Reports, 19*(10), 1-9 https://doi.org/10.1007/s11920-017-0825-3

Hill, & Nakayama, E. Y. (2000). Client-centered therapy: Where has it been and where is it going? A comment on Hathaway (1948). Journal of Clinical Psychology, 56(7), 861–875. https://doi.org/10.1002/1097-4679(200007)56:7<861::AID-JCLP5>3.0.CO;2-J

Iwakabe, S., Edlin, J., Fosha, D., Gretton, H., Joseph, A. J., Nunnink, S. E., Nakamura, K., & Thoma, N. C. (2020). The effectiveness of accelerated experiential dynamic psychotherapy (AEDP) in private practice settings: A transdiagnostic study conducted

within the context of a practice-research network. *Psychotherapy*, *57*(4), 548–561. https://doi.org/10.1037/PST0000344

Iwakabe, S., Edlin, J., Fosha, D., Thoma, N. C., Gretton, H., Joseph, A. J., & Nakamura, K. (2022). The Long-Term Outcome of Accelerated Experiential Dynamic Psychotherapy: 6- and 12-Month Follow-Up Results. *Association*, *2022*(3), 431–446. https://doi.org/10.1037/pst0000441

Jaworska-Andryszewska, P., & Rybakowski, J. K. (2019). Childhood trauma in mood disorders: Neurobiological mechanisms and implications for treatment. *Pharmacological Reports*, *71*(1), 112–120. https://doi.org/10.1016/J.PHAREP.2018.10.004

Joseph, S. (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications. *Psychology and Psychotherapy: Theory, Research and Practice*, *77*(1), 101-119 https://doi.org/10.1348/147608304322874281

Knefel, M., & Lueger-Schuster, B. (2013). An evaluation of ICD-11 PTSD and complex PTSD criteria in a sample of adult survivors of childhood institutional abuse. *European Journal of Psychotraumatology*, *4*(SUPPL.). https://doi.org/10.3402/ejpt.v4i0.22608

Kolaitis, G., & Olff, M. (2017). Psychotraumatology in Greece. *European Journal of Psychotraumatology*, *8*(4), Article: 135175. https://doi.org/10.1080/20008198.2017.1351757

Lakeman, R. (2020). Advanced empathy: A key to supporting people experiencing psychosis or other extreme states. *Psychotherapy and Counselling Journal of Australia*, *8*(1), 1-17. https://pacja.scholasticahq.com/article/71092.pdf

Lange, T. M. (2020). Trans-affirmative narrative exposure therapy (TA-NET): A therapeutic approach for targeting minority stress, internalized stigma, and trauma reactions among gender diverse adults. *Practice Innovations*, *5*(3), 230–245. https://doi.org/10.1037/PRI0000126

Lanius, R. A., Bluhm, R. L., & Frewen, P. A. (2011). How understanding the neurobiology of complex post-traumatic stress disorder can inform clinical practice: a social cognitive and affective neuroscience approach neuroscience approach. *Acta Psychiatrica Scandinavica*, *124*(5), 331–348. https://doi.org/10.1111/J.1600-0447.2011.01755.X

Lanius, R. A., Vermetten, E., Loewenstein, R. J., Brand, B., Schmahl, C., Bremner, J. D., & Spiegel, D. (2010). Emotion Modulation in PTSD: Clinical and Neurobiological Evidence for a Dissociative Subtype. *American Journal of Psychiatry, 167*(6), 640-647. https://doi.org/10.1176/appi.ajp.2009.09081168

LeBeau, R. T., Davies, C. D., Culver, N. C., & Craske, M. G. (2013). Homework Compliance Counts in Cognitive-Behavioral Therapy. *Cognitive Behaviour Therapy, 42*(3). 171-179. https://doi.org/10.1080/16506073.2013.763286

Lipton, B., & Fosha, D. (2011). Attachment as a Transformative Process in AEDP: Operationalizing the Intersection of Attachment Theory and Affective Neuroscience. *Journal of Psychotherapy Integration*, *21*(3), 253–279. https://doi.org/10.1037/A0025421

Main, M. (1995). Recent studies in attachment: Overview, with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 407–474). Analytic Press, Inc.

Markin, R. D., McCarthy, K. S., Fuhrmann, A., Yeung, D., & Gleiser, K. A. (2018). The process of change in Accelerated Experiential Dynamic Psychotherapy (AEDP): A case study

analysis. *Journal of Psychotherapy Integration*, *28*(2), 213–232. https://doi.org/10.1037/INT0000084

Marshall, E. M., & Frazier, P. A. (2019). Understanding posttrauma reactions within an attachment theory framework. *Current Opinion in Psychology*, *25*, 167–171. https://doi.org/10.1016/J.COPSYC.2018.08.001

Marzilli, E., Cerniglia, L., Tambelli, R., Trombini, E., de Pascalis, L., Babore, A., Trumello, C., & Cimino, S. (2021). The covid-19 pandemic and its impact on families' mental health: The role played by parenting stress, parents' past trauma, and resilience. *International journal of environmental research and public health, 18*(21), Article: 11450. https://doi.org/10.3390%2Fijerph182111450

McBride, H. L., Joseph, A. J., Schmitt, P. G., & Holtz, B. M. (2020). Clinical recommendations for psychotherapists working during the coronavirus (COVID-19) pandemic through the lens of AEDP (Accelerated Experiential Dynamic Psychotherapy). *Counselling Psychology Quarterly, 34*(3–4), 411–431. https://doi.org/10.1080/09515070.2020.1771283

McIntosh, K., MacKay, L. D., Andreou, T., Brown, J. A., Mathews, S., Gietz, C., & Bennett, J. L. (2011). Response to Intervention in Canada: Definitions, the Evidence Base, and Future Directions. *Canadian Journal of School Psychology, 26*(1), 18-43. https://doi.org/10.1177/0829573511400857

McLaughlin, K. A., Colich, N. L., Rodman, A. M., & Weissman, D. G. (2020). Mechanisms linking childhood trauma exposure and psychopathology: a transdiagnostic model of risk and resilience. *BMC Medicine 2020 18:1*, *18*(1), 1–11. https://doi.org/10.1186/S12916-020-01561-6

McLaughlin, K. A., & Lambert, H. K. (2017). Child trauma exposure and psychopathology: mechanisms of risk and resilience. *Current Opinion in Psychology, 14,* 29-34. https://doi.org/10.1016/j.copsyc.2016.10.004

Ministry of Children and Family Development. (n.d.) *Child and Youth Mental Health Performance Indicators.* Retrieved April 19th, 2023, from https://mcfd.gov.bc.ca/reporting/services/child-and-youth-mental-health/performance-indicators

Motsan, S., Bar-Kalifa, E., Yirmiya, K., & Feldman, R. (2021). Physiological and social synchrony as markers of PTSD and resilience following chronic early trauma. *Depression and anxiety, 38*(1), 89-99. https://doi.org/10.1002%2Fda.23106

Murphy, D., Elliott, R., & Carrick, L. (2019). Identifying and developing therapeutic principles for trauma-focused work in person-centred and emotion-focused therapies. *Counselling and psychotherapy research, 19*(4), 497-507. https://doi.org/10.1002%2Fcapr.12235

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (pp. 423–430). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199737208.003.0021

O'Connell Kent, J. A., Jackson, A., Robinson, M., Rashleigh, C., & Timulak, L. (2021). Emotion-focused therapy for symptoms of generalised anxiety in a student population: An exploratory study. *Counselling and Psychotherapy Research*, *21*(2), 260–268. https://doi.org/10.1002/CAPR.12346

Paivio, S. C., Jarry, J. L., Chagigiorgis, H., Hall, I., & Ralston, M. (2010). Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma. *Psychotherapy Research*, *20*(3), 353–366. https://doi.org/10.1080/10503300903505274

Patterson, T. G., & Joseph, S. (2007). Person-Centered Personality Theory: Support from Self-Determination Theory And Positive Psychology. *Journal of Humanistic Psychology*, *47*(1), 117–139. https://doi.org/10.1177/0022167806293008

Record-Lemon, R. M., & Buchanan, M. J. (2017). Trauma-Informed Practices in Schools: A Narrative Literature Review. *Canadian Journal of Counselling and Psychotherapy*, *51*(4). Retrieved from https://cjc-rcc.ucalgary.ca/article/view/61156

Reisz, S., Duschinsky, R., & Siegel, D. J. (2018). Disorganized attachment and defense: exploring John Bowlby's unpublished reflections. *Attachment & Human Development*, *20*(2), 107-134. https://doi.org/10.1080/14616734.2017.1380055

Rogers, C. R. (1959). A Theory of Therapy, Personality, and Interpersonal Relationships: As Developed in the Client-Centered Framework. In S. Koch (Ed.), Psychology: A Study of Science. *Formulations of the Person and the Social Context, 3*, 184-256.

Rogers, C. R. (1980). *A Way of Being*. Houghton Mifflin Company

Rogers, C. R. (1951/2020). *Client-Centered Therapy: Its Current Practice, Implications and Theory* (70th Anniversary ed.) Constable.

Rogers, C. R. (1964). Toward a modern approach to values: The valuing process in the mature person. *Journal of Abnormal and Social Psychology*, *68*(2), 160–167. https://doi.org/10.1037/H0046419

Ronen-Setter, I. H., & Cohen, E. (2020). Becoming "Teletherapeutic": Harnessing Accelerated Experiential Dynamic Psychotherapy (AEDP) for Challenges of the Covid-19 Era.

Journal of Contemporary Psychotherapy, 50, 265-273. https://doi.org/10.1007/s10879-020-09462-8

Rothbaum, B. O., & Schwartz, A. C. (2002). Exposure Therapy for Posttraumatic Stress Disorder. *American Journal of Psychotherapy, 56*(1), 59-75. https://doi.org/10.1176/appi.psychotherapy.2002.56.1.59

Saraiya, T. C., Fitzpatrick, S., Zumberg-Smith, K., López-Castro, T., E. Back, S., & A. Hien, D. (2020). Social–Emotional Profiles of PTSD, Complex PTSD, and Borderline Personality Disorder Among Racially and Ethnically Diverse Young Adults: A Latent Class Analysis. *Journal of Traumatic Stress, 34*(1), 56-68. https://doi.org/10.1002/jts.22590

Schimmenti, A. (2017). The trauma factor: Examining the relationships among different types of trauma, dissociation, and psychopathology. *Journal of Trauma & Dissociation*, *19*(5), 552–571. https://doi.org/10.1080/15299732.2017.1402400

Schmitt, J. P. (1980). Unconditional positive regard: The hidden paradox. *Psychotherapy*, *17*(3), 237–245. https://doi.org/10.1037/H0085917

Shahar, B., Bar-Kalifa, E., & Alon, E. (2017). Emotion-focused therapy for social anxiety disorder: Results from a multiple-baseline study. *Journal of Consulting and Clinical Psychology*, *85*(3), 238–249. https://doi.org/10.1037/CCP0000166

Shebuski, K., Bowie, J. A., & Ashby, J. S. (2020). Self-Compassion, Trait Resilience, and Trauma Exposure in Undergraduate Students. *Journal of college counseling, 23*(1), 2-14. https://doi.org/10.1002%2Fjocc.12145

Sherin, J. E., & Nemeroff, C. B. (2011). Post-traumatic stress disorder: the neurobiological impact of psychological trauma. *Diaglogues in Clinical Neuroscience, 13*(3), 263–278. https://doi.org/10.31887/DCNS.2011.13.2/JSHERIN

Simpson, J. A., Rholes, W. S., Eller, J., & Paetzold, R. L. (2020). Major principles of attachment theory. In *Social psychology: Handbook of basic principles* (pp. 222-239). Guildford Press.

Statistics Canada. (2022, November 9). *Disaggregated trends in poverty from the 2021 Census of Population*. https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-X/2021009/98-200-X2021009-eng.cfm

Straussner, S. L. A., & Calnan, A. J. (2014). Trauma Through the Life Cycle: A Review of Current Literature. *Clinical Social Work Journal*, *42*(4), 323–335. https://doi.org/10.1007/S10615-014-0496-Z

Sutton, T. E. (2018). Review of Attachment Theory: Familial Predictors, Continuity and Change, and Intrapersonal and Relational Outcomes. *Marriage & Family Review, 55*(1), 1–22. https://doi.org/10.1080/01494929.2018.1458001

Timulak, L., Keogh, D., Chigwedere, C., Wilson, C., Ward, F., Hevey, D., Griffin, P., Jacobs, L., Hughes, S., Vaughan, C., Beckham, K., & Mahon, S. (2022). A Comparison of Emotion-Focused Therapy and Cognitive-Behavioral Therapy in the Treatment of Generalized Anxiety Disorder: Results of a Feasibility Randomized Controlled Trial. *Psychotherapy, 59*(1), 84-95. https://doi.org/10.1037/PST0000427

Timulak, L., & Pascual-Leone, A. (2015). New Developments for Case Conceptualization in Emotion-Focused Therapy. *Clinical psychology and psychotherapy, 22*(6), 619-636. https://doi.org/10.1002%2Fcpp.1922

Travis, L. A., Bliwise, N. G., Binder, J. L., & Horne-Moyer, H. L. (2001). Changes in clients' attachment styles over the course of time-limited dynamic psychotherapy.

Psychotherapy: Theory, Research, Practice, Training, 38(2), 149–159. https://doi.org/10.1037/0033-3204.38.2.149

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M. H. (2008). Post-traumatic stress disorder in Canada. *CNS neuroscience & therapeutics*, *14*(3), 171–181. https://doi.org/10.1111/j.1755-5949.2008.00049.x

van der Kolk, B. A. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America*, *12*(2), 293–317. https://doi.org/10.1016/S1056-4993(03)00003-8

Vaz, A. [Psychotherapy Expert Talks] (2016, July 14). *Diana Fosha on Accelerated Experiential Dynamic Pyschotherapy (AEDP): Trusting vitality* [Video]. YouTube. https://youtu.be/PIZOsE6kM3E

Wampold, B. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238

Wang, Y., Chung, M. C., Wang, N., Yu, X., & Kenardy, J. (2021). Social support and posttraumatic stress disorder: A meta-analysis of longitudinal studies. *Clinical Psychology Review, 85*, Article 101998. https://doi.org/10.1016/j.cpr.2021.101998

Watson, J. C., McMullen, E. J., Rodrigues, A., & Prosser, M. C. (2019). Examining the role of therapists' empathy and clients' attachment styles on changes in clients' affect regulation and outcome in the treatment of depression. *Psychotherapy Research*, *30*(6), 693–705. https://doi.org/10.1080/10503307.2019.1658912

Wilkins, P. (2000). Unconditional positive regard reconsidered. *British Journal of Guidance & Counselling, 28*(1), 23–36. https://doi.org/10.1080/030698800109592

Wilkinson, M. (2017). Mind, brain and body. Healing trauma: the way forward. *Journal of Analytical Psychology*, *62*(4), 526–543. https://doi.org/10.1111/1468-5922.12335

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Zandberg, L., Kaczkurkin, A. N., McLean, C. P., Rescorla, L., Yadin, E., & Foa, E. B. (2016). Treatment of Adolescent PTSD: The Impact of Prolonged Exposure Versus Client-Centered Therapy on Co-Occurring Emotional and Behavioral Problems. *Journal of traumatic stress, 29*(6), 507-514. https://doi.org/10.1002%2Fjts.22138