

**Relational Healing: Exploring the Therapeutic Relationship in Trauma Counselling**

**Capstone Counselling Psychology Research Project**

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CPC 695: Counselling Psychology Research Project

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City University of Seattle in Calgary

2025

## Introduction

In the field of psychology, trauma refers to the emotional and psychological response to one or more significantly distressing events, such as witnessing or experiencing violence, abuse, neglect, the death of a loved one, sexual assault, natural disasters, and more (American Psychological Association, 2024). 70% of individuals globally reported experiencing trauma (World Health Organization, 2024). The exact prevalence of traumatic experiences is difficult to determine due to underreporting such fundamentally distressing experiences, but trauma does not discriminate. Trauma is a likely inescapable human experience that can impact any individual(s) at any age and any moment of life, often when least expected. The *American Psychological Association* (2024) states that symptoms of trauma include emotional dysregulation, social withdrawal, flashbacks, chronic pain, memory loss, nausea, and increased heart rate, among others. The adverse effects of encountering a single traumatic event or a series of events are likely long-lasting if unaddressed, leading to symptomology consistent with anxiety, depression, addiction, and PTSD (Birkeland et al., 2022; SAMHSA, 2017).

Trauma, and healing from it, inevitably involve a relationship with another person or many people. Today, trauma-focused therapeutic modalities are evidence-based treatment approaches psychologists implement to support clients in alleviating the emotional, physical, and psychological effects of their traumatic experiences (Burns, 2022; Peters et al., 2021; Sripada et al., 2023; Russell & Shapiro, 2022). However, evidence-based approaches are critiqued; they tend to privilege statistical models over qualitative studies, and in applying such strict measures, they reduce, distort, and devalue the depth, complexity, and richness of human interaction (Markula & Silk, 2011).

Understanding the complexities, nuances, and subtleties of the therapeutic relationship between psychologists and clients with trauma in counselling is, therefore, critical, as trauma is

such an inevitable and damaging human experience. To develop this more complex, more realistic, more nuanced understanding, in my project, I review the literature on trauma, the literature on therapeutic relationships, and conclude by reviewing the literature on relationships in trauma counselling and conclude by proposing the methods for a study that aims to address the weaknesses in the literature. Before presenting these reviews, it is essential, however, to first describe what trauma is and how psychologists have come to understand it.

### **Understanding What Trauma Is**

Trauma is a term that most individuals are likely to recognize. Colloquially, the word trauma is often misused to add dramatics to the description of an embarrassing or unpleasant event (Edelman, 2023). So, what is an appropriate definition of trauma? Where does the understanding of this term originate from? Given that my topic aims to understand the depths, complexities, and nuances of the therapeutic relationship when working with clients who have experienced trauma using trauma-focused therapeutic modalities, I start by looking at the history of trauma and the development of our understanding of it today. Grasping the historical evolution of trauma within a psychological framework is critical for making sense of modern therapeutic relationships and trauma counselling, as it sheds light on how our changing understanding of trauma has shaped our current therapeutic modalities and practices.

**Trauma and psychology: A brief history.** Our understanding of trauma today is shaped by centuries of history. The word “trauma” dates back to the mid-1600s, originating from the Greek word for wound, τραῦμα, or traûma (Kolaitis & Olf, 2017). Throughout the years, our current understanding of trauma has taken on many names. It was initially used to describe only physical harm, but due to the contributions of Jean-Martin Charcot (1825–1893), Pierre Janet (1859–1947), and Sigmund Freud (1856–1939), it now encompasses emotional and

psychological wounds as well (Craparo et al., 2019; Kolaitis & Olf, 2017; McCullough, 2001; Micale, 1994; Micale, 1995; Schimek, 1987; van der Kolk & van der Hart, 1989).

In the 19th century, physicians John Erichsen and Herbert Page were among the first to describe the effects of trauma on humans, explicitly referring to the frequent railway accidents that resulted in “railway spine” (Gasquoine, 2020). Their patients would report symptoms such as tremors, anxiety, and memory loss (Gasquoine, 2020). Around the same time, Jean-Martin Charcot, a French neurologist, studied hysteria, a disorder characterized at the time by exaggerated or inappropriate emotional behaviour, as a neurological condition (Micale, 1994; Micale, 1995). His work involved using hypnosis to investigate and treat hysterical symptoms, primarily in women (Micale, 1994; Micale, 1995). He later developed the notion that hysteria could also occur in men, not just women, which was considered radical and widely criticized at the time (Micale, 1994; Micale, 1995). Charcot's research on hysteria laid the foundation for the idea that trauma is connected to psychological symptoms, as he was the first to understand that the symptoms of hysteria were not merely psychological but physiological (Micale, 1994; Micale, 1995; Ringel, 2019). Pierre Janet, a student of Charcot, proposed that traumatic memories could be separated from other aspects of consciousness, leading to symptoms of hysteria (Craparo et al., 2019). Dissociation as a response to traumatic events aligns with modern understandings of posttraumatic psychopathology (Craparo et al., 2019; van der Kolk & van der Hart, 1989).

Sigmund Freud, the father of psychoanalysis, was initially influenced by the work of Charcot and Janet (Libbrecht & Quackelbeen, 1995). Freud's interest in traumatic events contributed to several significant findings and theories that shaped our understanding of trauma today. He collaborated with Josef Breuer to develop “the talking cure” after observing that Breuer's historically known patient, Anna O., a woman suffering from hysteria, experienced

relief from significant symptoms (e.g., mood swings, blurred vision, headaches, and amnesia) after having recalled and discussed past experiences, particularly experiences we would now consider “traumatic events” (Marx et al., 2017). “The talking cure,” also known as the “cathartic method,” is an approach that allows the patient to discuss their experiences openly (Launer, 2005; Marx et al., 2017). By using hypnosis and free association, the goal is to release pent-up emotions and bring forth repressed feelings (Launer, 2005; Marx et al., 2017). Freud and Breuer discovered that when patients talked through repressed memories, particularly those related to traumatic events, their symptoms of hysteria lessened (Kenny, 2016; Marx et al., 2017). Freud termed the emotional release that occurs through remembering and verbalizing trauma as “abreaction” (Kenny, 2016; Marx et al., 2017). This method contributed to the development of the theory that traumatic experiences are repressed into the unconscious due to subconscious desires and mental defences against the traumatic memory, which can lead to symptoms such as paralysis and anxiety (McCullough, 2001; Schimek, 1987). Freud proposed that neuroses stem from repressed memories of childhood sexual abuse or molestation, a concept later known as seduction theory (McCullough, 2001; Schimek, 1987). Seduction theory served as the initial model that connected trauma to its symptoms (McCullough, 2001; Schimek, 1987).

The term “hysteria” was replaced due to the influence of war (Schestatsky et al., 2003). During the American Civil War, the terms “nostalgia” and “soldier's heart” were used to describe soldiers' traumatic responses (Corvalan & Klein, 2011). After having experienced direct combat, witnessing comrades and innocent civilians killed by the masses, and potentially suffering injuries themselves, soldiers would return home and experience an inability to sleep, tremors, nightmares, consistent fear and panic, among other detrimental symptoms (Corvalan & Klein, 2011). Moving into the 20th century, during World War I, the terms “shell shock” and “war neuroses” referred to the same symptoms experienced by soldiers exposed to violence and heavy

explosives (Fairbairn, 1943). However, at this time in history, when social institutions were focused on producing a body of willing, obedient, docile workers conducive to an industrial and capitalist production in which the vast profits of owners remained hidden, it was generally believed that experiencing a traumatic stress response was due to a flaw in one's character or morality (Fairbairn, 1943). A flaw that requires the individual to work harder to overcome rather than placing any burden on the authorities to provide ethical care. Freud's early work, influenced by Charcot and Janet's theories, provided the language for physicians to begin making sense of what was occurring, how traumatic experiences could shape the psyche, and the inception of psychotherapeutic methods to treat trauma (Libbrecht & Quackelbeen, 1995; Marx et al., 2017; McCullough, 2001; Schimek, 1987). At this time, due to the observation of symptom presentation, the understanding of trauma was attributed almost entirely to the effects of war. World War II reinforced war as the event resulting in the symptomology classified as "shell shock." For several decades to follow, traumatic responses were solely classified as war-related. It was not until much more recently in history that other experiences became recognized as potential factors of experiencing the symptomology of trauma.

In the 1970s, the Feminist movement enabled psychologists and activists to acknowledge that trauma was not limited to war-related phenomena (Britt & Hammett, 2024). The psychological impact of rape, domestic violence, and child abuse was brought to light (Britt & Hammett, 2024). This vastly expanded the understanding of what trauma is and who may experience it, getting it beyond only soldiers of war (Britt & Hammett, 2024).

In 1980, the American Psychological Association formally introduced Post-Traumatic Stress Disorder (PTSD) in the DSM-III (3rd ed.; American Psychiatric Association, 1980). This was a monumental time, as it legitimized trauma as a psychologically influential experience directly linked to psychiatric diagnoses (North et al., 2016; Scott, 1990). At this point, PTSD was

classified as an anxiety disorder (DSM-III; 3rd ed.; American Psychiatric Association, 1980). The DSM-5, published in 2013, introduced a new diagnostic category called Trauma- and Stressor-Related Disorders (5th ed.; American Psychiatric Association, 2013). This new category emphasizes the significant impact of trauma and stress on psychological well-being and differentiates it from anxiety.

The DSM-5 has addressed ambiguities and inaccuracies regarding the criteria for PTSD (5th ed.; DSM-5; American Psychiatric Association, 2013; North et al., 2016). However, North and colleagues (2016) argue that there are still issues with the DSM-5 trauma criteria. They point out inconsistencies between exposure criteria and the definition of trauma (North et al., 2016). The research by North and colleagues (2016) emphasizes the need to differentiate trauma from stressful events, highlighting the distinction between a physical experience and an emotional or physiological response to that experience. This critique indicates a lack of clear operational definitions within the DSM-5 (North et al., 2016). In the most recent publication, the DSM-5-TR, the American Psychiatric Association clarified the meaning of trauma, providing the most up-to-date definition of trauma as of 2025 (5th ed. Revised; DSM-5-TR; American Psychiatric Association, 2022).

In the 21st century, more elements are integrated into understanding trauma. Judith Herman proposed Complex Post-Traumatic Disorder (C-PTSD) in the 1990s to describe long-term or chronic exposure to traumatic events, particularly those experienced interpersonally, such as child abuse (Heim et al., 2022). Thus, a new perspective emerges that trauma does not need to stem from a single event or experience but may arise from long-term or repeated exposure to traumatic stress, resulting in what is termed “complex trauma” (Heim et al., 2022; Nestgaard & Schmidt, 2021). This, in turn, shifted the understanding of trauma.

Recently, researchers like Bessel van der Kolk, a psychiatrist and author, emphasized how trauma is retained in both the body and the brain and the compounding effects this can have (Van der Kolk, 2014). Neuroimaging studies demonstrate how trauma impacts the physical structure of the brain. A meta-analysis conducted by Xia and colleagues (2022) found that individuals who had experienced significant trauma and met the criteria for PTSD displayed alterations in both their brain structure and activity. Specifically, they identified changes and deficits in the physical structure and function of the amygdala, as well as damage to the prefrontal cortex, striatum, and insula (Xiao et al., 2022). These brain regions contribute to vision, hearing, movement, memory, emotional processing and regulation, as well as fear responses (Xiao et al., 2022). The impact of trauma is now recognized to manifest in various ways, including intergenerational effects, which can influence families, communities, or entire cultures, as seen with Indigenous peoples in Canada (Bombay et al., 2014; Toombs et al., 2023).

Understanding the historical development of the word trauma in a psychological context is essential for understanding therapeutic relationships and trauma counselling today, as it reveals how our evolving comprehension of trauma from only physical injury to complex emotional and psychological distress has directly shaped the development of trauma-focused therapeutic methods, diagnostic criteria, societal and individual perception of trauma, and the relational dynamics between client and clinician. The work of historical figures such as Charcot, Janet, Breuer, and Freud laid the foundation for recognizing the psychological and emotional connections to trauma, influencing the development of talk therapies and validating the importance of emotional expression within a supportive therapeutic relationship (Marx et al., 2017; McCullough, 2001; Micale, 1994; Micale, 1995; Schimek, 1987). Historical breakthroughs in this area, such as trauma-related diagnoses (e.g., PTSD) and later complex trauma, demonstrate how deeply interpersonal and prolonged trauma can be in shaping individuals'

worldviews and daily experiences (Heim et al., 2022; North et al., 2016; Scott, 1990). Knowing this emphasizes the need for attuned, safe, and relationally sensitive counselling approaches when working with any presenting concern, especially when it involves trauma. Critiques of reductionist and symptom-based models highlight the importance of acknowledging that the human experience is highly unique and complex, begging the idea that effective trauma counselling must move beyond simply protocols and evidence-based interventions to focus on the nuanced, empathetic, validating, and witnessing connection between a clinician and a client. This understanding of where trauma originates and how it is generally understood and acknowledged in psychology sets us up to adopt a critical approach to developing strong therapeutic relationships. The complex historical evolution of trauma highlights the need for a comprehensive understanding of trauma and nuanced therapeutic relationships in trauma counselling.

### **Trauma in Psychology: Today**

Due to this extensive history, we now understand that there is no single definition of trauma, as we acknowledge every part of the human experience and interpretation that is unique. Therefore, trauma may look different for everyone. Today, trauma is recognized more broadly as the emotional, psychological, and physical response of individuals who have witnessed or experienced a distressing event (American Psychological Association, 2024). The conventional definition of a distressing event, also referred to as a traumatic event, is defined by the American Psychiatric Association (2022) and the World Health Organization (2021) as “experiences involving actual or threatened death or serious injury or sexual violence or events that are extremely threatening or horrific in nature” (American Psychological Association, 2024). This definition is narrow and problematic as it excludes psychological trauma that does not involve sexual or physical violence (American Psychological Association, 2024). This understanding of

trauma is derived from a war-based and pathological Western perspective. As such, clinicians are left with a reductive and disconnected understanding of the exceptionally critical human experience that is trauma. Using this definition in research and clinical practice may result in discredited traumas and care discrimination. A broader understanding of what constitutes a traumatic experience is necessary to guide professional practice ethically. Part of counselling and the therapeutic relationship is based on the clinician's understanding of trauma and how it may be experienced. As such, if the knowledge of trauma is flawed, so will the therapeutic relationship. We already know that the therapeutic relationship is crucial to the efficacy of therapy (American Psychological Association, 2024; Yadav et al., 2024). Suppose, I suggest, the understanding of trauma is skewed and incomplete. In that case, the therapeutic relationship cannot be created in a way that genuinely honours the traumatic experiences faced by the client, leading to less successful outcomes in trauma counselling. The discrepancy in the operational definition of a traumatic experience needs to be addressed to prevent future issues in clinical practice and ensure that this problem is not replicated in future research.

A more inclusive definition, provided by the American Psychological Association (2024), considers a traumatic or distressing event to be an experience that leads to significant fear, helplessness, dissociation, confusion, or any other disruptive emotional or psychological experiences that are substantial enough to negatively affect a person's attitudes, beliefs, behaviours, and other aspects of functioning. It can consist of a single event, a series of events, or ongoing circumstances perceived as physically or emotionally threatening (American Psychological Association, 2024). Trauma is the response, not the event and as such, the ways in which psychologists understand trauma need to evolve (Edelman, 2023). In turn, this evolving understanding of trauma likely influences therapeutic modalities, approaches, and theories by emphasizing the need for safety, empathy, and attunement in the therapeutic relationship.

Examining trauma theory today, therefore, is our crucial next step for informing the relational component of trauma-focused interventions and is central to effective trauma counselling.

**Trauma theory in psychology.** Decades of research encompassing psychological, sociological, and neurological perspectives have led to the development of today's trauma-informed care practices. Contemporary Trauma Theory (CTT) expands on Janet and Freud's trauma-focused work on memory and consciousness by incorporating bio-psychosocial factors into the theoretical conceptualization of trauma (Goodman, 2017). CTT is a theoretical framework that emphasizes the importance of understanding the intricate ways trauma affects an individual's functioning and moves away from the historical ideas that trauma is related to a character flaw or weak morality (Goodman, 2017). CTT focuses on the impact trauma has on development, behaviours, and overall well-being (Goodman, 2017). This shifts perspective from identifying what is “wrong” with someone to what happened to someone (Goodman, 2017). The central properties of CTT are dissociation (a core defensive mechanism), attachment (development of interpersonal relationships), reenactment (the tendency for individuals who have experienced interpersonal trauma to seek relationships and environments that align with the original traumatic event), long-term impact on functioning (particularly when a traumatic event occurs in childhood), and impairment in emotional capacities (emotional numbing and/or inability to self-regulate) (Goodman, 2017). The conceptual foundation of CTT allows a more comprehensive understanding of the impact of trauma, addressing brain development, social-emotional skills, and behaviour (Goodman, 2017).

Contemporary Trauma Theory (CTT) identified the need for Trauma-Informed Care (TIC), serving as a paradigm shift for trauma theory (Goodman, 2017; Yadav et al., 2024). TIC was introduced by Harris and Fallot in 2001 and has been widely accepted into practice (Harris

& Fallot, 2001; Yadav et al., 2024). This approach prioritizes creating a safe, supportive, and empowering environment for counselling and all other health services (Yadav et al., 2024). By recognizing the overwhelming significance of trauma in society, TIC integrates awareness of trauma into every step of the therapeutic process (Yadav et al., 2024). A trauma-informed approach views symptoms and behaviours related to the experience of trauma as the individual's best effort to cope and survive the traumatic event(s) (Brown et al., 2012; Goodman, 2017; Yadav et al., 2024). Depending on the individual, the methods of coping with trauma may be adaptive within the context of the traumatic event(s) but have become maladaptive and no longer serve them (Yadav et al., 2024).

Trauma-informed practice can be integrated into evidence-based therapeutic modalities such as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) (Yadav et al., 2024). TIC is used to address various mental health concerns in which trauma plays a significant role in the symptom presentation and etiology (Yadav et al., 2024). Adopting a trauma-informed lens is considered best practice and has become the new standard of care in mental and physical health services (American Psychological Association, 2024; Yadav et al., 2024).

As understood today in Contemporary Trauma Theory and Trauma-Informed Care, trauma theory emphasizes that healing occurs within relationships (Goodman, 2017; Harris & Fallot, 2001; Yadav et al., 2024). Recognizing that trauma often originates in relationships, restorative therapeutic relationships are essential for effective treatment (American Psychological Association, 2024; Yadav et al., 2024). When psychologists or other mental health professionals intentionally acknowledge the pervasive impact of trauma through a trauma-informed lens, they create environments and therapeutic relationships that promote healing (American Psychological Association, 2024; Brown et al., 2012; Goodman, 2017; Yadav et al., 2024).

Healing from trauma requires relational depth. Since trauma primarily originates within interpersonal relationships—through abuse, neglect, or violence—healing must also occur within the safety of a strong therapeutic relationship. Currently, trauma is defined narrowly and understood through a reductive, pathologizing lens that frequently undermines the power of relationships. This strict framework limits clinicians' ability to fully witness, validate, and respond to clients' lived adverse experiences, which in turn compromises the effectiveness of trauma counselling. Knowing this, I advocate for a broader, more relationally based, context-sensitive understanding of trauma. This approach would recognize the uniqueness of each individual's response to trauma and the essential role human connection plays in healing. Critiques of current clinical and diagnostic practices call for a shift toward trauma counselling approaches that focus on the client-clinician relationship. To honour the profoundly personal and relational nature of trauma, psychologists must adopt a broader understanding, placing therapeutic relationships as the centre of effective trauma counselling practice.

### **Trauma in Therapy: The Therapeutic Relationship**

Freud and Breuer's "talking cure" legitimized verbal expression as treatment (Marx et al., 2017). This method introduced transference, where patients unconsciously project feelings onto the therapist, recreating relationship dynamics and forming attachments (Weiss, 2023). The "talking cure" and transference established the therapeutic relationship in counselling (Kaluzeviciute, 2020; Marx et al., 2017; Weiss, 2023).

*In my early professional years, I was asking the question, How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?*

*—Carl R. Rogers*

The current literature in the field of psychology emphasizes the significant impact of the therapeutic relationship on outcomes, regardless of the modality (Podolan & Gelo, 2024). There

is a growing shift toward relationally based orientations, recognizing the therapeutic relationship as essential for change and success (Podolan & Gelo, 2024). For instance, Wenzel (2025) introduced relationship-focused cognitive behavioural therapy, highlighting the therapeutic relationship as a key predictor of outcomes and dropout rates. Empathy, authenticity, attunement, safety, and support foster healthier relationships within and outside the therapeutic setting (Podolan & Gelo, 2024).

**Omissions in clinical training and relational competence.** While trauma-focused therapeutic modalities are described as relationally based, the reality is that many clinicians lack the competency to skillfully create and maintain therapeutic relationships, particularly in the context of trauma counselling (Kumar et al., 2022). Kumar and colleagues (2022) found that the most significant omission in psychologists' training was not theoretical content or techniques but relational and interpersonal skills.

In the psychological literature, definitions of a therapeutic relationship are less frequent than their usage. Its significance and components are often discussed; however, definitions vary depending on the theoretical approach of the literature. This inconsistency challenges clinicians, hindering their understanding of developing a therapeutic relationship. Bachelor (2013) conducted an exploratory factor analysis on the therapeutic alliance from both clinician and client perspectives. Although the paper examines this critical aspect of the therapeutic relationship, it does not clearly define the therapeutic relationship as a whole (Bachelor, 2013).

Such omissions are deeply concerning. How can clinicians engage in therapy intended to be rooted in relationships yet not know how to build that relationship? If the therapeutic relationship is one of the strongest predictors of success in counselling, how can trauma counselling be effective without a strong relational foundation? There is an apparent disconnect between the

knowledge produced in trauma psychology and the lived experiences of clinicians and those seeking support.

To better understand the nuances and subtleties of the therapeutic relationship, we must next understand what the therapeutic relationship is. Gelso and Carter (1985) define it as “the feelings and attitudes that therapist and client have toward one another and how they are expressed” (p.159). This description highlights cognition, emotion, and behaviour as working components, as well as the reciprocity in a therapeutic relationship (Gelso & Carter, 1985). As such, they propose the therapeutic relationship to be a dynamic, shared, and evolving experience (Gelso & Carter, 1985). Kazantzis and Dobson (2022) describe the therapeutic relationship as an exchange between people in which they share intimate emotions, thoughts, and values to facilitate change. They emphasize that the partnership is intentional, and the relationship may provide healing itself without additional therapeutic interventions (Kazantzis & Dobson, 2022; Wenzel, 2025).

A therapeutic relationship is fundamentally different from a typical relationship. Based on the literature and my own experience, a structured, supportive relationship is characterized by safety, defined by clear ethical boundaries, influenced by power dynamics, and enriched by the unique personal characteristics of the parties involved. Though reciprocal in process, the therapeutic relationship is intentionally one-sided in purpose. The clinician and client contribute relationally, cognitively, and emotionally, with the understanding and intention to solely benefit the client. The asymmetrical structure enables a client-centred focus due to the safe, ethical, and non-judgmental space it creates. This disconnection between theory and practice is not isolated. Despite the literature in counselling and psychology affirming the central role of therapeutic relationships in treatment outcomes, education and training continue to prioritize content, models, and techniques over relational depth (Podolan & Gelo, 2024). While relational

orientations are gaining traction, there remains an inconsistency in how therapeutic relationships are defined, taught, and understood, especially in trauma-focused work. Relational qualities such as empathy, authenticity, attunement, and safety are essential to therapeutic change (Podolan & Gelo, 2024). Kazantzis and Dobson (2022) emphasize that the therapeutic relationship may be healing, even without additional interventions. However, the structured, ethically bound, and asymmetrical nature of this relationship is rarely explored in depth during clinical education.

**The overarching impact of trauma.** The nature of trauma further complicates this picture. Clients with trauma histories often experience hyperarousal, emotional dysregulation, mistrust, and difficulty with boundaries and their sense of safety (Zukerman et al., 2023). These relational challenges require more than theoretical knowledge; they demand attuned trauma-informed relational capacities. However, the research exploring trauma's impact on the therapeutic relationship remains limited. Mair (2021) and Podolan and Gelo (2023) offer insights into key elements of the therapeutic relationship: physical and emotional safety, risk, and healing conditions.

Safety is a fundamental component of the therapeutic relationship and counselling, both for the clinician and the client, and it is a prerequisite for change (Mair, 2021). Creating a safe counselling space involves physical and emotional safety (Lyndon et al., 2023).

**Physical Safety.** Physical safety in counselling refers to the absence of bodily harm or danger within the therapeutic environment (Podolan & Gelo, 2024). In 2020, Sinclair conducted a mixed-methods analysis exploring physical safety and the environment in counselling. The results of this research in the United Kingdom indicate that the most critical factors for both clients and clinicians in creating physical safety and comfort included comfortable seating, room temperature, soundproofing, the absence of interruptions, and accessibility to the space (Sinclair, 2020).

Research on physical safety in counselling in North America was sparse. Though it has been redacted, the American Psychological Association (2008) published a journal article on physical safety in counselling. However, this focus is almost entirely on clinician safety from dysregulated clients rather than the clients' feelings of physical safety within the therapy environment (American Psychological Association, 2008). This clinician-centred focus fails to consider that clients with trauma histories may associate the physical space in which counselling takes place (i.e., closed door, small room, unfamiliar or new space, smell of the room, body positioning and proximity to the exit, among other factors). Regardless of the objective safety of the environment, the client will likely be unable to engage effectively in counselling if their sense of safety is low. There is little guidance as to how to ensure the best physical safety of the counselling space for individuals with trauma histories.

While clinicians and researchers typically attribute client safety to physical safety, most clients consider safety to encompass emotional safety as well (Lyndon et al., 2023). This is a fundamental difference to note as the majority of research will be facilitated by clinicians and professionals, leading the literature to be composed of aspects of client safety that are not the most important or influential to the client experience.

**Emotional Safety.** One may be safe, given that one's physical safety is accounted for; however, a client's sense of safety is entirely different (Lyndon et al., 2023). Feeling safe most commonly comes from being emotionally safe (Lyndon et al., 2023). Emotional safety is the subjective experience of feeling accepted, embraced, and supported for who you are, including your wants and needs, without fear of judgment (Lyndon et al., 2023). Emotional safety is built through respectful interactions, being genuinely heard and understood, and maintaining autonomy (Lyndon et al., 2023). Lyndon and colleagues (2023) highlight that a growing body of qualitative research demonstrates that clients value emotional safety as the most crucial part of

their experience in any healthcare setting. This creates an environment where clients feel vulnerable and authentic, promoting deeper connections, increased self-expression, and healing (Lyndon et al., 2023; Ort et al., 2022).

Carl Rogers developed the idea of unconditional positive regard as a foundational aspect of a person-centred approach to counselling (Ort et al., 2022). Rogers describes unconditional positive regard as the warm acceptance of each aspect of a client's experience, respecting and valuing the person regardless of different values regarding specific behaviours (Ort et al., 2022). The non-judgmental and caring attitudes within Rogerian work support emotional safety for the client (Lyndon et al., 2023; Ort et al., 2022). Clients can share their thoughts, behaviours, or experiences without fear of judgement, non-acceptance, or scrutiny.

While the literature emphasizes that safety is a prerequisite for healing, they primarily focus on describing how safety should be created, not how it is received or interpreted by clients with complex trauma histories (Lyndon et al., 2023; Mair, 2021; Ort et al., 2022; Podolan & Gelo, 2024). The understanding of physical and emotional safety is general and does not consider that trauma fundamentally alters an individual's ability to experience, feel, or recognize safety. This omission in the literature suggests the assumption that once ideal safety conditions are met, all clients can engage in counselling. However, this is highly likely not to be the case for clients with trauma histories, for whom the threshold for perceiving and experiencing safety is significantly elevated and potentially skewed. Mair (2021) conducted a qualitative research study using interpretative phenomenological analysis to explore clients' experiences of safety in therapy. This research identified key factors contributing to emotional safety: attachment theory, the provision of a secure base for the client, and the client's perception of their emotional safety, which is influenced by the clinician's body language during interactions (Mair, 2021). Given the profound impact of trauma on a client's relational capacities, the therapeutic relationship must be

intentionally cultivated through relational competence, which is often missing in current training and practice.

### **Understanding Therapeutic Relationships: Attachment Theory**

Typically, therapeutic relationships are theoretically understood through *Attachment theory*, which provides a primary lens for understanding how safety is co-created in counselling (Mair, 2021). Attachment theory, first introduced by British psychiatrist John Bowlby in the 1950s, is a psychological framework that explains how early childhood emotional bonds with caregivers influence an individual's self-perception and their ability to develop relationships and connections with others (Bowlby, 1988; Mair, 2021). This theory posits that early attachments have a profound impact on individuals' emotional, social, and cognitive development, thereby creating lifelong patterns (Bowlby, 1988; Mair, 2021).

These patterns are defined as attachment styles: secure, anxious, and avoidant (Bowlby, 1988; Mair, 2021). Secure attachment occurs when an individual feels safe, supported, and recognized by their primary attachment figure (Bowlby, 1988; Mair, 2021). It develops when the caregiver is consistently responsive, emotionally available, and attuned, allowing the individual to explore experiences with the confidence that they can return for support and comfort when distressed (Bowlby, 1988; Mair, 2021). A secure attachment fosters a positive internal working model of oneself and others as trustworthy and deserving of care (Bowlby, 1988; Mair, 2021).

Insecure attachments, including anxious and avoidant styles, differ from secure attachments. Anxious attachment develops when primary caregivers are inconsistent in responsiveness (Bowlby, 1988; Mair, 2021). This unpredictable pattern causes individuals to feel uncertain about whether their needs will be met. Long-term anxious attachment can lead to hypervigilance, a fear of abandonment, and a need for reassurance, resulting from relationship inconsistency and a lack of trust in themselves and others (Bowlby, 1988; Mair, 2021). Avoidant

(dismissive) attachment emerges when primary caregivers are emotionally unavailable or rejecting (Bowlby, 1988; Mair, 2021). This results in individuals learning to suppress their emotional intimacy and connection needs, leading them to rely solely on themselves (Bowlby, 1988; Mair, 2021). Over time, this may manifest as discomfort with closeness and vulnerability, resulting in emotional detachment as a means of protecting oneself due to a significant lack of trust in one's ability to rely on others (Bowlby, 1988; Mair, 2021).

Though Bowlby's attachment theory focuses on primary caregivers as the most significant influence on attachment, Mair (2021) expands this idea to include the clinician-client relationship. Mair (2021) finds that emotional safety comes from providing clients with a secure base to explore themselves and their positive or painful experiences. This literature suggests that a clinician's role as an attachment figure is incredibly healing and beneficial to therapeutic success (Mair, 2021).

Attachment theory is applied incredibly broadly to the client's sense of safety in general therapeutic contexts. There remains little exploration as to how insecure and disorganized attachment styles, commonly seen in individuals with severe and early trauma histories, may disrupt the ability of clients to perceive or trust the establishment of emotional safety, even in the case that the clinician is attuned and supportive. In the absence of trauma-specific analysis of attachment theory, the literature overlooks how early relational trauma may result in typical safety-building strategies being ineffective or potentially triggering.

**A secure base.** Mair (2021) finds that forming a secure attachment in one's relationship with the clinician leads to a strong therapeutic relationship, providing the client with the security necessary for emotional safety. A high degree of emotional safety stems from the capacity to provide a true, secure base through consistency. The therapeutic relationship becomes incredibly impactful when the clinician serves as an attachment figure, particularly for clients who lacked

this secure base in early life (Lyndon et al., 2023; Mair, 2021). Approaching this dynamic with attunement, ethical boundaries, and emotional availability fosters a profound sense of safety, encourages personal growth, and promotes support, increased autonomy, and encouragement (Mair, 2021). However, clinicians must be cautious not to create overdependence or enmeshment within a therapeutic relationship (Mair, 2021). The establishment of a secure base is likely to be far more challenging to achieve with clients who have experienced trauma as a result of mistrust, adverse experiences with interpersonal vulnerability, and possible emotional unavailability. Further investigation as to how trauma influences a secure base is necessary to understand how this connection can be made with trauma survivors, offering a secure relationship in which clients may heal.

**Body language.** Mair (2021) highlights nonverbal communication as a significant factor in the client's perceived safety in counselling. Safety is communicated through voice tone, posture, facial expressions, and eye contact (Mair, 2021). This study demonstrates that clients feel safe when clinicians use a “soft” and “relaxed” tone of voice and posture (Mair, 2021). Facial expressions that indicate active listening are critically important, as they imply that the client's words are acknowledged as valuable, which in turn fosters a sense of emotional safety (Mair, 2021). Eye contact and gaze also significantly contribute to a sense of safety (Mair, 2021). When clinicians avert their gaze or stop eye contact, clients report feeling more unsafe than when direct eye contact is maintained (Mair, 2021).

Furthermore, when clients make eye contact more effortlessly, they feel safer and more at ease in their relationship with the clinician (Mair, 2021). Attunement with the client is critical (Mair, 2021). The clinician's verbal responses and body language match, as incongruence between body language and verbal communication must create a sense of insecurity (Mair, 2021). Interestingly, all of these factors are the same as those that mediate the attachment process

during development (Lyndon et al., 2023; Mair, 2021). Mair (2021) thus allows us to infer that the polyvagal theory, which posits that humans subconsciously evaluate safety and threats in their environment, plays a significant role in establishing safety in the counselling setting.

Mair (2021) strongly emphasizes the importance of nonverbal attunement with clients, including eye contact, tone of voice, and posture, in conveying emotional safety. Unfortunately, there is no discussion as to how trauma may result in hypervigilance to non-verbal cues or changes. Consider direct eye contact, clinician body posture, or clinician voice tone, while typically considered non-threatening, may signal danger to a client with a trauma history, as it could be perceived as threatening or controlling (Zukerman et al., 2023). The same behaviours that foster safety, in general, may evoke fear or mistrust in trauma-impacted clients. (Zukerman et al., 2023). This complex factor of trauma counselling and the therapeutic relationship is problematically underexplored, especially considering that each individual's perception of emotional safety and harm is unique (Zukerman et al., 2023).

**How safe is safe?** Podolan and Gelo (2023) synthesized theoretical perspectives on safety in psychotherapy, finding safety universally crucial for effective counselling (Podolan & Gelo, 2023). This synthesis identified key reasons for this (Podolan & Gelo, 2023). Safety provides emotional and psychological protection, facilitates healing and restoration, encourages curiosity and openness, allows risk-taking, and enables self-exploration and integration (Podolan & Gelo, 2023). Most importantly, Podolan and Gelo (2023) found an ideal balance between being too safe and not safe enough that allows progress in therapy to occur (Podolan & Gelo, 2023). An overly safe and protected environment prevents challenges, stress, and discomfort, all qualities that promote the learning and implementation of coping strategies and resilience (Podolan & Gelo, 2023). Conversely, insufficient safety can lead to fear and mistrust in therapy (Podolan & Gelo,

2023). Thus, a client must experience optimal safety to engage in emotional risks and self-exploration effectively.

This paper integrates safety concepts in therapy through a literature review, not empirical research (Podolan & Gelo, 2023). The literature supports their hypotheses; however, future research should explore the practical implementation of these concepts in therapy sessions. The balance between excessive and inadequate safety among diverse client demographics warrants attention, as defining “enough safety” is critical for practical application (Podolan & Gelo, 2023). Recently, Podolan and Gelo (2024) emphasized that client and clinician safety within their relationship must be adaptable to ensure it is “safe enough” for change to occur. Research on creating a safe counselling space and recognizing a client's tolerance for safety and distress is essential for clinicians to effectively implement this aspect of the therapeutic relationship and achieve positive outcomes.

Podolan and Gelo (2024) suggest creating “optimal safety” to encourage growth in counselling. Though this theory is conceptually sound, it is practically vague, especially in terms of trauma-focused counselling. The adverse effects of trauma, such as hyperarousal and emotional dysregulation, likely result in individuals having a more narrow or unpredictable window of tolerance, which means that the amount of emotional stimuli and stress they can handle healthily is reduced (Trotter & Baggerly, 2018). Without a trauma-informed analysis of this theory, the “safe enough” concept, when applied generally, can result in harm to the client and the therapeutic relationship. This omission highlights that a trauma history alters not only the requirement for safety but also the requirement of the interpretation of it, a concept with which the literature has yet to integrate into practical frameworks.

**Therapeutic boundaries.** Therapeutic boundaries are ethically required in any therapeutic relationship (Canadian Psychological Association, 2024). They are guidelines, limits,

and expected behaviours that establish a safe environment for clients and clinicians (Canadian Psychological Association, 2024). Amis (2017) stated that setting clear boundaries and creating expectations for the clinician and client at the start of therapy is best practice.

The literature assumes that clients will interpret structured boundaries as safe, which is an assumption that may not be the reality for trauma survivors. Individuals who have experienced traumatic events involving boundary violations, such as manipulation, neglect, or child abuse, may misinterpret rigid boundaries as controlling, cold, or indicative of potential abandonment. Alternatively, these individuals may engage in enmeshment or boundary-testing to ensure security. Other than the suggested possibilities of challenges with therapeutic boundaries in trauma counselling, there are no trauma-informed guidelines as to how clinicians may effectively adapt boundaries or communicate them.

**Power relations.** Understanding power relations is essential when investigating the development of the therapeutic relationship, as an inherited imbalance in power between clinician and client can negatively impact the therapeutic process and success (Proctor, 2021). Power relations are inherent and inevitable within the therapeutic relationship (Amis, 2017). The clinician's position is that of education, knowledge, experience, and authority (Amis, 2017). If this power imbalance is misused or exploited, whether intentionally or unintentionally, the therapeutic relationship is at risk of rupture (Amis, 2017).

While theory supports the empowerment of clients, there are space practical and trauma-specific strategies to navigate the best power relations inherent in counselling with clients who have experienced interpersonal trauma. A more in-depth understanding of how to proactively attune to the client within the intrinsic dynamics of the therapeutic relationship is required.

**Personal characteristics.** Literature discussing therapeutic outcomes and the therapeutic relationship outlines how the personal characteristics of the client and the clinician interact and

may influence the relationship as a result (Stubbe, 2018). In a professional therapeutic context, individual characteristics include personality traits and qualities, beliefs and values, previous experiences, and worldview, encompassing culture, religion, and ethnicity (Wenzel, 2025). A client and clinician with similar or complementary personal characteristics are shown to result in stronger therapeutic relationships, leading to improved therapeutic outcomes (Wenzel, 2025). This research found that key characteristics of the clinician that contributed to building the therapeutic relationship were flexibility, experience, honesty, respect, trustworthiness, confidence, friendliness, warmth, alertness, openness, and interest (Wenzel, 2025).

Wenzel's (2025) research overlooks the potential for trauma to distort clients' perceptions of characteristics such as confidence or directness. Nuance is required to develop a therapeutic relationship with clients who may misread or mistrust otherwise positive traits. Currently, practical adaptations are missing from training, literature, research, and education.

Despite this research, questions remain. How do clinicians tailor relational approaches when trauma histories and responses vary so widely? How do we balance safety with the discomfort required for growth? While emotional and physical safety, attachment, and nonverbal communication are well-supported factors of the therapeutic relationship between clinicians and clients, current literature assumes normative responses to safety, offers minimal considerations of trauma-specific adaptations, lacks empirical research as to how complex trauma histories alter relational perception, and risks promoting relational strategies that may inadvertently cause harm or reduced efficacy in counselling. Understanding the therapeutic relationship without trauma-specific nuance results in frameworks that are insufficient for the clients who arguably need support the most.

## **Method**

This observational study aims to identify effective ways to build a therapeutic alliance with clients facing trauma-related issues while engaging in trauma-focused therapeutic interventions. It analyzes real-time interactions, focusing on nonverbal cues, relational dynamics, rapport building, managing client distress, and navigating ruptures in the therapeutic relationship. Data is collected through therapy session observations and semi-structured interviews with participating psychologists in Calgary, Alberta, determined by their office locations.

**Participants.** Participants include Registered Psychologists focused on trauma and clients in trauma-related counselling. The research involves four psychologists and eight clients (two per psychologist). Psychologist criteria include being a Registered Psychologist in Alberta, working in private practice in Calgary, focusing on trauma, and being willing to be observed or recorded. Exclusions include community or government agency work, locations outside the study area, non-trauma specializations, and clients who are unwilling to participate. Client criteria include a trauma-related concern, willingness to be observed, residence in or near Calgary, regular counselling attendance (weekly or bi-weekly), and being over 18. Open demographic characteristics apply, including gender, ethnicity, marital status, education, language, and occupation. Client exclusions include personality disorders, active psychosis, inability to attend counselling regularly, and non-participation in person. Both current and new clients will be included in exploring therapeutic alliances. I will contact private practices in Calgary via email or phone to invite qualifying psychologists. Client participants will be recruited through their psychologists, online advertisements, word of mouth, and postings in public spaces. Interested participants will be evaluated via email for inclusion in the study.

**Procedure.** This observational and interview study aims to analyze real-time interactions between therapists and clients, focusing on nonverbal cues, relational dynamics, and therapeutic techniques. Data will be collected by observing therapy sessions (live or recorded) with consent,

and thematic coding will be used to identify specific behaviours, voice tones, body language, and interaction patterns, including moments of rupture and repair. Observing how psychologists manage client distress, such as connections, ruptures, discomfort, and disclosures, is crucial, as these may evoke past traumas. I will conduct semi-structured interviews with psychologists to gain insights into their feelings during sessions, their methods for addressing client distress, and their formulation of therapeutic relationships. The study will involve two to four sessions with each client, followed by one interview per psychologist, for a total of eight interviews.

Before commencing the study, ethical approval will be obtained from the review board. After four psychologists and eight clients (two per psychologist) are selected through random selection from the pool of volunteer applicants, the research team will discuss the process of obtaining informed consent. This ensures that all parties understand the nature of the study, data handling, confidentiality rights, and withdrawal options. The lead researcher will observe therapy sessions (live or recorded) and code specific behaviours from both client and psychologist, including non-verbal cues (body language, facial expressions), relational dynamics (engagement patterns), therapeutic techniques, moments of rupture and repair (conflict resolution), and distress management (therapist responses to client distress). Following two to four sessions, the lead researcher will conduct semi-structured interviews, focusing on the psychologist's reflections on session dynamics, distress management strategies, therapeutic techniques, and their emotional experiences during sessions. Interviews will last 30-45 minutes and be audio-recorded (with consent) for thematic analysis. Due to the potential for emotional distress experienced by client participants, each will be allowed to end sessions at any time and discontinue participation in the study without penalty, per ethical standards. Further, each client will be offered a debrief with a third-party psychologist after each session to address emotional and psychological distress as well as engage in de-escalation and regulation tools.

Clients will have two to four therapy sessions. The research team will observe and record data using the coding system above. Semi-structured interviews will undergo thematic analysis to identify key therapeutic strategies for the relationship. Additionally, psychologists' perceptions will be compared to their observed behaviours, clarifying intentional and unintentional actions. Findings from observational and interview data will combine for a comprehensive understanding of the therapeutic process and alliance development with traumatized clients.

**Data storage.** All data will be stored on encrypted servers or in locked office cabinets, secured behind two locks. The research team will have access to both online and physical data. All recorded data, including video, audio, and interview transcripts, will be securely stored and encrypted for confidentiality.

**Risks, benefits, and limitations.** The potential research risk is the Hawthorne effect, which causes clients to alter their presentation, disclosures, and behaviour when they are aware they are being observed (Mostafazadeh-Bora, 2020). Holding back, over-dramatizing, or changing their presentation in sessions could affect the effectiveness of their counselling experience, potentially limiting the benefit of counselling.

This research study would significantly benefit psychologists, counselling as a practice, and trauma support. Trauma is an inevitable human experience that substantially hinders the well-being of those who experience it. Unfortunately, no one is immune to it at any age or stage of life. Trauma often disrupts individuals' ability to connect with and trust others. The physical and emotional symptoms of trauma are immensely distressing and disruptive to individuals' lives. When experiencing distress, our nervous system becomes dysregulated as a protective measure. The downfall of our bodies' attempts to keep us safe is that we cannot reason or process emotions while in a dysregulated state. Clients cannot process and heal if they are in a counselling space and with someone who does not calm their nervous system and allows them to relax, trust, and be

vulnerable. Proper and effective care for individuals with trauma relies on the ability of psychologists to create therapeutic relationships, and this provides effective counselling. Everyone has a right to care. Understanding the nuances and subtleties of therapeutic relationships when trauma is involved will increase the access and continuation of care. The importance of understanding the most effective way to build, maintain, and repair the therapeutic alliance with clients experiencing trauma-related symptoms is evident. It will help support countless individuals and their families.

Limitations of the current study are important to consider. As mentioned, the observer bias, also known as the Hawthorne effect, refers to the participants' behaviour (Mostafazadeh-Bora, 2020). Secondly, there may be an observer bias during the observational section of the study. My experiences, perceptions, and biases may influence the interpretation of non-verbal cues and relational dynamics. The inclusion criteria of having a trauma history, seeking support, and consenting to participate may limit the diversity of the sample. The generalizability of this research study is low due to the small sample size, limited geographic location, and small demographic. Furthermore, this study is conducted exclusively in a private practice setting. Future research should expand the number of participants, demographics, geographical location, and settings (e.g., community-based care, inpatient treatment).

**Reflexivity.** My interest in the therapeutic relationship in trauma counselling originates from my years of professional experience working at Hull Services in Calgary, a therapeutic campus-based care program. This program provides mental health and behavioural treatment to youth who have endured significant and horrific trauma, frequently at the hands of those closest to them. During my time at Hull, I have formed wonderful, close, trusting, and powerful therapeutic relationships with these young people. My academic and practicum experience during my graduate degree brought forward profound but straightforward questions: How do I

connect with youth who have endured unimaginable trauma? How did I do that? Their experiences in interpersonal relationships have been tumultuous, so how do they now trust me? A stranger? Why? How did I do that? Moreover, how do I continue to develop those relationships in clinical practice skillfully? Unfortunately, I was unable to identify a clear answer. My interest in trauma counselling relationships and my experiences sparked the idea for this research.

### **Conclusion**

One central theme that has emerged across history, theory, and practice is that healing happens in relationships. While trauma-focused therapeutic modalities offer valuable structure, they cannot replace the significance of a secure, attuned, and ethically grounded therapeutic relationship. Trauma is incredibly complex, widespread, and deeply personal. Trauma-focused counselling requires not only clinical tools and interventions but also relational depth. However, many clinicians are not adequately prepared to meet this need. Despite increasing awareness, the field of psychology and counselling has not yet prioritized relational training, especially within trauma counselling. The therapeutic relationship is not a byproduct of treatment; it is the treatment. Without understanding how trauma impacts individuals' ability to form connections, trust, safety, and boundaries, our evidence-based practices risk overlooking the human heart of therapy. This work calls for a change: more research, increasingly robust relational training, deeper and more purposeful clinical reflection, and a greater emphasis on how we are with clients, not just what we do. I invite all clinicians, but especially clinicians who work closely with trauma, to consider the following questions: Are we building the kinds of therapeutic relationships in which our clients can heal? Moreover, if not, what must we learn, unlearn, and do differently?

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