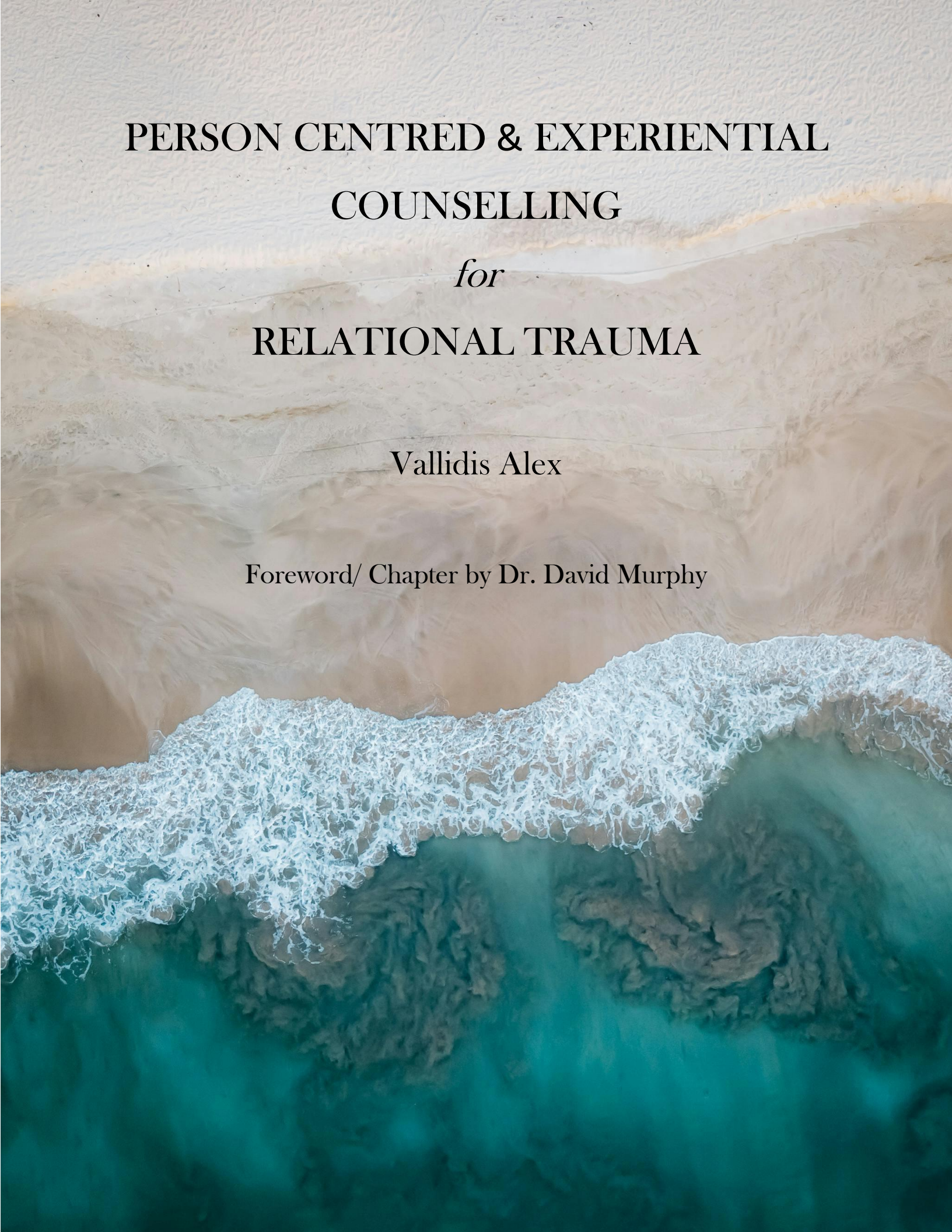
# PERSON CENTRED & EXPERIENTIAL COUNSELLING *for* RELATIONAL TRAUMA

Vallidis Alex

Foreword/ Chapter by Dr. David Murphy



# Person Centred Experiential Counselling for Relational Trauma

*To Lemon*

This Publication is the result of research in the refugee field, studying a specific intervention based on the Person-centred and experiential approach.

The research was conducted in the framework of the programme *"Promoting Resilience of Refugee Children at Risk"* implemented by PRAKSIS in partnership with UNHCR, the UN Refugee Agency. It took place at the community centre of PRAKSIS in Athens from 2023 to 2024.

The scientific supervision of the model's implementation was undertaken by the ICPS College for Humanistic Sciences.

Nottingham University Professor Dr. David Murphy contributed to the creation of the model through the development of the model Person – Centred Experiential Counselling for Depression.

# Person Centred Experiential Counselling for Relational Trauma

Vallidis Alex

1st Edition

2025, Athens/ Greece

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Contents

1. About the Authors .....pp. 10

2. Acknowledgements .....pp. 12

3. Foreword .....pp. 14

4. Introduction .....pp. 16

5. A Person-Centered and Conceptualization of trauma

by Dr. Murphy .....pp. 32

6. Person-Centred and Experiential

Theory of Relational Trauma .....pp. 42

7. Refugee Children experiencing gender-based violence .....pp. 60

8. The therapeutic process in PCE-rt .....pp. 68

9. Intensive Lab Training (ILT) .....pp. 84

10. Research Informed Supervision (RIS) .....pp. 88

11. Future research .....pp. 94

Appendix ..... pp. 102

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# 1. About the Authors

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Alex Vallidis holds a BSc in Psychology from Panteion University and is a Person-Centred Psychotherapist MSc. He serves as the Academic Lead for Psychology and Psychotherapy programs at both undergraduate and postgraduate levels at ICPS College for Humanistic Sciences and UCLan University.

His extensive research work includes exploring the use of encounter groups for individuals experiencing psychosis, and encounter interventions for the education of psychologists. He is also the co-author of guidelines for the prevention of self-harm in adolescents and stress management strategies for professionals working with refugees, in collaboration with UNICEF and Merimna NGO .

Alex has worked alongside PRAKSIS and Save the Children to modify tools used in Best Interest Assessment forms for the reunification of unaccompanied children with their families in Europe. He co-created programs with NGO Merimna to train teachers on how to support students during bereavement throughout the COVID-19 pandemic. This program received the EU Mental Health Award.

In addition to his clinical and research pursuits, Alex supervises postgraduate research on topics such as trauma, child development, person-centered therapy, fragile processes, and refugee populations. His career has involved working with individuals facing psychosis, substance misuse, bereavement, and children experiencing extreme social violence due to war, displacement, and gender-based violence.

Alex is a permanent member of the Science and Research Committee and the European Training Standards Committee of the European Association for Psychotherapists. He also serves as a Board Member for PCE World and PCE Europe, as well as for the National Organization for Psychotherapy in Greece. In Greece, Alex coordinates the Research Group, focusing on the development of psychotherapy methodologies through mixed-design research proposals.

**David Murphy**, PhD., is a Chartered Psychologist, Full Member of the Division of Counselling Psychology, and Associate Fellow of the British Psychological Society and registered member of General Psychotherapy Council. He is Professor of Psychology and Education and Director of the Centre for Research in Human Flourishing at The University of Nottingham, England. David's previous books include the Person-Centred Experiential Counselling for Depression Third Edition (in Press, with Peter Pearce) published by Sage. Person-Centred Experiential Counselling for Depression Second Edition (2018) published by Sage. He is editor of the official British Psychological Society-Wiley published Counselling Psychology: A textbook for study and practice (2017). He is Co-editor of Relational Depth: New Perspective and Developments (2012, with Rosanne Knox, Sue Wiggins and Mick Cooper), published by Palgrave MacMillan, and Co-editor of Trauma and the Therapeutic Relationship (2013, with Stephen Joseph) published by Palgrave MacMillan. He has over 90 peer review journal papers and book chapters in the field of counselling, psychotherapy, and education. He also was editor of the journal Person-Centered & Experiential Psychotherapies, the international journal for the World Association for Person-Centred and Experiential Psychotherapy and Counselling.

# 2. Acknowledgments

I would like to express my deepest gratitude to my family—Lemon, Sophie, and Jim—for the support I have received throughout the years. Your belief in me has been my constant source of strength.

I would also like to extend my sincere thanks to my colleagues, whose contributions have been crucial in my professional development, particularly Danae, Vangelis, Nicky and Elli. Your support and collaboration have played an important role in my growth.

A special acknowledgment goes to ICPS College for Humanistic Sciences, which has been central to my development since 2013, and to the UNHCR Representation in Greece Child Protection Unit for their trust and support in my work, with heartfelt thanks to Dr. Tsovili and Ms. Dritsa.

I am especially grateful to Professor David Murphy, not only for his inspiration in personal development and his integration of person-centered values, but for his genuine kindness, research, and commitment to these principles.

I would also like to recognize the people who have profoundly shaped my work: Carl Rogers, Peter Schmid, Margaret Warner, and John Bowlby. Their groundbreaking contributions have deeply influenced my approach.

Finally, the greatest thanks of all go to the children and their families who have trusted me with their stories over the years. It has been an honor to support them, and I am profoundly grateful for the privilege of being a part of their lives.

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# 3. Foreword – by Dr. David Murphy

The problem of childhood trauma is a vast and expansive one and a matter of concern for all psychotherapists. Whether working with children directly impacted by trauma in their lives or with adult survivors of childhood trauma, an understanding of how the person-centred experiential approach to psychotherapy can be helpful is essential. It was an honour to be invited by Alex Vallidis to provide this foreword and contribute a chapter in his book on the topic. Alex Vallidis is a person-centred experiential therapist with vast experience of working with young people and children impacted by trauma. In this book he takes the reader through the process of developing a model that incorporates core and essential aspects of person-centred experiential theory and connects these to other work in the field of relational trauma. His knowledge is expansive in the area and yet he discusses the approach in ways that convey a warmth and genuine care for the wellbeing and personal growth of traumatized youth.

This book will be a useful resource and companion for person-centred experiential practitioners working with your people who have experienced trauma. The approach taken by Alex Vallidis recognizes that trauma within the lives of young people is often ongoing, out of their control and has a substantial effect on the development of their personality. Whilst many people consider trauma therapy from the perspective of a single or small number of traumatic events, this book provides a way of conceptualizing and understanding the impact of ongoing, multiple and relational traumatic events. Alex Vallidis shows the readers how the person-centred experiential approach can provide a helpful heuristic for not only understanding relational trauma in young people, but also in how practitioners can work with this approach within this community. He does this by first grounding his conceptualization in theoretical and empirical research. This

research is phenomenologically grounded in the experiences of young people and their therapists. He has considered what are the benefits of the approach he has developed and provides some elementary evidence for these effects. Whilst the research that has so far been conducted into his approach is in the early stages, he has certainly not shied away from evaluating practice and integrating the findings into the development of the theory.

My own experience in this area is as a person-centred experiential therapist who has worked in the field of trauma for a number of years. I have always worked with my clients in a person-centred way, believing in their innate capacity to grow, develop and ultimately accommodate traumatic experiences into a new, revised and more resilient self-concept. This work has been across a huge range of client presenting traumas and the approach has always been adequate. My colleague and friend Professor Stephen Joseph have developed practice and training for person-centred experiential trauma work. My current colleague and PhD student Jen Holland has recently completed a multiple baseline trial of person-centred experiential therapy for adults who have experienced deep trauma. The findings of this study show highly promising results. What Alex Vallidis has contributed to our knowledge in this field is how this approach can be applied with this unique client group. The young, vulnerable and traumatized clients and what they need from therapy and their therapist is brilliantly articulate in this short companion book.

I am so pleased to see this work in print and congratulate all involved in its production. This is a highly valuable contribution to practice.

# Chapter 4. Introduction

**Person-Centred and Experiential Counselling for Relational Trauma**

Person-Centred and Experiential Counselling for relational trauma is a person-centred model of brief intervention, grounded in the principles of person-centred psychotherapy, and incorporating elements from the experiential paradigm. This model is distinguished by two key components.

The first component concerns the stance of the therapist, emphasizing the importance of the client engaging in a therapeutic relationship where the clinician is not perceived as a dominant or authoritative figure. This aspect is especially critical for clients who have spent much of their lives subjected to power imbalances (Bochatay et al., 2021). This intervention was developed in response to work with child refugees—an especially vulnerable group who have only recently been recognized as having full human rights (Goldhagen et al., 2020). Child refugees, in particular, often face severe rights violations, and the absence of control in their lives frequently leads to trauma (Dangmann et al., 2022).

The second component of the model focuses on trauma—specifically complex trauma rather than just acute trauma. In this context, trauma is not defined strictly in clinical terms but is instead viewed as part of the natural human experience in adversity, connected to growth and resilience (Joseph, 2021). While trauma can be more readily identified in the body through biological responses, psychological trauma often manifests in ways that are more subtle and difficult to recognize, even for professionals. Moreover, trauma is often accompanied by stigma, further complicating its recognition and treatment (Schomerus et al., 2021).

This model does not aim to "cure" trauma in the traditional sense. Instead, it is based on the experiences gained from the author's everyday practice, working with people experiencing psychosis, drug addiction, bereavement, the aftermath of war, and gender-based violence. In all these cases, the author observed that the therapeutic relationship itself enhances the client's inherent capacity for growth. By placing the relationship at the center of the process of growth, the model acknowledges the client's existing strengths and potential for recovery, rather than focusing solely on the pathology of trauma.

**Context and Research**

This intervention, developed from 2023 to 2024, was carried out within the framework of the programme " Promoting Resilience of Refugee Children at Risk" was implemented by Praksis, in partnership with UNHCR ", implemented by PRAKSIS in partnership with of UNHCR, the UN Refugee Agency.  The research program took place in urban settings, focusing particularly on piloting therapeutic methods for the recovery and healing of child survivors of gender-based violence (GBV). Supported by the UNHCR and conducted by the NGO PRAKSIS, this program was active until December 2024.

The intervention is rooted in extensive research supervised by the academic department of ICPS College for Humanistic Sciences. All data that informed the development of the intervention were approved by the ICPS College ethical committee. From March 2023 to June 2024, the intervention was carried out at the NGO PRAKSIS community center, with the results presented at the 16th World Conference for Person-Centered and Experiential Psychotherapy and Counseling.

**1st Research - Evaluating the Impact of Person-Centered and Experiential Counseling on Relational Trauma: A Mixed-Methods Study of Child GBV Survivors in Refugee Settings.**

Three forms of data were collected during the intervention:

1. Quantitative Data: Collected during the 5th and 10th sessions using the International Trauma Questionnaire (Cloitre et al., 2018) and the Post-Traumatic Growth for Children Scale (Tedeschi & Calhoun, 1996).
2. Qualitative Data: Gathered through post-intervention interviews with children, analyzed using Thematic Analysis (Braun & Clarke, 2023).
3. Expert Feedback: Provided by cultural mediator and Social Scientist on the intervention's implementation.

The synthesis and triangulation of this data enabled the presentation of three comprehensive case studies. These case studies integrated quantitative results with qualitative insights, demonstrating the intervention's impact on alleviating symptoms of trauma and enhancing post-traumatic growth. The analysis of the cases follows the explanatory sequential method (Ivankova et al., 2006). In these cases, CPTSD (Complex Post-Traumatic Stress Disorder) scores fell below diagnostic thresholds, and self-concept improved through the therapeutic relationship.

These data were generated from the analysis of the pre-test and post-test results of three participants who completed the program.

**Table 1.: Intervention Outcomes (Quantitative)**

| Participant | PTSD (Pre-Test) | PTSD (Post-Test) | Self-Organization (Pre-Test) | Self-Organization (Post-Test) | Complex PTSD (Pre-Test) | Complex PTSD (Post-Test) | Complex PTSD (Follow-Up) |
|---|---|---|---|---|---|---|---|
| Participant 1 | 20 | 19 | 12 | 3 | 32 | 23 | N/A |
| Participant 2 | 17 | 19 | 17 | 5 | 34 | 24 | N/A |
| Participant 3 | 18 | 14 | 11 | 9 | 29 | 23 | 8 |

Key Post-Traumatic Growth Changes:

Participant 1: Learned what's important, handles problems better, appreciates kindness.

Participant 2: More likely to take action, expresses emotions better, handles challenges.

Participant 3: Increased confidence in taking action, solving problems, sustained progress.

The analysis of data from the three participants demonstrates meaningful improvements in trauma symptoms, emotional regulation, and personal growth through the intervention. Across the participants, PTSD scores showed varying degrees of improvement, with reductions in symptom severity noted for two participants (e.g., 18/24 to 14/24, 20/24 to 19/24), while one experienced a slight increase (17/24 to 19/24), highlighting individual variability. Self-

organization scores consistently improved, reflecting enhanced emotional regulation and personal organization, with significant drops such as 17/24 to 5/24 and 11/24 to 9/24. Complex PTSD scores also showed significant reductions, with some participants demonstrating dramatic sustained improvements over time (e.g., from 29/48 to 23/48 and further to 8/48- 6 months after the intervention). In addition to these quantitative changes, post-traumatic growth was evident in all participants. They reported greater confidence in handling problems, increased motivation to take positive action in their lives, and a newfound appreciation for the kindness of others. Overall, the intervention facilitated reductions in trauma-related distress, improved emotional functioning, and fostered resilience and personal growth, with some participants showing enduring benefits well beyond the intervention period.

The findings from the Interviews with the children reveal several key themes that highlight the multidimensional impact of the intervention. Participants consistently reported a positive experience during sessions, marked by feelings of safety, comfort, and emotional support (Greenberg, 2014). The therapist’s kind, understanding, and empathic stance emerged as a significant factor in fostering trust and self-awareness. Empathic mapping was identified as both enjoyable and beneficial, aiding in self-expression and enhancing practical skills, particularly in the experience of relating to other children in the school. However, the data also highlighted challenges outside the intervention, with some participants expressing mixed emotions at home due to unresolved sibling conflict or lingering trauma. Another critical finding was the positive shift in family dynamics when abusive influences, such as the father's presence, were mitigated, leading to improved emotional stability and a more relaxed home environment.

The following themes were derived from the analysis of the interview with the cultural mediator, who was present during the sessions and provided commentary on the therapeutic intervention process.

The thematic analysis reveals a multifaceted and dynamic therapeutic process that fostered safety, creativity, and emotional growth. The therapist's friendly, non-authoritative approach created a comfortable environment where children and cultural mediators felt at ease, enabling trust and openness. Creative tools like the empathic mapping facilitated expression for children who struggled with verbal communication, allowing emotions to be explored in a manageable and non-overwhelming way. The flexibility of the sessions, tailored to each child's needs, encouraged autonomy, empowering children to lead the process and even reverse roles by asking the therapist questions, fostering a sense of mutuality. Playfulness and gamification added an engaging, interactive dimension, while straightforward language made complex issues like addiction accessible. Over time, the sessions evolved to deeper emotional work, helping children build self-esteem, process difficult emotions, and gain self-acceptance. This innovative, adaptive approach highlighted the therapeutic balance between addressing challenging emotions and maintaining a safe, enjoyable, and empowering experience for the participants.

The following themes emerged from the analysis of the interview with the social Scientist, who collaborated with families during the intervention and provided insights from a social environment perspective.

The thematic analysis highlights the intervention's ability to foster trust, emotional awareness, and individual growth while addressing systemic and contextual challenges. A strong focus on building relationships, characterized by respect, kindness, and empathy, enabled children and

families to feel supported and valued. Tools like the empathic mapping helped children process emotions, organize their thoughts, and reflect on harmful roles, fostering self-awareness and promoting positive changes in family dynamics. The intervention was particularly impactful for older children (12+), with parents reporting calmer behaviors and improved relationships at home. However, younger children found it harder to fully engage, and external factors such as unstable living conditions or caregiving responsibilities sometimes hindered participation. The approach's flexibility and cultural sensitivity addressed these barriers, while ten sessions provided a strong foundation for change, though additional long-term or group-based support could further enhance social skills and reduce isolation. The findings emphasize the importance of systemic improvements and collaborative efforts to ensure these children are holistically supported, while maintaining the intervention's culture of dignity, respect, and empowerment.

This thorough analysis of data suggests that the intervention holds promise as an effective Person-Centered and Experiential Counseling model for addressing relational trauma among child GBV survivors in refugee settings.

**2nd Research - Enhancing PCE for relational trauma, Through Empathic Mapping: A Qualitative Exploration of Therapeutic Processes and Outcomes.**

This research examines the development of empathic mapping in trauma therapy, specifically as a method of intensifying key therapeutic characteristics. Rather than functioning as a stand-alone technique, empathic mapping enhances essential aspects of therapeutic practice, such as facilitating the communication of empathic understanding and helping therapists stay connected to the client's experience without becoming overwhelmed by their own traumatic histories (Berger, 2018). The mapping process symbolizes the client's incongruence, which often drives

them to seek therapy, providing a visual and structured representation of their experience (Purton, 2013). Two expert trauma specialists participated in this intervention as clients, offering qualitative feedback on their experiences.

Their reflections focused on several core areas, including client frame of reference/track, psychological holding, experiential specificity, accepting presence, content directiveness, emotion focus, dominant or overpowering presence, clarity of language, core meaning, and emotion regulation sensitivity. These areas are aligned with the Person-Centered and Experiential Psychotherapy Process Scale (PCEPC), which offers a comprehensive framework for evaluating therapeutic processes (Freire et al., 2014).

A thematic analysis, guided by Braun and Clarke's (2006) framework, was conducted to identify key patterns in the specialists' feedback, revealing several central themes. First, empathic mapping enhanced empathic understanding and therapeutic presence, helping therapists maintain their connection with the client's experience while avoiding immersion in their own trauma. Second, the mapping created structure amid chaos by visually organizing clients' emotions, reducing feelings of overwhelm, and providing a holding mechanism for difficult emotions. Participants also reported that empathic mapping restored the power balance in the therapeutic relationship, empowering clients by co-creating a tangible representation of their experience.

Additionally, the mapping process increased experiential specificity and emotional regulation, offering clients clarity and the ability to revisit their mapped experiences, which reinforced therapeutic progress. Finally, the visual representation of the client’s incongruence motivated continued therapy by providing a sense of direction and purpose. These findings underscore the potential of empathic mapping, as connected to the PCEPC scale, as a valuable tool in trauma-

focused therapy, supporting empathic communication, emotional processing, and therapeutic balance.

**3rd Research – Is Person-Centred Counseling for Relational Trauma a Person-Centred Model?**

The research was conducted with two specialists in Person-Centred theory, each with over 12 years of experience as trainers, supervisors, and psychotherapists. Their expertise extends to the knowledge of inclusion criteria for the person-centred paradigm.

The interviews were conducted following the experts' participation in a lab session, where a professional implemented a 10 minute lab to the specialists. Afterward, a semi-structured interview took place, guided by the theories outlined above.

**Sanders (2000):** Differentiated person-centered principles into primary and secondary categories.

**Warner (2001):** Established criteria for inclusion in the person-centered paradigm.

The transcripts from these interviews were analyzed using thematic analysis, allowing for a connection between the experts' experiences (Braun & Clarke, 2006).

According to the experts, empathic mapping is not perceived as directive by the therapist; rather, it facilitates the flow of the therapeutic process. The participants noted that empathic mapping effectively communicated empathy, which reinforced their perception that the therapist respected and trusted the client's actualizing tendency. They highlighted that the most significant aspect of the mapping process was that it was shared with the client, allowing the client to see precisely

what the therapist was expressing and to make adjustments if needed. This experience provided clients with a tangible record of being understood by the therapist.

Furthermore, empathic mapping clarified that the therapist entered the session without stereotypes, demonstrating a clear intention to understand the client's experiential context. Emphasizing the client's perspective fostered a sense of security within the therapeutic relationship and promoted psychological contact. The participants felt that the process was closely connected to experiential inquiry, with the therapist perceived as someone genuinely interested in clarifying the client's experience without exerting pressure.

**Integrating Empathy, Structure, and Growth: Advancing Person-Centered Approaches for Relational Trauma**

Following the findings from the research mentioned above, empathic mapping enhances empathy and collaboration by allowing clients to co-create their mapped experiences, fostering trust and understanding (Makkreel, 1996). It provides structure to complex emotions, reducing overwhelm and supporting emotional regulation (Roseman, 2013). The process emphasizes client autonomy, promoting security and psychological contact without the therapist appearing directive (Erskine et al., 2022). Aligned with person-centered principles, it respects the client's experiential context and supports their actualizing tendency (Kaufman, 2023). By symbolizing incongruence visually, empathic mapping restores therapeutic balance, motivates continued therapy, and provides direction for addressing relational trauma (Hickle & Lefevre, 2022).

**The Empathic mapping and refugee children**

Empathic mapping offers a developmentally sensitive and trauma-informed approach for working with refugee children who have experienced relational trauma, displacement, and systemic instability. These children often face chronic disruptions in attachment, language, and safety, which impair their ability to symbolize and regulate internal states. Empathic mapping enables them to co-construct visual representations of their inner experiences, reducing emotional overload and supporting affective regulation (Roseman, 2013). By transforming overwhelming sensations into organized, visual narratives, children gain a sense of agency and coherence, which is essential in processing complex trauma (Pynoos et al., 1999). This aligns closely with Rogers' (1959) theory of incongruence, wherein psychological distress arises from unassimilated experience; the mapping process helps restore congruence by giving symbolized form to fragmented or denied internal realities.

Furthermore, the child-led nature of empathic mapping upholds core person-centred values, particularly autonomy, psychological contact, and the actualizing tendency (Rogers, 1957). As such, therapists avoid imposing adult interpretations and instead follow the child's subjective world — a principle particularly vital when linguistic, cultural, or developmental barriers exist. This is reinforced by Makkreel's (1996) hermeneutic framing of empathy as a mutual act of interpretation, where meaning is generated in relationship. Refugee children, who often navigate between conflicting cultural identities and internalized trauma narratives, benefit from this shared meaning-making process, especially when supported by a relational figure such as a cultural mediator or trusted adult (Betancourt et al., 2015; Derluyn & Broekaert, 2007). Moreover, studies have shown that children are more likely to engage and disclose emotionally when nonverbal and creative methods are employed, especially in post-trauma contexts (Malchiodi, 2005; Thomson & Jaque, 2017). Thus, empathic mapping provides a structured yet

non-directive therapeutic tool that supports emotional safety, therapeutic alliance, and symbolic integration — offering refugee children not just a means of expression, but a pathway to healing within a person-centred frame.

**Navigating the Journey Through PCE-rt: A Guide for Readers**

Readers are encouraged to approach this book with curiosity and openness, viewing each chapter as a step toward understanding and applying Person-Centred and Experiential Theory in trauma work. Chapters 5 and 6 & 7 provide a theoretical foundation, focusing on relational trauma and the experiences of refugee children. Chapter 8 outline the therapeutic process, where the theory of therapy is accompanied by specific vignettes from sessions with a fictional client, illustrating key moments of therapeutic work within the intervention. In Chapter 9, the intensive lab training of the model is introduced, with specific issues covered during training and a structured approach to intensify preparedness for counselors working with the model. In Chapter 10, research-informed supervision is introduced, along with the elements through which a person-centered counselor can draw insights from research and focus on personal growth, protection from secondary trauma, and professional development. In Chapter 11, insights are shared for future research, primarily outlining the next steps in recognizing relational trauma as a mediating factor for many aspects of psychological distress. This structure offers a comprehensive guide for engaging with the complexities of PCE-rt.

Following these chapters, the appendices will provide detailed insights into the method and analysis sections of the findings shared throughout the book, offering readers additional clarity and depth on the research process.

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# Chapter 5. A person-centred conceptualisation of trauma

## by Dr. David Murphy

Carl Rogers developed his theory of personality based on his understanding of what happens within the therapeutic process with clients. He learnt from his clients and from his own direct experience in trying to be of help to them. It is often not well recognised that in the early stages of his theorising, Rogers worked with returning veterans of World War II along with John Wallen (Rogers & Wallen, 1946). Together they developed the non-directive approach to therapy tailored for working with traumatised men and women who were part of the wartime effort. Why is this significant? Primarily because the tailoring of his early non-directive counselling approach was being applied prior to much of the later work Rogers did in the development of his theory of personality. It is difficult to imagine that this work did not in some way influence his thinking about personality as he was exposed to detailed accounts of wartime trauma. Of course, this would have been in addition to the experiences he gained from working with traumatised children and families in the Child Guidance Centre in Rochester. In this sense, it is no surprise that the person-centred theory of therapy has been so well-placed to provide both an explanatory model for the experiences of trauma that people face and the practice of therapy offered to support individuals and groups in the wake of their trauma.

Rogers' theorising and therapy in the field of trauma is significant as he has provided a way of approaching trauma work through the metaphor of a growth model. Of course his theory accounts for human distress, suffering and development of those experiences we associate with post-traumatic stress, but Rogers' theory sets these in the context not of pathology or disorder but

instead he frames these reactions as quite natural consequences to the organismic tendency to survive, adapt and striving for growth. The implication of the growth model in the context of trauma has been described through the concept of posttraumatic stress (Joseph, 2004; Murphy 2009) and posttraumatic growth (Joseph & Linley, 2005; Murphy & Joseph, 2011; 2014) both of which are being driven by the actualising tendency and organismic valuing process (Rogers, 1951).

In this chapter I provide an account of how person-centred theory can be used to understand the impact of trauma on an individual. This will cover the development of posttraumatic stress responses following a traumatic event and how continued exposure to trauma leads to the development of a particular form of traumatised processing within the self. Both can form useful conceptualisations for the person-centred therapist working in settings where their clients report exposure to trauma in their history. It is important to note that Rogers's theory is based on the principles of an organismic psychology. What this means is that the body is integral to every experience, the body is experiencing and cannot be considered as separate. There are common misunderstandings about Rogers's theory which often place too much emphasis on his theory of the self-concept. In this chapter, I shall provide regular 'signposts' that highlight what I am talking about as being situated in an organismic process and not as a detached self, abstracted and separate to experiencing in the environment. This can be useful for practitioners as much of what is encountered when working with traumatic processes in clients is felt to be alive and actively (re)experienced in the body.

**A theory of the development of the self: an organismic perspective**

Person-centred theory suggests that the development of the self can be easily understood as an emergent and interactive process that is a part of the broader context of the human organism's innate tendency toward actualisation. Rogers (1951) proposed that much like all other living organisms, the human organism possesses an inherent tendency to grow, develop, and realise its full potential. This tendency is not imposed externally but emerges from the interaction with other people, objects, places and within our habitats. Thus, the human organism is situated within a much broader and dynamic system of process. The emergent process is a fundamental property of life itself. It is within this organismic conceptualisation that the concept of a self begins to form.

The self-concept, as Rogers (1951) described, is processual structure and constellation of an evolving configuration of perceptions, values, beliefs that the individual experiences as or about "me" or "I." A self-structure does not simply appear but is shaped over time and gradually becoming and influenced by the social-relational conditions present in early development. When the individual is cared for, supported and nurtured with congruent acceptance and empathic understanding, they are more than able to remain in direct contact with their own experiencing and thus are able to maintain a basic trust in their organismic valuing process. Direct contact with the organismic valuing process is the intrinsic ability to discern what is right for them based on felt experience.

However, development does not occur in a vacuum. The emergence of conditions of worth—which are the expectations or evaluations imposed by others and restrict acceptance to only some behaviours or attributes—can lead to distortion of experience to fit in with the existing self-concept. When such conditions exist, the person will come to feel that certain experiences, behaviours, feelings or thoughts are unacceptable to those from who they feel the need to receive

positive regard. The result is a discrepancy between the self and experience. The organismic experiencing and the self-structure are now at odds (Rogers, 1951). Rogers referred to this discrepancy as an incongruence and this is felt as a basic tension and anxiety within the self. This is essentially a transdiagnostic universal explanation of the experience of psychological distress.

The person-centred view, particularly from an organismic perspective, places great value on the nature of the relational environmental conditions. Where individuals perceive unconditional positive regard, empathic understanding, and genuineness, then the person will grow in a social constructive direction. In the absence of these conditions, the person can develop psychological tension, become distress or anxious and could also engage in more personally or other focused destructive actions. If the conditions exist, Rogers (1951) proposed that the self can be reorganised and move toward becoming a more fully functioning person. The fully functioning person is someone who is open to experience, lives in the present moment, and operates from an internal locus of evaluation.

**The impact of trauma on the self-concept and organismic functioning**

To understand trauma from within the person-centred theoretical stance, it is first necessary to determine what is meant by trauma. As the next chapter deals specifically with relational trauma, the focus of this chapter is to provide an account of trauma that might occur through a single event, series of unusual or catastrophic events (such as during war) or that result in what is probably best referred to as acute traumatic stress. Following exposure to such an event a number of experiences tend to follow. Firstly, individuals may re-experience the event through intrusive recollections, which can manifest as thoughts, emotions, dreams, or nightmares about the

incident. This re-experiencing is often accompanied by intense distress and, in extreme cases, the person may feel as though the event is occurring in the present moment.

Secondly, avoidance behaviours are common, where individuals attempt to prevent or evade reminders of the event. Psychological avoidance might involve steering clear of thoughts, discussions, or feelings related to the incident. Behavioural avoidance could mean avoiding places or activities that trigger memories of the event. While these avoidance strategies might give the impression of coping, prolonged use can lead to significant negative consequences in both psychology and behavioural experiences.

Thirdly, there may be changes in cognition or what is referred to as emotional numbing. Lastly, heightened arousal states can also be prevalent. When these experiences significantly disrupt social and occupational functioning, a diagnosis of PTSD may be warranted although that is not necessary for the purpose of person-centred experiential therapy to ensue.

So how can person-centred theory account for the traumatic stress phenomena? In two previous articles this theory has been set out in a clear and concise manner (Joseph, 2004; Murphy, 2009). As the traumatic event occur, the person is faced with unprecedented task of having to process experience that overwhelms the self-concept. This may, for example, be in the sense that the world is no longer perceived in the same manner as before the event. Janoff-Bulman (1992) uses the idea that cherished beliefs about the world that we hold as assumptive frameworks (these are similar to conditions of worth) are shattered. In the face of a trauma, a person’s expectations about life are upended. The world may no longer seem as if it is a predictable or safe place to be. Assuming the person had previously considered the world to be safe and they perceived themselves to be in control of their environment, trauma can shatter such assumptions in an

instant. We all carry assumptions about the world. These can be cultural, social norms or beliefs and values we have taken on. When our worlds are literally turned upside down through the trauma, the organism continues to strive to function optimally. Attempts to process trauma related experiences seem to no longer fit into the self-concept with the theretofore ease of cognitive distortion easing the way. Instead, the person is now left with a swirling dynamic experiencing process that includes messages and meanings from the world that do not fit.

**The role of post-traumatic growth**

Following the trauma, the natural tendency of the person is to want to fit the new and trauma related experience into the existing self-concept. If this is to happen, a substantial effort will be made to deny and distort experience. The process of recovery can often go in one of two directions. One involves the oscillating between periods of intense re-exposure to the trauma event with periods of deep avoidance. This is natural and in organismic terms it makes sense to think of the organism controlling just how much re-exposure can be sustained and when the defence system kicks in to protect from further harm. This is when avoidance starts and the organism is more in a process of maintaining. However, as Joseph and Linley (2005) pointed out, as the organismic valuing process determines how much and how far to go in trauma processing, it is the social-relational environment that can be the difference between assimilation of trauma related experiences or accommodation of the trauma. The latter of these might be considered to represent a significant change to the self-concept. The former indicating little or no change but is an attempt to ‘get back to how I used to be’. A phrase we have probably all heard before.

Assimilation of trauma related experiences

According Joseph and Linley (2005), whilst it is the natural tendency of the organism to move towards accommodation, people are also cognitively conservative and will veer towards similarity, especially when the social-relational conditions are not conducive to growth. In these instances, a person will seek to maintain the self-concept even after a traumatic event has occurred. If the person is not met with the right social-relational conditions, trauma related experiences will be distorted to fit in with the pre trauma self-concept, and the once shattered assumption are tenuously restored. Through active distortion and denial, the pre-traumatic stance and outlook become the lens through which experiences are processes and acted upon.

**Accommodation of trauma related experiences**

Conversely, accommodation means that trauma related experiences are taken on by the person as new and meaningful features to a more highly differentiated world and outlook. This will be possible when the social-relational conditions allow as defined by Rogers (1957) six necessary and sufficient conditions. Accommodation of trauma related experience involves a reconfiguration of a self-concept. New meaning and purpose for life with changes in outlook upon and towards relationships or more existential living will often be noticeable differences. In a previous article by Joseph, Murphy and Regel (2012), the concept of affective-cognitive processing was presented as a means for explaining accommodation processes within the overall theory of personality. In this approach, appraisal mechanisms are active, social support factors are identified and the changes to the structure of personality are outlined as critical processes for trauma recovery and growth.

**Conclusion**

In this chapter I have provided an overview of how the concept of trauma can be conceptualised within the theory of person-centred personality and psychotherapy. In the following chapter, the phenomenon of relational trauma will be specified.

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# Chapter 6. Person-Centred and Experiential Theory of Relational Trauma

**Attachment and Relational dimensions of the "Conditions of Worth"**

Relational trauma, derives from hurting interpersonal relationships, particularly in early life, has been extensively studied across various theoretical frameworks (Fonagy et al., 2003; Riggs, 2019). John Bowlby's attachment theory underscores how unmet attachment needs due to neglect, abuse, or inconsistency can lead to insecure attachment styles (Maisel, 2020). This concept expanded by Mary Ainsworth's identification of ambivalent and disorganized patterns (Spies & Duschinsky, 2021). Two key concepts are under discussion from the person-centered view: first, the focus on the early years of the person, and second, the deterministic nature often attributed to attachment theories.

Regarding the first issue, the concept of "conditions of worth" plays a central role in understanding the development of the individual. Conditions of worth, as foundational elements of the self-structure, influence how a person perceives themselves and their capacity to establish new relationships (Lakin & Murphy, 2024). Not only are conditions of worth central to the development of the person, but the here-and-now experience of worthiness also plays a crucial role (Greenberg & Elliott, 2012). By examining conditions of worth through a two-dimensional lens, we can better understand their impact.

The first dimension is the message conveyed, such as "I am worthy if I work hard." The second dimension is the tone accompanying the message, which can lead to either a rigid or fluid sense of self (Mearns & Thorne, 2000). For example, there is a significant difference between an inner dialogue like, "I am worthy if I work hard; this has helped me in life, but sometimes I can allow

myself to rest," and one that states, "I am only worthy if I work too hard." While the content of these self-messages may appear similar, the tone and underlying inner culture are profoundly different.

The person-centered relationship offers a unique space for the individual to explore and soften this internal tone (O'Leary, 2008). Through relational experiences that emphasize acceptance and empathy, the person can begin to shift from rigid, self-imposed conditions of worth to a more fluid and compassionate self-perception. This relational process not only fosters greater flexibility in the person's inner dialogue but also supports the development of a more authentic and adaptive sense of self.

If we view the self as a dynamic, life-creating process that evolves continuously, it becomes clear that behavior cannot be predicted deterministically. Instead, by examining the relational field and the underlying mechanics of the person within it, we can explain and contextualize relational phenomena.

The deterministic essence of attachment theories can also be reconsidered through this lens. Both issues—the formative role of early experiences and the predictability of behavior—find resolution in recognizing the significance of worth in personal development. A person's intrinsic pursuit of feeling worthy is essential for their sense of safety, which serves as the cornerstone of development (Porges, 2022). Thus, understanding worth not only provides insights into the formation of the self but also emphasizes its critical role in fostering relational and psychological well-being.

**The Good enough and Fully Functioning person**

Donald Winnicott highlighted the role of the “good enough” caregiver and the developmental impact of disrupted attunement, which can suppress the “true self’’ (Tuber, 2019). In contemporary western society, individuals increasingly struggle with an ideal self that demands perfection in every aspect of life (Curran & Hill, 2019). This perfectionism is often fueled by an internalized judge, shaped by the relentless stream of information and role models absorbed from internet videos and social media (Storr, 2017). Compounding this issue is the pressure of living in a highly competitive society, where the narrative suggests that only the "fittest of the fittest" will thrive. Many individuals, particularly those with disadvantaged beginnings—such as refugee children —find themselves starting this race of perfection from a significant deficit. These children often connect their sense of self-worth to the idealized role models presented online. Consequently, they may feel unworthy and unsafe when comparing themselves to the highly curated successes promoted by the media.

From a person-centered perspective, the true self emerges when individuals tune into their authentic needs and symbolize their experiences in the here and now (Ryback, 2013). Empathy and unconditional positive regard, central elements of person-centered therapy, provide a relational space where all experiences are valued without comparison to an external locus of control (Amari, 2022). This therapeutic environment fosters a sense of worthiness, allowing individuals to develop an internal locus of control and align with what genuinely matters to them. Simultaneously, it supports their intrinsic need to belong and feel connected.

By shifting focus from external validation to the process of self-discovery, person-centered therapy helps individuals move away from the unattainable goal of perfection and towards the dynamic, evolving process of becoming (Rogers, 2012). This approach enables individuals to embrace their "good enough" selves and remain attuned to the richness of their lived, here-and-

now experiences. Moving towards becoming a fully functioning person involves developing greater openness to experience, self-trust, and a commitment to personal growth and authenticity. This process includes embracing emotions and experiences without distortion, fostering congruence, resilience, and the ability to build meaningful connections with others (Rogers, 1963).

**Empathic Validation and Relational Growth**

If we divide the person into sources of internal relationships, we can identify three main domains. The first domain is connected with the person's relationship with their beloved ones. The second refers to the relationship with oneself, and the third relates to their relationship with the world and the community (Watts et al., 2022). These three types of relationships are phenomenologically internalized by the person, contributing to a sense of belonging—or the lack of it.

This discussion on relational trauma is particularly important because the need for a sense of belonging is not exclusive to children at risk. In Western societies, children are increasingly exposed to highly competitive environments at an early age, especially following the COVID-19 pandemic (Goldfeld et al., 2022). Furthermore, economic crises and the war in Europe have generated a widespread sense of instability and insecurity, leading to higher levels of distress (Chudzicka-Czupała et al., 2023; Massag et al., 2023; Rogoff, 2022). Empathy becomes central in this battle for mental survival in the modern world.

From a person-centered theory perspective, we can conceptualize the self as a line striving to expand into new experiences, as illustrated in *Figure 1*. The texture of this surface represents the

relationship the person has with themselves. A more compassionate relationship allows experiences to be acknowledged and worked through. In contrast, more rigid selves resemble ice, where many experiences accumulate on the frozen surface. This rigidity poses a danger, as breaking the frozen surface can be harmful to the person, illustrated in *Figure 2*.

**Figure 1.**

**Figure 2.**

The fear of new experiences and the threat of self-collapse often lead to a fragile sense of self (Warner, 1991). This fragility reduces the individual's ability to accurately symbolize their experiences and act upon them, narrowing their perspective due to the distress caused by the inability to tolerate the experience (Veilleux, 2023). At this stage, the person is typically in the early phases of change, where external factors predominantly influence their life (Rogers,1958). In this survival-oriented state, the person is focused on enduring rather than thriving, which underscores the critical role of empathy in relational therapy and counseling.

Empathy is the cornerstone of relational interventions because the patterns observed in clients are often survival mechanisms (Bonanno, 2021; Joseph, 2021; Constant et al., 2021). True change for the individual, as illustrated in the two figures, involves transforming the entire texture of perception rather than altering isolated elements (Rogers,2013). Empathy fosters a culture of inclusion within the relational field, which the client internalizes as they build a continuous relationship with themselves (Erskine et al., 2022). In the therapeutic space, the client experiments with relational trust, relying on the counselor to maintain a balance between being present and actively engaged.

Empathy is neither a technique nor a passive stance of distant affirmation, which clients often perceive as absence (Michaelson, 2002; Carrión, 2015; Yalom, 2002). Instead, the counselor must remain fully present and engaged, similar to walking a tightrope (*Figure 3*). On one side lies passive affirmation, and on the other, a directive stance—both of which can reflect the counselor's own survival mechanisms, much like the survival behaviors seen in clients.

Figure 3.

When a person-centred counselor feels avoidant and fearful of the therapeutic relationship, they often engage with the client in a passive manner (Grafanaki & McLeod, 2002). This approach can steer the process into a vague and unproductive space, leaving the client feeling unattended. Such a stance is frequently linked to the counselor's internalized representation of the "ideal therapist," which can stifle their creativity and spontaneity in the therapeutic process (Bohart, 1999).

Another pitfall to be avoided is the counselor’s tendency to adopt a survival stance rooted in their own crises or anxieties. For instance, in our lives, during moments of crisis—such as when a house catches fire—the instinct is to take immediate action. However, this instinctive "do something" response may not always serve the therapeutic process, especially when listening to a client (Jordan, 2023).

What is essential is cultivating a space of trust in the client's process while simultaneously avoiding self-identification with the client’s crisis (Herman, 2023; Brown, 2022). The counselor must resist the urge to overidentify with the client’s experiences or impose their own anxieties, ensuring the focus remains on the client’s journey and growth (Joseph, 2021). This dynamic is particularly prominent when working with trauma. Empathic mapping serves as a safety net, allowing the counselor to stay connected to the client’s narrative and phenomenological perspective while remaining creative, congruent, and engaged.

This balance also protects the counselor by fostering trust in the client’s ability to navigate traumatic content (Carnes & Northcut, 2017). Separating empathy from identification further safeguards the counselor, enabling them to stay connected while experiencing compassion satisfaction (Wagaman et al., 2015). This protective dynamic significantly reduces the risk of

vicarious trauma, supporting the counselor's well-being as they engage deeply with the client's healing journey.

**Person Centred Counseling for relational trauma and Neuro-psychotherapy**

Relational trauma often appears as emotional distress, profoundly influencing an individual's worldview (Treisman, 2016). Bulman's conceptualization identifies three core disruptions: benevolence, meaningfulness, and self-worth. Traumatized individuals may view the world as dangerous or unjust, life as chaotic, and themselves as unworthy (Rizeq & McCann, 2023). This erosion of self-concept parallels Warner's notion of fragile psychological processes, wherein past trauma heightens susceptibility to emotional dysregulation. Warner highlights the challenges such individuals face in feeling emotionally safe, particularly in group or therapeutic contexts, due to hypervigilance and defensive tendencies (Warner, 2016).

Fear is an essential emotion deeply embedded in the brain's architecture, primarily governed by the amygdala (Šimić et al., 2021). The amygdala plays a central role in fear processing, receiving sensory threat information through two pathways: the "low road" for quick, unconscious reactions, and the "high road" for more detailed, conscious threat analysis (LeDoux, 2015). LeDoux (2015) highlighted the distinction between unconscious emotional responses mediated by the amygdala and the conscious experience of emotions involving higher cortical regions. This region, in coordination with the autonomic nervous system, activates responses such as "fight or flight" (via the sympathetic system) or "freeze" (via the parasympathetic system) to ensure survival (Roelofs & Dayan, 2022). Fear responses are immediate and largely subconscious, shaped by neural pathways that prioritize quick reactions to perceived threats

(Grogans et al., 2023). However, chronic overactivation, as seen in trauma or prolonged stress, can dysregulate this system, leading to heightened vigilance or emotional numbing (Rosen & Schulkin, 2022). The interplay between brain regions like the prefrontal cortex, responsible for regulating fear, and the hippocampus, which contextualizes threats, underscores the importance of a balanced neural response to fear for maintaining emotional and physical stability (Bardel et al., 2024).

When revisiting humans as inherently relational beings, fear emerges as a fundamental experience, far more common than expected in the natural order. In nature, a person would only reach a heightened state of fear when faced with a life-threatening stimulus, with the nervous system subsequently re-regulating itself through the organism's homeostasis function (LeDoux, 2021). However, in modern environments, particularly within Western capitalist societies, this regulatory process is frequently disrupted (Alacreu-Crespo, et al., 2024). Here, stimuli that threaten an individual’s self-worth—rooted in whether important Others will love and accept them—overwhelm the organism’s capacity for homeostasis, leaving individuals in prolonged states of relational distress. In this context, fear becomes closely tied to the externalization of self-worth (Misamer et al., 2021). The "important Other" is not a person with whom one can engage, like a parent or spouse, but rather an abstract force: the norm. Specifically, it is the norm of perfection, perpetuated and reinforced by social media. These newly imposed conditions of worth are strongly linked to feelings of belonging, creating an ongoing cycle of threats to one’s self-value as individuals struggle to meet impossible standards.

Person Centered Relational therapy directly addresses these issues by creating a space where clients, through Rogers' concept of unconditional positive regard, can connect with Others without the fear of losing their value. This restorative relational experience allows the client to

begin structuring a new relationship with self and others. Rogers' metaphor of the potato, growing toward even the smallest shed of light, exemplifies the organism's potential to thrive when offered the right conditions (Lawton et al., 2014). Through these therapeutic experiences, individuals can internalize a new relational dynamic with themselves and gradually test and expand this new sense of self in connection with others, leading the way for healing and growth.

**Changing from Trauma Psychopathology to biological realism of trauma**

We will now examine the mechanisms of restoration in our body, focusing on how physiological processes facilitate healing, and explore potential connections between these mechanisms and the impact of psychological trauma**.** First, the stopping of bleeding occurs through **the hemostasis process.** The goal of hemostasis is to immediately stop bleeding by forming a stable clot at the site of vascular injury (Malik et al., 2021). Just as a wound requires the right conditions—such as oxygen, nutrients, and the absence of infection—for proper healing, trauma recovery depends on creating a supportive and nurturing environment free from judgment and re-traumatization. This resonates deeply with Kenneth Doka's (1999) concept of "disenfranchised grief," which highlights the profound distress that arises when an individual's suffering is unacknowledged or invalidated. In such cases, traumatized individuals may find solace in diagnostic validation, which not only normalizes their experiences but also mitigates feelings of alienation. Conversely, fear of stigma can lead to denial of their trauma, fostering internalized shame and self-concealment (Carvalho & Seabra, 2024). This dynamic aligns with Carl Rogers' theory, which describes the alienation between self and experience that arises when an individual's conditions of worth remain unmet, perpetuating cycles of psychological distress and estrangement (Diamond, 2022). A person-centered approach to trauma, much like the healing of physical

wounds, prioritizes creating the conditions necessary for restoration by acknowledging and validating the unique pain and experiences of each individual, fostering an environment of acceptance, understanding, and wholeness (Joseph et al., 2016).

**In the inflammatory phase**, physical wounds trigger immune cells to clear debris and release growth factors (Ellis et al., 2018). The psychological trauma manifests in the here and now as emotional dysregulation—intense and immediate feelings such as anger, sadness, or confusion that overwhelm the individual (Parker, 2024). During this process, the internal tone directly mirrors the person's struggle to self-regulate; if self-compassion is absent, the inner voice may amplify self-blame or hopelessness (Malik, 2021). According to Vygotsky, dysregulated internal speech fails to provide the necessary structure for organizing thoughts and emotions, leaving the person stuck in a cycle of chaotic and unmediated responses (Fossa et al., 2020).

**In the Proliferative Phase**, Fibroblasts and keratinocytes rebuild tissue, forming granulation structures (Arif et al., 2021). In psychological trauma, individuals begin seeking support, building coping strategies, and reconstructing a sense of safety (Calhoun et al., 2022**.** However, as D.G. Larsson's (1990) concept of self-concealment highlights, individuals who feel stigmatized may struggle to externalize shifts in perception, keeping these changes hidden from others**.** This internalization can disrupt the natural therapeutic process, where externalizing and sharing perceptions in a supportive environment would otherwise facilitate their integration and resolution**.** By withholding these changes, the individual inhibits the collaborative and validating feedback loop essential for adapting to new self-perceptions and fostering psychological growth.

These processes do not follow a linear progression in relational trauma, nor do they attempt to impose a universal norm for trauma recovery. Instead, they underline the universality of the human experience while respecting individual variations in healing (Bohart, 1993). A clinical

model of trauma recovery, though helpful, can sometimes inadvertently encourage individuals to adopt an external locus of control, leading to passivity in their journey. However, intensifying the already existing therapeutic conditions—such as fostering a safe, empathetic, and attuned environment—can provide the person with the facilitative space needed for the **processes of remodeling and maturation.** A new symbolization of experience is deeply tied to changes in perception, extending beyond shifts in cognition or emotional schemas (Joseph, 2004). In the context of psychological trauma, this phase may last a lifetime, as relational wounds are often re-initiated and re-experienced through ongoing life events, requiring continuous renegotiation and integration.

Revisiting trauma through the lens of the relational self is particularly valuable for addressing individuals who have internalized social injustice, experienced war, or feel excluded by the society they are trying to engage with, such as children and refugees. This approach shifts the focus away from clinical authority, emphasizing shared humanity and the relational contexts that shape healing. By grounding the model in human realism, it validates the lived experiences of individuals, fostering connection and empowerment rather than reinforcing exclusion.

**Survival and Silence: The Dissociative Cost of Disrupted Relationships in Refugee Children**

Refugee children often carry deep relational wounds shaped by traumatic disruptions, particularly in their trust toward primary attachments such as parents, and toward the systems that promise protection and safety. These disruptions frequently lead to a fragmentation of the self, where the internal configuration of identity prioritizes survival over emotional expression or need recognition (Betancourt et al., 2015). In such survival-driven states, core developmental needs—such as belonging, safety, and relational attunement—are often suppressed, increasing

the likelihood of dissociation as a protective mechanism (Kirmayer et al., 2011). Dissociation, in this context, represents a silent cry for relational validation, an urgent need to be seen and understood by another (Schore, 2001). The pathway toward healing, therefore, must be paved with empathic attunement, especially given the complex cultural intersections refugee children inhabit. Mental health professionals, who often come from differing cultural frameworks, may inadvertently project biases or stereotypes into the therapeutic space, obstructing trust (Tribe & Morrissey, 2004). Culturally sensitive practices, such as empathic mapping, offer a structured means to recognize and bracket these biases, allowing the practitioner to meet the child not only in their psychological distress but also within their cultural and relational realities (Rousseau & Measham, 2007). In this way, therapy becomes a site of repair rather than replication of harm.

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# Chapter 7: Refugee Children experiencing gender-based violence.

The purpose of this chapter is to explore the experiences of refugee children who have experienced gender-based violence (GBV), with a focus on their unique vulnerabilities in contexts of displacement and trauma. These children face multiple challenges, as the violence they have endured often disrupts their development and emotional well-being, particularly in environments where safety and stability are lacking (Taha et al., 2024). This chapter seeks to provide a deeper understanding of the profound impact GBV has on their mental health, relationships, and overall growth, emphasizing the critical need for support.

Gender-based violence (GBV) is a very important issue affecting millions of individuals worldwide, disproportionately impacting vulnerable populations, including refugee children. Defined as any harmful act perpetrated against someone based on their gender, GBV includes sexual violence, exploitation, child marriage, and psychological abuse (Rapinyana & Baratedi, 2023). Over the past decade, forced migration has reached unprecedented levels, with over 108 million people forcibly displaced worldwide, 41% of whom are under the age of 18 (Popescu et al., 2024; UNHCR, 2023). As of June 2023, an estimated 43.3 million children were forcibly displaced, a figure nearly double that of previous years (Popescu et al., 2024; UNICEF, 2023).

Various interconnected factors contribute to the prevalence of gender-based violence (GBV) among refugee children. Displacement and poverty create economic hardships, often compelling families to adopt harmful measures, such as marrying off young daughters, as a means of survival (Qahar et al., 2024). The lack of strong legal protections and the weak enforcement of existing laws in host countries leave children particularly vulnerable to abuse (Dayıoğlu, et al.,

2024). Overcrowded and poorly resourced refugee camps exacerbate the situation by failing to provide safe spaces for children (Iliopoulou, 2024). Moreover, cultural and social norms rooted in gender discrimination and patriarchal values continue to sustain GBV in refugee communities (Tastsoglou et al., 2021). The COVID-19 pandemic has worsened these challenges, with school closures and economic struggles heightening children's vulnerabilities even further (Munir, 2021).

Greece, a crucial entry point for refugees entering Europe, faces significant challenges in addressing gender-based violence (GBV) among refugee children (Tatsoglou et al., 2021). The country has provided refuge to a significant population of displaced individuals, including a substantial number of children. Among these, unaccompanied minors are particularly vulnerable to exploitation (Catsaras, 2024). Reports from humanitarian organizations reveal that over 800 cases of GBV were reported in refugee camps in 2021, with numerous incidents involving children. Overcrowding in camps like Moria, before its destruction in 2020, exacerbated these issues by creating inadequate child protection measures and exposing children to heightened risks. Despite efforts such as transferring vulnerable individuals to mainland shelters, significant gaps persist in Greece's prevention and response mechanisms, leaving many children at continued risk (UNHCR, 2019; UNHCR, 2021; UNICEF 2020).

The consequences of gender-based violence (GBV) are profound and long-lasting, significantly affecting the physical, psychological, and social well-being of survivors (Gaur, 2023). Physically, GBV can result in injuries, unwanted pregnancies, and sexually transmitted infections. Psychologically, survivors often experience trauma, depression, and anxiety, which can impede their personal development and quality of life (Grose et al., 2021). Socially, stigma

and discrimination frequently isolate survivors, creating barriers to their reintegration into communities and further intensifying their challenges (Islam, 2024).

In refugee contexts, where access to medical and psychosocial support is limited, the impacts of GBV are accumulating (Mathis et al., 2024). For children, interrupted education and social stigma can have lifelong consequences, sustaining cycles of poverty and vulnerability (Burke et al., 2023).

Key recommendations to address gender-based violence (GBV) include strengthening legal protections by ensuring host countries, such as Greece, enforce laws that safeguard children from GBV and hold perpetrators accountable (Anderson & Claes, 2022). Improving camp conditions by addressing overcrowding and poor infrastructure is essential to create safer environments for children (Barai & Faruk, 2023). Providing specialized services, including access to medical care, psychological support, and legal aid, is crucial for survivors' recovery and resilience (Bhadra & Dyer, 2022). Investing in education and awareness programs that empower refugee children, educate communities about GBV, and challenge stigmas is vital to long-term prevention (Leitão et al., 2023).

Gender-based violence (GBV) is a critical global issue exacerbated during humanitarian emergencies, where vulnerabilities increase and protective mechanisms weaken. Effective GBV coordination in emergencies is essential to ensure accessible services for survivors and implement prevention measures, yet it remains underexplored despite its recognized importance (Raftery et al., 2022).

**Why Person-Centered Experiential Therapy for Relational Trauma (PCE-RT) is a Culturally and Power Imbalance Sensitive Intervention**

This model aims to address the pervasive issue of power imbalance. Here, the therapist is neither positioned as an expert nor a figure of authority, as is often emphasized in Western society, but rather as a human being dedicated to understanding the phenomenology of the "Other" (Schmid, 2001). By "Other," we refer to individuals such as children, refugees, or others who have experienced systemic power imbalances.

Trauma can generally be categorized into two types: acute trauma and chronic trauma, the latter often discussed in research as complex trauma (Maercker et al., 2022). While Post-Traumatic Stress Disorder (PTSD) is characterized by symptoms such as intrusive thoughts, avoidance behaviors, hyperarousal, and hyperactivity, chronic trauma involves deeper impacts (Forkus et al., 2023). Research indicates that chronic trauma is more closely associated with negative self-beliefs and the development of fragile self-concepts (Scalabrini et al., 2022).

Human beings are inherently relational and social. Addressing trauma requires more than just an initial response; it needs long-term interventions aimed at rebuilding a shattered sense of self. This fragile self-concept often stems from a history of relational ruptures, exclusion, or fear—whether at the familial, societal, or national level. For children who experience chronic trauma, particularly in the context of gender-based violence (GBV) or displacement, the most pressing need is for relationships that are stable, respectful, and safe (Bürgin et al., 2022).

Children who have been excluded or failed by their primary caregivers—often their families—crave relationships in which respect and safety are critical. Findings from research on child refugees and GBV survivors highlight that children possess the ability to internalize the

conditions within therapeutic relationships, specifically empathy and unconditional positive regard (Glucksman, 2022). This internalization allows them to create an "inner culture" or a relationship with the self that serves as a safe mental space. This "inner sanctuary" can provide resilience against the recurrence of systemic disappointments and the resurfacing of memories that reinforce feelings of helplessness and unworthiness.

However, such therapeutic interventions can only be effective if the child's immediate safety and survival are assured. Children under constant threat or struggling to meet basic needs cannot fully benefit from interventions aimed at self-concept development. This idea aligns with Maslow's hierarchy of needs, which emphasizes the importance of fulfilling physiological and safety needs before addressing higher-order needs (Rojas et al., 2023).

Observations from children in crisis, such as those living in camps, show that even amidst extreme adversity, children can develop a sense of self that promotes trust, safety, and hope (Umer & Elliot, 2021). This highlights the remarkable resilience of children when they are provided with even minimal relational stability and child-centered care.

The most effective way to protect children from chronic trauma, particularly gender-based violence, is to address systemic issues such as war, poverty, and lack of education. While this may sound idealistic given the prevalence of global conflict, it remains a critical goal. On a relational level, fostering stable relationships and promoting the qualities inherent in person-centered care—empathy, respect, and safety—allows children to internalize these values. Over time, this fosters the development of a self-concept rooted in hope and resilience, even when external systems fail them.

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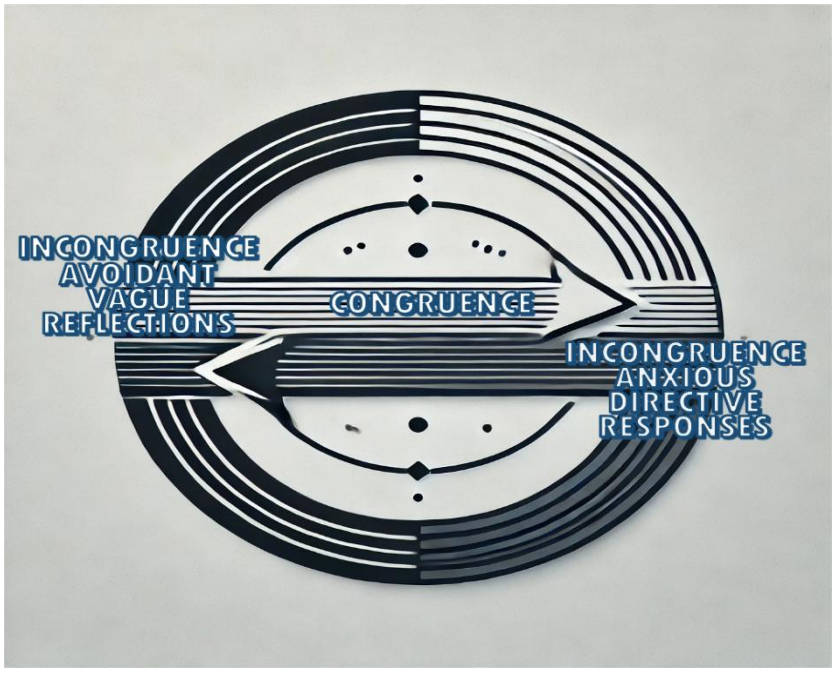
# Chapter 8. The therapeutic process in PCE-rt

This chapter explores the complexities of working with relational trauma through a person-centered and experiential perspective. Rather than offering specific techniques, we present key therapeutic characteristics—elements that guide the practitioner in thinking about relational trauma and the individuals they work with. These characteristics are rooted in the theory of personality within the Person-Centered Approach and its experiential expressions within the PCE paradigm (Tudor & Merry, 2002; Watson et al., 1998).

Through the exploration of a single therapy case, we will highlight moments that illustrate how therapeutic work can be deepened by attuning to the client's experiential meaning while also supporting the therapist in managing their own traumatic responses—such as becoming distant (Avoidant – vague reflection), overly stressed, or excessively involved in the therapeutic process (Anxious – Guiding reflection). We can observe that in the middle is congruence (Figure 3.), which is connected to the creation of a safe stance in the relationship with the therapist. In this state, the therapist is able to be genuine, interested, and creative, promoting two dimensions of effective trauma work:

1. **Experiential specificity** – Important for the client to accurately symbolize and articulate their experiences (Freire et al., 2014).
2. **Warmth and relational safety** – Essential for fostering trust and emotional security (Podolan & Gelo, 2023)

*Figure 3. The Incongruence and Congruence Continuum of the Therapist.*




However, it is important to emphasize that each therapeutic relationship is unique and unfolds through supervision, genuine inquiry, and the therapist's personal growth. No single chapter can provide a definitive guide for navigating such complex relational dynamics.

In this chapter, I introduce the concept of *empathic mapping*—not as a technique or a solution for when nothing else works, but as a visual representation of the process unfolding between therapist and client. This approach seeks to harness the power of therapeutic encounters: where one person (the client) is experiencing incongruence, and the other (the therapist) offers the ultimate gift of presence—momentarily setting aside their own thoughts and beliefs to create a space in which the client can feel seen, validated, and truly belong.

**Working with Emotions (Connection with needs)**

*Session excerpt 1.*

**Client:** I just don't understand why this bothers me so much. I mean, it's not a big deal, right? These things happen every day. People take things, borrow stuff without asking—it's just life. I should be able to let it go, move on. But for some reason, I can't.

**Therapist:** It sounds like this is difficult to lose personal items.

**Client:** Yes.

**Therapist:** And you feel as though there's no clear reason for these emotions?

**Client:** Right. It's not just about someone taking my stuff—it's about how it feels like they don't respect me.

**Therapist:** Is it that they don't seem to value you, in a way that makes you feel unseen?

**Client:** Yeah, exactly. It's like they don't seem to value me, like I'm not seen. It's not just the action—it's what it says about how they see me, or maybe don't see me at all.

**Therapist:** And this is connected to a feeling. You're saying that a feeling is created when you don't feel seen—when you feel like you don't matter.

**Client:** Yeah… when I feel like I don't matter, it creates this feeling inside me. It's hard to explain, but it's like a mix of anger and sadness. Like I want to be acknowledged, to be considered—but instead, I feel invisible.

**Therapist:** So, the sense of being invisible is linked to both sadness and anger at the same time?

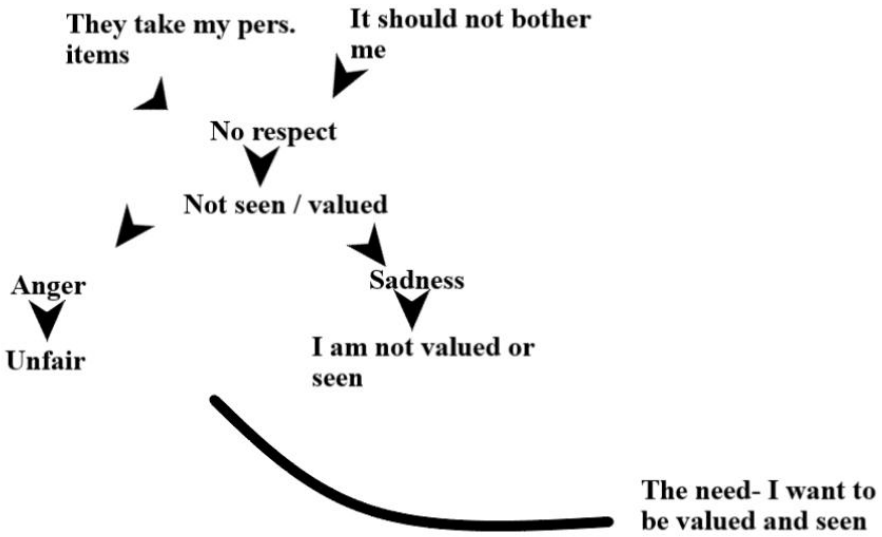
**Client:** Yeah, exactly. The sadness comes from feeling like I don't matter, like I'm not important enough for them to consider me. And the anger… I guess that comes from feeling like I should matter, like it's unfair that I'm being ignored or disrespected.

**Therapist:** So the sadness is connected to feeling invisible, and the anger comes from the unfairness of it—almost like a sense that you deserve to be seen.

**Client:** Yes, that's it. The sadness comes from feeling invisible, like I'm just… not there in their eyes. And the anger comes from the unfairness of it, because I do deserve to be seen. I shouldn't have to feel this way.

*Empathy mapping example 1.*

In this excerpt of the session, we see that empathic responses are conveyed in a structured format




in front of the client. This map is created collaboratively as the therapist and client discuss, and it is presented in a table visible to the client. Through this, the client gains control over how the therapist understands them and the therapeutic process (Rogers, 1975). The client is also empowered to correct the therapist if there is a misunderstanding of what was said.

This is particularly important because misunderstandings are a common issue in psychotherapy. Many people struggle to set boundaries due to fears rooted in past experiences of power imbalances (Gaillard et al., 2009). By allowing the client to actively correct the therapist—such as by erasing a word that does not accurately reflect their experience—balance is restored. This action sends a strong message from the outset: this is a space where the client is valued, and their phenomenological experience will be respected and protected.

Another key aspect of this mapping process is that it prevents the therapist from generalizing the client's content (Zaki et al., 2008). Often, therapists unintentionally reinterpret or steer

discussions in directions they are more comfortable handling. However, by creating the map in real-time, the therapist ensures they are capturing the client's exact experience rather than imposing their own interpretations (Curran et al., 2019).

Furthermore, the structure provided by the map helps the client perceive a logical sequence in their experience, reducing feelings of being unheard or powerless. This structured approach fosters clarity, validation, and a greater sense of agency within the therapeutic process (Levitt, et al., 2006).

Two key elements of empathy are intensified and closely connected to the mapping process. The first is accuracy—empathic responses must be precise, ensuring that the words on paper capture not only the essence of what the client is saying but also the underlying meaning behind their words (Rogers, 1975). This deeper level of empathy, often referred to as a deep empathic response, carries a certain level of risk, which is why the map remains central and adaptable, ready to be revised if needed.

The second key element is economy—the words chosen to represent the client's meaning should be concise and efficient (Rogers, 1957; Bazirake & Zimmermann, 2018; Kahneman, 2011). This ensures the process maintains a natural flow, allowing the therapist to facilitate with minimal intrusion (Gill et al., 2018).

Together, these two characteristics—accuracy and economy—enable speed, depth, and precision in symbolizing the client's experience (Maibom, 2022). When experiences are accurately symbolized, they become more comprehensible, leading to meaningful shifts in perception, which, in turn, foster real change in everyday life.

Working with emotions is crucial in addressing relational trauma, as emotions serve as cues for the client's underlying needs (Ecker et al., 2024). From a person-centered perspective on child development, an individual inherently possesses all the information necessary to guide their actualizing tendency (Brodley, 2001). However, as they grow and become part of various systems—such as family, school, and work—they adapt their sense of self to fit these roles, often to meet the conditions of worth imposed by these systems.

The need for acceptance and belonging is fundamental, and as a result, individuals may begin to censor their emotions (Roded & Raviv, 2017. When this suppression persists over time, certain emotions lose their connection to cognition, leading to a lack of symbolization and, consequently, neglect. Unacknowledged and unsymbolized needs contribute to psychological distress (Schmid, 2005).

Rather than directly focusing on symbolizing emotions and needs, the therapist's role is to remain attuned to moments when the client's narrative hints at this disconnection. Understanding and recognizing these moments is key to facilitating meaningful therapeutic work.

**Authentic Curiosity: Embracing Genuine Interest in the Other**

A crucial aspect of Person-Centered Therapy, particularly when working with relational trauma, is the therapist's ability to create an internal space of authentic curiosity and a genuine desire to learn about the client (Knox, 2008). This extends beyond the client's struggles to include what brings them joy and meaning in everyday life. Such an approach should not be seen as a therapeutic technique but rather as a form of validation—an acknowledgment of the often-

overlooked parts of the self that the client may not initially perceive as connected to therapy (Bolton et al., 2017).

Psychologists and psychotherapists may sometimes derive a sense of accomplishment from focusing primarily on what is problematic in a client's life. However, true therapeutic engagement also involves recognizing and exploring the aspects that sustain the client—what allows them to continue, what provides relief, and what nurtures resilience (Rezapour-Mirsaleh et al., 2023). Understanding these elements fosters a more meaningful encounter and a more holistic way of relating to the client.

If we reconsider the first condition of Person-Centered Therapy—psychological contact—not as a binary state (existing or not, like a 0 or 1 in a computer) but rather as a continuum, we can better appreciate how this condition allows the client to feel understood and relationally safe (Rogers, 1992). Emotional regulation is influenced by proximity; mammals instinctively sense when someone is genuinely listening and interested in their narrative, leading to a felt sense of safety (Panksepp, 2010).

Curiosity is inherently linked to interest, and interest flourishes in the absence of fear and judgment—both of which are essential for cultivating relational safety. Too often, the question "What brings you to counseling?" implicitly focuses on distress and problems. Instead, therapists should explicitly communicate an authentic perspective: in this space, all experiences are valued equally, not just those that signify suffering. This shift in approach reinforces a therapeutic environment where clients feel fully seen, heard, and accepted.

**Configurations of self (Control over Internal Incongruence)**

*Session excerpt 2.*

**Therapist:** It feels like you don't know what's happening inside you, and there's a lot of tension—missing them and feeling angry at the same time, yes?

**Client:** Yes… I miss them and wonder if they're okay, but I also feel angry, like they left me and didn't protect me. I don't understand how I can feel both.

**Therapist:** It is difficult to understand how you feel both… Is it like you have two voices inside? One caring and one angry with them?

**Client:** Yes… one side worries and says, "Maybe they had no choice, maybe they still love me," while the other side says, "They sent me away, they let this happen."

**Therapist:** Two parts of you that feel distant—one hoping they love you, and the other feeling the pain of not being protected.

**Client:** Yes… one part remembers the good and wants to believe they miss me, while the other holds the pain and asks why they didn't stop it.

**Therapist:** The battle inside of these selves is making you exhausted and confused.

**Client:** Yes… they keep fighting, one trying to hold on and the other feeling betrayed, and I don't know where I stand between them.

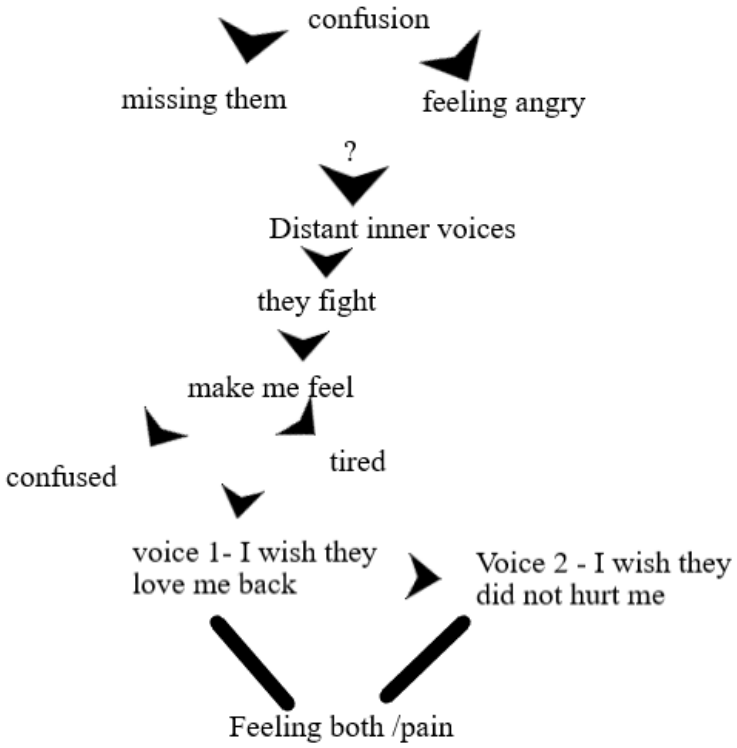
**Therapist:** Is one part saying, "I would love that they love me back," and the other, "I would love that this person did not hurt me"?

**Client:** Yes… one part just wants to feel loved, while the other wishes the pain had never happened.

**Therapist:** It seems that they can both be true… but with pain.

**Client:** Yes… I can love them and still be hurt, I can miss them and still be angry, but carrying both feels too heavy.

*Empathy mapping example 2.*




One of the primary challenges in experience processing for clients is the problematic inner dialogue arising from different configurations of the self (Murphy, 2019). If this internal dialogue remains unsymbolized, it can perpetuate a felt sense of distress and discomfort. However, symbolizing this inner talk can alleviate symptoms and foster a greater sense of control over various aspects of the self—each of which is associated with distinct emotions and needs (Greenberg, 2019).

Initially, these inner voices may seem disconnected from one another. However, if we help clients specify the experiential meaning of each voice and link it to the corresponding emotion and need, these elements no longer feel so distant. A crucial aspect of emotional regulation is making sense of one's own experiences, both for oneself and in relation to others (Holodynski & Friedlmeier, 2006).

When working with a client to map their inner experience, it is essential to embrace the idea that all inner voices represent the client's attempts to adapt to a challenging reality (Kim et al., 2020). This perspective is particularly important when addressing self-configurations, especially in the context of relational stress.

Rather than focusing solely on the content of these voices, exploring the relationships between them allows for a deeper understanding of how different needs and internal representations can coexist. By doing so, we help the client embrace a pluralistic sense of self—one that can hold multiple emotions simultaneously. This is not a fixed outcome but an ongoing process, as the person continues to develop a new way of relating to themselves.

**Therapeutic Process Focused on Feedback**

Empathic mapping is an intense process, and it is crucial to clarify from the outset that the process must align with the client's needs. Safeguarding the client's well-being throughout this journey is essential. This means encouraging them to tune into internal cues, such as recognizing when they feel the need to pause or step back (Maarseveen et al., 2022).

For children, we often introduce the idea of an *imaginary red button* they can press if they feel overwhelmed, giving them a tangible way to express their need for a break. Exit strategies from overwhelming moments can take different forms, such as stopping the session or shifting the focus to a topic that fosters a sense of safety. For example, with teenagers, discussing their favorite football team or close friends has served as an effective exit point.

This process helps clients symbolize their experiences in a way that fosters self-trust and respect for their own limits. It also allows them to revisit challenging experiences when they feel ready (Wall, 2021). Interestingly, children tend to instinctively respect their own limits and avoid pushing themselves too far. In contrast, adults in therapy often develop strong expectations for change and may neglect their natural pace, which can sometimes lead to re-traumatization (Schippert et al., 2021). Recognizing and respecting these limits is key to a therapeutic process that promotes healing rather than overwhelm.

**Closing Thoughts: The Role of Empathic Mapping in Self-Discovery and Healing**

There are no fixed recommendations for how the map should be used, as its role depends on the unique needs of both the client and the therapist. This is an essential part of the process that should be discussed collaboratively with the client.

From what we understand so far, empathic mapping is often associated with heightened experiences of incongruence and psychological distress, as it brings internal conflicts into clearer focus. This is why the client must take the lead in determining the level of specificity and depth they are comfortable with.

Early responses from children indicate that the mapping process fosters self-organization, which has significant implications for addressing complex trauma. Importantly, the map is not meant to be kept solely by the practitioner or archived—it belongs to the client. They are free to use it however they wish, whether as a tool for reflection or simply as an experience confined to the session.

This approach aligns with working in the *here and now*, allowing for flexibility. Each session can begin with a new map, continue from where the last one left off, or proceed without mapping at all, depending on what feels right for the client at that moment.

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# Chapter 9. Intensive Lab Training (ILT)

This training model follows a structured best-practice approach, integrating theory, demonstrations, group lab exercises, reflective practices, and labs designed to build on topics to be explored further in supervision. The training schedule consists of 10 sessions, each lasting 3.5 hours, providing a comprehensive framework for skill-building and conceptual understanding. It is recommended for psychotherapists trained in person-centered counseling. However, for professionals from other therapeutic paradigms, a preliminary cycle of six training sessions focusing on the theory of Person-Centered Therapy is required to ensure foundational understanding. The training emphasizes two key directions: the structured format of each session (Table 2.) and the focused discussion of relevant theoretical concepts (Table 3.), ensuring a balanced blend of practical and theoretical learning tailored to enhance therapeutic skills.

The structure of each training session is carefully organized into three parts, with 10-minute intervals separating each section, to maximize learning and engagement. The first hour begins with a concise presentation of the session's central issue, followed by a live demonstration by the trainer working with a trainee on a specific, pre-designed case study. This lab aims to practically illustrate the theoretical concepts. The second part involves two trainees working together in front of the group using a prepared scenario. This exercise allows them to reflect on their experience and connect it with the session's theoretical theme. In the final section, trainees form small groups of three for practical lab work, dedicating 7 minutes each to practice. They then spend 3 minutes individually writing down issues related to the session's theoretical content. The session concludes with a 30-minute group supervision period, during which these issues are

discussed collectively, fostering deeper understanding and collaborative learning. This structured approach ensures a balance of theory, practice, and reflection within each session.

***Table 2.*** *Structure of Intensive Lab Training Sessions.*

| Part | Description | Duration | Activities |
|---|---|---|---|
| **Part 1** | Presentation and Demonstration | 1 hour | The trainer presents the session's central issue and demonstrates its application using a pre-designed case study with a trainee. |
| **Part 2** | Trainee Pair Practice and Reflection | 1 hour | Two trainees work together on a prepared scenario in front of the group, connecting their experience to the theoretical issue. |
| **Part 3** | Small Group Labs and Supervision | 1 hour | Small groups of three conduct 7-minute labs, followed by 3-minute individual reflections. Issues are discussed in a 30-minute group supervision session. |

**Note:** Each part is separated by a 10-minute break to ensure focus and transition between activities.

***Table 3.*** *Topics covered across the 10 Training sessions.*

| Number of Training Session | Title and Content |
|---|---|
| 1 | Trauma Theory, GBV and Child Protection |
| 2 | Person-Centred and Experiential Theory on Relational Trauma |
| 3 | Intensive Lab Training (ILT) - The Elements of Empathy |
| 4 | ILT - Congruence and Proximity in Therapy |

| | |
|---|---|
| 5 | ILT - Working with Emotions |
| 6 | ILT - The Configurations of Self |
| 7 | ILT - Empathy Mapping |
| 8 | ILT - Scales, Introducing Research-Informed Supervision |
| 9 | ILT - PCE rt and Neuropsychotherapy |
| 10 | ILT – Collaborative Growth. The Fully Functioning Therapist |

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# Chapter 10. Research Informed Supervision (RIS)

In this chapter, we introduce a new model that proposes the integration of research within the framework of psychotherapy supervision. Rather than merely presenting a model, we advocate for a research-informed approach that blends empirical inquiry with the supervisory process. This raises an essential question: What type of research is relevant, and how can it be effectively applied in supervision?

To answer this, we draw upon the foundational work of Carl Rogers, who posed similar inquiries to the scientific community when investigating the relational elements that contribute to psychological growth. Rogers transcribed and analyzed numerous therapy sessions before formulating the six necessary and sufficient conditions of the therapeutic relationship, which subsequently shaped his theory of personality. Inspired by this methodical approach, we propose a Research-Informed Supervision (RIS) model that integrates structured inquiry into the supervisory process.

The Three Core Elements of Research-Informed Supervision

1. Case-Based Mixed-Methods Design

   Supervision is grounded in a mixed-method approach, incorporating both qualitative and quantitative data to analyze each case comprehensively. This allows for a deeper understanding of therapeutic effectiveness and the relational dynamics at play.

2. Self-Reference and Thematic Analysis for Personal Growth

The supervisee engages in self-reflection and thematic analysis to explore recurring challenges, personal biases, and areas requiring professional development. This element ensures that supervision is not merely procedural but also experiential and transformative for the therapist.

3. Structured Agenda and Pre-Session Preparation

   Supervisees take an active role in shaping the supervision process by identifying key concerns prior to the session and communicating them to the supervisor. This structured agenda fosters focused, goal-oriented discussions that enhance the efficacy of the supervisory relationship.

By integrating research methodologies into supervision, this model aims to create a dynamic, evidence-based framework that strengthens both the therapeutic process and the professional growth of psychotherapists. Through Research-Informed Supervision, we bridge the gap between empirical inquiry and clinical practice, ensuring that supervision is not only reflective but also systematically informed by research.

**Case-Based Mixed-Methods Design**

This supervision model integrates quantitative assessment and qualitative inquiry to enhance therapeutic reflection and improve outcomes in child therapy. At the beginning of the therapeutic process, the therapist, in collaboration with the supervisor, administers pre-test assessments using quantitative metrics such as the ITQ (Impact of Trauma Questionnaire) and the Post-Traumatic Growth for Children scale. These assessments establish a baseline for tracking progress and are

repeated two to three times throughout the therapy process to avoid over-familiarization with the test items while ensuring meaningful measurement of change.

Each time the therapist receives a new set of scores, a quantitative pre-post analysis is conducted. This analysis informs a dedicated supervision session where the therapist shares observations with a group of other practitioners. In this session, the therapist connects the data with their self-reflections on the therapeutic relationship, integrating objective findings with subjective insights. This discussion fosters collaborative inquiry, where practitioners collectively explore patterns in the data, client responses, and the therapist's personal engagement in the therapeutic process.

Following the completion of 15 therapy sessions, a researcher (not the therapist) conducts a qualitative interview with the child. In this interview, the child provides a personal narrative explaining the changes reflected in the quantitative metrics. This step ensures that the numerical data is contextualized within the child’s lived experience, bridging the gap between empirical measurement and personal meaning.

The final phase of the model involves integration and further inquiry. The researcher shares the combined quantitative and qualitative findings with the therapist, who then presents them to the supervision group. This leads to a new round of discussion and analysis, refining therapeutic understanding and supervision practices. By continuously cycling through data-driven reflection and collaborative inquiry, this model ensures that both empirical evidence and experiential insights inform therapeutic supervision and practice.

**Self-Reference and Thematic Analysis for Personal Growth**

This structured supervision exercise is designed to help practitioners reflect on their emotional responses and deepen their self-awareness in therapeutic relationships with children. The process begins when a practitioner identifies a significant issue or thought related to their therapeutic relationship with a child. For example, a practitioner might express, *"I feel overwhelmed by the relationship because I get angry with the caregivers when the child shares their experiences of abuse."* This statement reveals overidentification with the child's trauma, which may prevent the practitioner from maintaining therapeutic congruence.

At this point, the supervision group recognizes that such emotional experiences exist at the edge of consciousness, influencing the therapist's ability to stay present. To explore this further, the practitioner's experience is reframed into open-ended reflective questions, similar to designing a semi-structured interview. Examples of such questions include: *How am I with anger?*, *What does protection mean to me?*, or *What is injustice to me?* These questions invite deeper introspection and encourage practitioners to engage with their underlying emotional reactions.

Once the reflective questions are formulated, all participating therapists engage in free writing. They write down their immediate thoughts and associations without self-censorship, knowing that they will not be asked to share their responses. After completing a paragraph, they analyze their own writing by coding their responses—breaking down their thoughts sentence by sentence and assigning a label or theme that represents the essence of their experience.

After coding responses from three or four questions, practitioners identify emerging themes within their reflections. These themes provide valuable insights into their personal emotional triggers, unconscious biases, and relational patterns. Finally, these themes are directed toward personal therapy for further exploration, ensuring that the practitioner continues to work on their

own emotional responses and unresolved conflicts, ultimately fostering greater self-awareness and resilience in their therapeutic work.

**Structured Agenda and Pre-Supervision Preparation**

The final characteristic of research-informed supervision is the integration of external expertise and dynamic learning structures to address the evolving challenges practitioners face in their work with children. As part of this process, supervisees document a list of issues they observe in their therapeutic practice. These issues may range from emotional difficulties in the therapeutic relationship to conceptual or challenges in treatment approaches.

In response, the supervisor engages with experts in relevant fields, inviting them to participate in supervision sessions to provide specialized insights and responses to the inquiries raised by the group. This expert involvement ensures that practitioners have access to cutting-edge knowledge and diverse perspectives, enriching their understanding and equipping them with evidence-based strategies to navigate complex cases.

Additionally, the supervision process remains flexible and adaptive to the needs of the practitioners. The supervisor may organize discussions centered around academic papers related to the struggles of a specific supervisee, fostering a scholarly dialogue that bridges research and practice. In other cases, the supervisor may collaborate with another supervisor to conduct an Intensive Lab Training, a hands-on, experiential learning format that allows practitioners to engage deeply with specific therapeutic processes, personal growth exercises, or reflective practices. These discussions and training sessions create a continuous cycle of learning, ensuring that supervision is responsive, research-informed, and practice-oriented.

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# Chapter 11. Future research

The Person-Centred and Experiential Counselling for Relational Trauma model is rooted in one of the most empirically supported therapeutic frameworks (Elliott et al., 2013). Its adaptation to populations such as refugee children experiencing complex relational trauma necessitates methodological sensitivity and theoretical coherence. Anticipating critiques of feasibility, generalizability, and research rigor, this discussion outlines and defends the three-phase mixed methods research design, underscoring its validity, relevance, and ethical grounding.

**Why a Mixed Methods Case-Based Approach?**

Skepticism may arise around the small sample, case-based design. However, this was not only methodologically deliberate but ethically and epistemologically appropriate. As Creswell and Plano Clark (2017) have emphasized, mixed methods within-case designs are particularly suited for exploring complex phenomena in under-researched or vulnerable populations. Relational trauma in children, especially refugee children, involves multi-layered variables psychological, relational, social, and cultural  that no single method can sufficiently capture (Kirmayer et al., 2011; Betancourt et al., 2015).

The methodological rationale is underpinned by Yin's (2018) framework for case studies in applied fields: they are most suitable when (1) the phenomenon is embedded in context, (2) researcher control is minimal, and (3) the boundaries between phenomenon and context are fluid, all conditions that hold true for therapeutic encounters with refugee children.

**Trauma, Instability & The Need for Within-Case Design**

The population under study, refugee children exposed to relational trauma and displacement, presents substantial ethical and logistical research challenges. Participation is affected by instability, burnout, and emotional fragility, particularly in children experiencing complex post-traumatic stress disorder (CPTSD) (Herman, 1992; Cloitre et al., 2014). The long-term developmental impact of such trauma on children's relational and emotional functioning is well-documented (Fazel et al., 2012).

In such contexts, longitudinal, highly controlled trials are often unethical or infeasible. Instead, we opted for ecological validity (Bronfenbrenner, 1979): the research mirrors the chaotic and change-prone environment in which these children live. By focusing on within-case dynamics, we allow the data to reflect lived experiences over time, reducing the risk of fragmenting their narratives or re-traumatizing them through rigid structures (van der Kolk, 2015).

**Capturing Therapeutic Change: Process Over Outcome**

Traditional evidence-based practice often prioritizes symptom reduction. However, in experiential person-centred therapy, the focus is on process change (Elliott et al., 2004). Especially in cases of relational trauma, it is the emergence of new experiencing, the reconstruction of interpersonal trust, and the development of emotional agency that reflect meaningful therapeutic shifts, not merely changes in standardized scores.

Thus, quantitative data via validated tools such as the Intranational trauma Questionnaire are complemented and contextualized by qualitative data from:

- the child participants (reflective dialogues),
- the cultural mediator (who bridges language and context),
- and the social scientist (who documents systemic, familial, and cultural dynamics).

This triangulation supports a hermeneutic understanding of change (McLeod, 2011; Rousseau & Measham, 2007).

**Reflexivity and Co-Construction of Knowledge**

The study also resists the researcher–subject divide. By involving trauma specialists and person-centred scholars in reviewing the implementation of the model, we enact a critical-constructivist validation loop (Morrow, 2005). These professionals provide:

- evaluative feedback on the model's applicability,
- insight into therapeutic elements observed,
- and contribute to theory refinement.

This epistemic reflexivity aligns with the person-centred emphasis on client expertise and Rogers' own appeal to non-hierarchical, dialogical knowledge production (Rogers, 1961).

**Integrating Cultural and Social Contexts**

Another possible critique may center on external validity or the perceived specificity of the context (i.e., refugees, particular cultural backgrounds). However, relational trauma is not culture-bound, its existence is shaped by context, but its mechanisms are human and relational.

The inclusion of a cultural mediator was essential for maintaining contact to the children's lived meanings, as well as to explore cultural expressions of trauma, shame, and safety — themes often obscured in Western diagnostic frames (Sue & Sue, 2003; Kirmayer et al., 2007).

By adopting a bio-psycho-social-cultural lens, the model acknowledges that healing does not occur in a vacuum but through interpersonal and socio-cultural processes, just as trauma does (Silove, 2013). Culturally responsive care is particularly important when working with refugee children, whose trauma is compounded by displacement, racism, and loss of identity (Rousseau & Measham, 2007). As such, the model not only supports therapeutic outcomes but advocates for structural and contextual understanding of mental health in forced migration.

**From Practice to Theory: Grounded Validation**

Finally, the model was not only assessed in practice but further validated through a second-level theoretical synthesis, involving interviews with two theoretical experts in person-centred and trauma therapy. This iterative consultation reinforces both the coherence of the theoretical underpinnings and the innovative bridging of person-centred values with trauma-sensitive interventions.

As Rogers (1959) stated, "the facts are friendly" — and our model welcomes data in its complexity, both experiential and empirical. In doing so, it resists simplistic positivism and instead advances a layered, rigorous, and human science approach to psychotherapy research.

**How This Methodology Emerged – Next Steps**

The author has been actively involved for many years in the European Association for Psychotherapy, working to establish new methodological approaches that truly capture the essence of therapy. A key principle in addressing complex therapeutic issues is the use of mixed-methods research at the case study level. While Randomized Controlled Trials (RCTs) are highly valuable for evaluating clinical interventions, they are limited when it comes to exploring and understanding therapeutic processes in depth (Greenhalgh et al., 2016).

A second important point is that research within this model is embedded in the clinical supervision process itself. The supervision model being promoted integrates ongoing case-level research using mixed methods. In this approach, the supervisor also functions as a researcher, and empirical research is generated as an inherent part of clinical practice (McLeod, 2011).

This model has been adopted by the Municipality of Athens in a new program providing psychosocial support to women who face GBV. It is also implemented in the research clinic of the College for Humanistic Sciences “Anikein”. Moreover, the supervision & research model (RIS) is currently being proposed in seven European countries — Hungary, Czech Republic, Slovakia, Ukraine, Belgium, Switzerland, and Greece — through the European Association for Person-Centred and Experiential Psychotherapy and counselling (PCE Europe).

The next steps for the model involve testing it in larger populations of children and training practitioners, ensuring they are also supervised to assess whether the observed improvements in clinical outcomes can be generalized. Additionally, a key hypothesis is that the internal experience of being exposed to a loss of control and power imbalance is linked to trauma. This suggests that the model could be tested with children who feel excluded or have experienced various forms of abuse. This includes refugee children, as well as those who have gone through parental divorce or other experiences they perceive as traumatic.

Another important direction for research is investigating how adults respond to the model. The hypothesis is that children are more adaptive, which was a primary reason for the observed changes in CPTSD scores. In contrast, these changes might take longer in adults, and exploring these differences would be valuable.

Furthermore, empathic mapping could be studied in group settings and through collective maps, providing additional insights into shared experiences and emotional patterns.

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# Appendix

**The analysis of the research presented in the Introduction**

**Research 1**

**1st Research - Evaluating the Impact of Person-Centered and Experiential Counseling on Relational Trauma: A Mixed-Methods Study of Child GBV Survivors in Refugee Settings.**

**Participants**

The study involved three refugee children (ages 9, 10, and 17) who had experienced complex PTSD due to exposure to gender-based violence (GBV), displacement, and shelter living conditions. The children were recruited from the PRAKSIS child protection program at a community center in Kolonos.

**Research Design**

A mixed-methods approach was employed, integrating both quantitative and qualitative data collection techniques. The study utilized a sequential explanatory design, where quantitative data were collected first, followed by qualitative data to provide further depth and understanding.

**Data Collection**

*Quantitative Data*

Pre- and post-intervention assessments were conducted using the following validated psychological measures:

International Trauma Questionnaire – Child and Adolescent Version (ITQ-CA) (Cloitre et al., 2021)

Posttraumatic Growth Inventory for Children (PTGI-C) (Cryder et al., 2006)

*Qualitative Data*

Two sets of qualitative data were collected:

Interviews with children: Conducted after the final intervention session to gather insights into their personal experiences, emotional processing, and perceived changes.

Expert interviews: Professionals involved in the children's care, including a social worker, a cultural mediator, and a trauma specialist, provided qualitative insights based on their observations and interactions with the children.

The qualitative data were analyzed using thematic analysis, identifying key themes related to trauma processing, self-organization, and psychological adaptation.

**Ethical Considerations**

Ethical safeguards were put in place to ensure the well-being and rights of all participants:

Each child was accompanied by a parent or legal guardian.

Parents/guardians were present during the initial session where research participation was discussed.

Informed consent forms and information sheets were provided and signed by parents/guardians.

Participants were informed that they could withdraw at any time without any impact on their treatment.

A psychologist was available at the center to provide support in case of distress.

A safeguarding policy was signed by all research team members to ensure compliance with ethical guidelines.

**Procedure**

Mid-test: Children completed the trauma and growth assessments after the 5th session

Intervention phase: The empathic mapping process was implemented within the PRAKSIS program.

Post-test: Children completed the same assessments after the intervention to measure change.

Qualitative interviews: Conducted with both children and professionals to contextualize quantitative results.

**Analysis**

1. Overview of the Mixed-Methods Approach

The study employed an explanatory sequential design where quantitative measures (e.g., PTSD, Self Organization, Complex PTSD, ITQ, and Post-Traumatic Growth scores) provided initial evidence of change. These data were then enriched and interpreted through qualitative insights drawn from participants' narratives, thematic interviews, and expert commentary (from cultural mediators and social scientists). This mixed-methods integration allowed the research team to triangulate findings, showing not only "if" change occurred (via scores and statistical summaries) but also "how" and "why" those changes were experienced by the children.

2. Quantitative Findings: Indicators of Change

A. Symptom Reduction in PTSD and Self-Organization

Participant 1:

*PTSD*: Decreased slightly (from 20/24 to 19/24)

*Self Organization*: Markedly improved (score reduced from 12/24 to 3/24)

*Complex PTSD*: Improved (from 32/48 to 23/48)

Participant 2:

*ITQ Total*: Mean score decreased from 3.08 (pre-test) to 1.83 (post-test)

Notable reductions were seen in self-organization items (e.g., Q7, Q9, and Q10), although some PTSD items (like Q2 and Q4) showed negative changes possibly reflecting increased awareness or persistent triggers.

Participant 3:

*PTSD*: Improved (score decreased from 18/24 to 14/24)

*Self Organization*: Slight improvement (score reduced from 11/24 to 09/24)

*Complex PTSD*: Improved (from 29/48 to 23/48)

*ITQ Total*: Mean score dropped modestly from 2.42 to 2.08.

B. Post-Traumatic Growth (PTG) Scores

Participant 1:

Mean PTG increased from 3.24 (pre) to 3.57 (post), with key items (e.g., "I have learned what is important to me", "I learned that I can handle my problems") showing positive shifts (+2 points each on a 4-point scale).

Some items, such as understanding others' feelings or getting along with family and friends, decreased, suggesting nuanced changes.

Participant 2 and 3:

> Similar trends were observed with slight increases in overall PTG scores, though with variability: for instance, Participant 2 showed positive changes in items related to personal agency (e.g., "Now it is more likely to try and change things in my life") alongside decreases in items reflecting social closeness.

C. Summary of Statistical Trends

Across participants, the quantitative data consistently indicated:

A general decrease in scores measuring PTSD and self-organization difficulties, suggesting reduced severity or frequency of symptoms.

Improvements in several domains of post-traumatic growth, indicating enhanced self-perception and coping strategies.

Some inconsistencies (e.g., certain items worsening) that hinted at ongoing challenges, particularly in areas related to interpersonal relationships.

3. Qualitative Findings: Illuminating the Lived Experience

A. Emergent Themes

Positive Experience with Meetings:

> Participants frequently commented on feeling "comfortable," "safe," and "happy" during sessions. For example, Participant 1 noted, "The meetings were a good thing for me; I had a great time," underscoring the therapeutic value of a secure environment.

The Therapist's Stance and Empathic Approach:

> Qualitative feedback emphasized the importance of the therapist's kindness, understanding, and non-authoritative attitude. Comments such as "I felt safe, trusting," and "helped me to understand myself" illustrate how the therapist's approach was instrumental in building rapport and facilitating change.

Self-Awareness and Emotional Expression:

> Activities like empathic mapping were particularly impactful. Participants described these activities as enabling them to express and manage difficult emotions. One participant remarked, "I used to not capture what I was feeling; now I like to do it," linking creative expression to improved emotional regulation.

Family and Social Dynamics:

> Some qualitative narratives pointed to ongoing challenges, such as negative experiences at home. For instance, Participant 2 mentioned, "I expected my brother to

change, but he hasn't changed at all," highlighting that while internal coping might improve, external relational issues can persist.

Participant 3's reflections on the impact of a father's absence further underline how changes in the family environment were intertwined with personal recovery.

Perception of Support and Growth:

Qualitative themes from expert commentary underscored that the intervention, through its flexible and culturally sensitive approach, not only addressed individual symptoms but also promoted systemic improvements in social interactions and self-acceptance.

B. Expert Perspectives

Cultural Mediator's View:

Emphasized that the therapeutic process, marked by creative tools and a safe environment, allowed children to explore and express emotions in a non-threatening manner.

Social Scientist's Insight:

Highlighted the significance of the intervention in fostering trust and social support, while also acknowledging that external factors (e.g., unstable home environments) could modulate the effectiveness of the therapy.

4. Integrated Synthesis: Explaining "How" and "Why" the Changes Occurred

A. Quantitative-to-Qualitative Connections

Reduction in PTSD and Self-Organization Scores:

The statistically significant reductions in scores (e.g., dramatic drop in self-organization difficulties for Participant 1) are mirrored in qualitative accounts of reduced fear, improved emotional control, and a newfound ability to express feelings. Statements like "I wasn't scared anymore" and "I can play with other people better now" provide narrative depth to the numerical improvements.

Post-Traumatic Growth Increases:

The measured increases in PTG scores correlate with qualitative reflections of personal empowerment, such as learning "what is important" and discovering that "I can handle my problems." Even where some items decreased (e.g., familial closeness), these nuances are clarified by qualitative data revealing that ongoing family issues (like sibling conflict or parental absence) continue to challenge the participants.

B. Understanding Mixed Outcomes

Areas of Positive Change:

> Both quantitative and qualitative data affirm that the intervention had a strong impact on reducing symptoms like hypervigilance and emotional numbness. For example, the improvement in items like "Not able to have feelings or feeling empty inside" aligns with narratives of enhanced self-awareness and emotional expression.

Areas of Continued Challenge:

> Increases in certain PTSD items (e.g., intrusive memories or avoidance behaviors) in the quantitative data are explained by qualitative insights that external triggers (such as negative family interactions) still exist. This dual evidence suggests that while the intervention is effective in building internal resilience, some external factors require additional support or longer-term intervention.

C. Systemic and Contextual Influences

Expert Feedback:

> The experts' observations add a layer of interpretation, suggesting that the intervention's success is partly due to its adaptability to each child's context and its focus on relational dynamics. The cultural mediator's emphasis on safety and creativity, alongside the social scientist's insights on the importance of systemic support, helps explain why some participants showed greater improvements in self-organization and emotional regulation than others.

5. Conclusion

The explanatory design shows that the quantitative improvements—reflected in lower PTSD and self-organization scores and modest gains in post-traumatic growth—are substantiated by qualitative narratives that describe increased feelings of safety, self-awareness, and improved emotional management. Although some challenges, especially in relational contexts, persisted, the combined data reveal a dynamic therapeutic process where both individual change and systemic factors interact. This mixed-methods synthesis not only validates the numerical outcomes with rich, lived experiences but also provides actionable insights into how future interventions might be tailored to address external stressors and further enhance social support.

By moving from numbers to narratives, the study offers a comprehensive picture of change—underscoring that effective therapeutic interventions must attend both to measurable symptom reduction and to the complex, context-rich experiences of the individuals involved.

## Research 2

## Enhancing PCE for relational trauma, Through Empathic Mapping: A Qualitative Exploration of Therapeutic Processes and Outcomes.

## Method

## Methods

### Participants

This study involved two expert trauma specialists who participated as clients in the empathic mapping lab. These specialists were selected based on their extensive experience in trauma therapy and their ability to critically evaluate therapeutic process. Their participation provided in-depth qualitative insights into the effectiveness and impact of empathic mapping within a therapeutic setting.

### Procedure

The empathic mapping intervention was conducted in a structured therapeutic setting. The therapist then introduced the concept of empathic mapping, emphasizing its role as a tool for enhancing key therapeutic elements rather than as a stand-alone technique.

Following the completion of the empathic mapping session, participants were invited to provide qualitative feedback on their experiences. This feedback was gathered through semi-structured interviews designed to explore their perceptions of the intervention's effectiveness, its impact on therapist-client connection, and its potential utility in trauma therapy.

### Data Collection and Analysis

Qualitative data were collected through recorded semi-structured interviews conducted immediately after each session. These interviews were transcribed verbatim and subjected to thematic analysis, following Braun and Clarke's (2006) guidelines. Thematic coding focused on identifying patterns related to the perceived benefits, challenges, and therapeutic implications of empathic mapping. Data analysis emphasized the ways in which empathic mapping contributed to the communication of empathic understanding and the maintenance of therapeutic presence without emotional overidentification.

### Ethical Considerations

Given the sensitive nature of trauma therapy, ethical approval was obtained from an institutional review board prior to the study. Participants provided informed consent and were assured of confidentiality and anonymity in data reporting. Measures were taken to ensure that the intervention did not induce emotional distress, and debriefing sessions were offered post-participation to address any residual effects.

This methodological approach enabled a comprehensive examination of empathic mapping as a therapeutic enhancement tool, offering insights into its applicability and effectiveness in trauma therapy.

## Analysis

| Quotes | Codes |
|---|---|
| 1. *I struggled to explain what was going on in my head. I had all these thoughts and emotions tangled up, but I couldn't find the right words to express them. The mapping process gave me a way to put them on paper, making it easier to see what I was feeling. It was like translating my emotions into something visible and understandable.* | Expressing emotions visually |
| 2. *One of the most powerful things about mapping was that I got to decide how my story unfolded……. I chose where to place each thought and emotion, and that gave me a sense of control. It wasn't just about what I felt—it was about organizing my feelings in a way that made sense to me. For once, my emotions weren't controlling me; I was controlling how I processed them.* | Empowerment through mapping |
| 3. *The therapist's kindness made all the difference. I didn't feel judged. I didn't feel like I had to filter my words or hide my feelings……..... That safety made it easier to open up.* | Therapeutic safety |
| 4. *I never thought I could actually show someone what was in my mind. Talking about emotions felt impossible, but putting them into drawings? That made it so much easier.* | Non-verbal expression of trauma |
| 5. *A. My emotions always felt like this huge storm I couldn't control. It was all too much. But when I started mapping, it was like breaking it down into smaller pieces. …….Suddenly, it wasn't a storm anymore—it was something I could actually deal with* | Emotional organization |

| | |
|---|---|
| *M. felt jumbled—too much to handle. Mapping made it clearer. I could see one thing at a time instead of drowning in it* | |
| 6. *I kept asking myself why I reacted so strongly to things. Then, after mapping, I saw the patterns. It made so much sense* | Understanding emotional connections |
| 7. *"The therapist didn't push. That's what made me trust them. I could go slow, which made all the difference."* | Non-authoritative guidance |
| 8. *I felt safe to speak as the therapist did not seem to judge me in any way… Sometimes I have encountered therapists as a client or supervisor who wanted to share their personal experiences.. this was not helpful* | Externalizing emotions |
| 9. *Something got me I wanted… hm… to finalize the map … something like playing at the same time … I did not understand that I was discussing something that it is so difficult to be put in words* | Symbolic representation of trauma |
| 10. *I saw myself in that and linking these words in the map gave me a broader picture ….* | Recognizing emotional patterns |
| 11. *I felt better .. I understand tha this is just the beginning and only one session but I felt more organized* | Handling trauma through mapping |
| 12. *As a trauma expert I saw in mapping the potential to be at the same time precise but not to feel trauma … it is strange* | Clarity in emotional experiences |
| 13. *I felt that I could lead the process* | Client autonomy |
| 14. *It hit me directly in the emotion …. It was real deep and this happened really quick* | Emotional release |

Note: Discussion & analysis is shared in Chapter 1

**Research 3**

**Is Person-Centred Counseling for Relational Trauma a Person-Centred Model?**

*Method*

*Participants*

Two specialists in Person-Centred theory participated in this study. Both individuals possessed over 12 years of professional experience as trainers, supervisors, and psychotherapists and were recognized experts in the inclusion criteria for the person-centred paradigm (Warner, 2001). Their extensive background ensured that their contributions were deeply informed by both practical experience and theoretical knowledge.

*Procedure*

A qualitative research design was employed to explore the specialists' perspectives following a brief experiential intervention. The procedure consisted of two main stages:

Lab Session:
Each participant attended a 10-minute lab session conducted by a professional practitioner. This session was designed to actively engage the participants with core person-centred principles, serving as both a practical demonstration and a stimulus for reflective discussion.

Semi-Structured Interviews:
Immediately following the lab session, semi-structured interviews were conducted with each specialist. The interview guide was developed based on established person-centred theoretical frameworks, drawing on Sanders' (2000) differentiation of person-centred principles into primary and secondary categories and Warner's (2001) criteria for inclusion in the person-centred paradigm. The semi-structured format allowed for both targeted questions and the flexibility to explore emergent topics relevant to the experts' experiences and reflections on the lab session.

*Data Collection*

All interviews were audio-recorded with the participants' informed consent and subsequently transcribed verbatim. These transcripts provided a comprehensive record of the specialists' insights, reflections on the lab session, and discussions regarding the theoretical underpinnings of person-centred practice.

*Data Analysis*

The transcribed interviews were analyzed using thematic analysis, following the six-phase approach outlined by Braun and Clarke (2006):

Familiarization: Researchers read and re-read the transcripts to become deeply acquainted with the data.

Initial Coding: Codes were generated across the data set to identify meaningful features related to person-centred principles and inclusion criteria.

Searching for Themes: Codes were organized into potential themes that captured the essence of the specialists' experiences.

Reviewing Themes: The emerging themes were reviewed in relation to the coded extracts and the entire data set to ensure coherence.

Defining and Naming Themes: Themes were refined and clearly defined, ensuring they accurately represented the data.

Producing the Report: The final thematic map was developed to illustrate the connections between the experts' experiences and the theoretical frameworks (Sanders, 2000; Warner, 2001).

This systematic process enabled the integration of the specialists' experiential knowledge with established theoretical constructs, thereby enriching the interpretation of the findings.

*Ethical Considerations*

The study adhered to ethical guidelines for research involving human subjects. Informed consent was obtained from both participants prior to their involvement in the lab session and interviews. Confidentiality was rigorously maintained throughout the study, with all personal identifiers removed from the transcripts to ensure participant anonymity.

| Participant | Participant's segments | Code | | |
|---|---|---|---|---|
| Participant 1 | *During the session, I felt that the mapping process allowed me to express my thoughts more clearly, and I could see that the therapist truly understood me.* | Empathy & Understanding | | |
| Participant 1 | *I appreciated how the therapist never imposed their views. Instead, they let me explore my own emotions at my own pace.* | Non-Directve | | |
| Participant 1 | *Seeing my thoughts mapped out in front of me made me feel validated. It was the first time I had a tangible proof that someone really listened.* | Validation & Recognition | | |
| Participant 1 | *The therapist never directed me towards a specific conclusion. They just followed my thoughts and let me take control of where we went.* | Autonomy & Self-Determination | | |

| | | | |
|---|---|---|---|
| Participant 1 | *I felt safe knowing that the therapist wasnt assuming things about me. They genuinely tried to see things from my perspective.* | Absence of Bias & Preconceptions | |
| Participant 1 | *Having my experiences visually represented made me realize connections I had not noticed before. It helped me understand myself better.* | Experiential Inquiry | |
| Participant 1 | *The therapist did not just listen passively; they actively showed me that my words mattered by engaging in the mapping process.* | Active Engagement | |
| Participant 1 | *I never felt pressured to use what was written in any specific way. It was my choice how to engage with it.* | Choice in Using Material | |
| Participant 2 | *At one point, I noticed how the therapist reflected my feelings without adding their own opinions. It reassured me that I was in charge of my process.* | Trust in Client's Tendency to Realization | |
| Participant 2 | *There was a moment when I wasn't t sure if I was making sense, but seeing my words mapped out confirmed that I was being understood.* | Psychological Contact | |
| Participant 2 | *I was able to correct something the* | Shared Decision-Making | |

| | | |
|---|---|---|
| | *therapist had noted, which made me feel like an active participant rather than just a patient.* | |
| Participant 2 | *Throughout the session, the therapist remained neutral, never guiding me but always being present in my process.* | Non-Directionality in Relationship |
| Participant 2 | *I was surprised that I did not feel the structure in a pressing way* | Free & Structured process |
| Participant 2 | *The mapping gave me a sense of ownership over my experience.* | Support for Self-Expression |
| Participant 2 | *I appreciated that the therapist never made assumptions. Instead, he asked questions that made me reflect further.* | Clarification without Influence |
| Participant 2 | *By the end of the session, I realized I had done most of the work myself, and that felt empowering.* | Empowerment through Self-Discovery |

**Questionnaires used**

1. **International Trauma Questionnaire – Child and Adolescent Version (ITQ-CA)**

Instructions:

Below are problems people can have after an upsetting or stressful event. Thinking about that event, please select how much the following things have bothered you in the PAST MONTH.

For items 1–6 and 12–17, please circle the number that best describes your experience using the following scale:

0 = Never

1 = A little bit

2 = Sometimes

3 = A lot

4 = Almost Always

**Section 1: Trauma-Related Experiences**

Bad dreams reminding me of what happened.
0 1 2 3 4

Pictures in my head of what happened. Feels like it is happening right now.
0 1 2 3 4

Trying not to think about what happened, or not having feelings about it.
0 1 2 3 4

Staying away from anything that reminds me of what happened (people, places, things, situations, talks).
0 1 2 3 4

Being overly careful (checking to see who is around me).
0 1 2 3 4

Being jumpy.
0 1 2 3 4

Interference Questions (Related to Items 1–6):

For each question below, please indicate if the problems listed above have interfered with the following areas (circle your answer):

Have any of the above problems interfered with getting along with friends?

Yes - No

Have they interfered with getting along with family?

Yes - No

Have they interfered with your school work?

Yes - No

Have they interfered with anything else that is important to you (hobbies, other relationships)?

Yes - No

Have they interfered with your general happiness?

Yes - No

Section 2: Trauma-Related Feelings and Beliefs

Below are additional problems that people report after traumatic or stressful events. These questions focus on how you feel and what you believe about yourself and others. Again, please select how much the following have bothered you in the PAST MONTH:

Having trouble calming down when I am upset (angry, scared, or sad).
0 1 2 3 4

Not being able to have any feelings or feeling empty inside.
0 1 2 3 4

Feeling like a failure.
0 1 2 3 4

Thinking I am not a good person.
0 1 2 3 4

Not feeling close to other people.
0 1 2 3 4

Having a hard time staying close to other people.
0 1 2 3 4

Interference Questions (Related to Items 12–17):
For each question below, please indicate if the problems listed above have interfered with the following areas (circle your answer):

Have any of the above problems interfered with getting along with friends?

Yes - No

Have they interfered with getting along with family?

Yes - No

Have they interfered with your school work?

Yes - No

Have they interfered with anything else that is important to you (hobbies, other relationships)?

Yes - No

Have they interfered with your general happiness?

Yes - No

*Reference:*
Cloitre, M., Shevlin, M., Brewin, C. R., Bisson, J. I., Roberts, N. P., Maercker, A., … Hyland, P. (2018). The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica, 138*(6), 536–546.

## 2. Posttraumatic Growth Inventory for Children (PTGI-C)

Tedeschi & Calhoun, 1996,
Cryder, Kilmer, Tedeschi, & Calhoun, 2006

1=Not at all true, 2=A little true, 3=Mostly true, 4=Very true

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| 1. I have learned what is important to me. | | | | |
| 2. I am now more likely to try to change things in my life that need changing. | | | | |
| 3. I have learned that life is important. | | | | |
| 4. I learned that I can count on myself. | | | | |
| 5. I understand spiritual things (like religious ideas) more now. | | | | |
| 6. I learned that some people will be there for me and help me if something bad happens. | | | | |
| 7. I feel closer to other people (friends or family) than I did before. | | | | |
| 8. I learned that I can handle my problems. | | | | |

| | | | | |
|---|---|---|---|---|
| 9. I feel like it is okay to let people know how I feel inside. | | | | |
| 10. I feel like I can deal with things the way they turn out. | | | | |
| 11. I feel like each day is important. | | | | |
| 12. I can better understand other people's feelings. | | | | |
| 13. I am able to do a better job on my work in school and at home. | | | | |
| 14. I have the chance to do some things I wouldn't have been able to do before. | | | | |
| 15. I try harder to get along with my family and friends. | | | | |
| 16. My religious beliefs are stronger now. | | | | |
| 17. I have learned that I can deal with more than I ever thought I could. | | | | |
| 18. I learned how nice some people can be. | | | | |
| 19. I have new things that I like to do (like hobbies, toys, etc.) | | | | |
| 20. I learned that sometimes I need other people to help me out. | | | | |
| 21. I have some new ideas about how I want things to be when I grow up | | | | |

**Semi structured Interview with children Following, the quantitative research**

- **Questions**

- How would you describe the sessions?
- How did you feel during the sessions?
- What do you remember from the sessions?
- What would you change?
- Can you describe what the psychologist was like?
- What made you feel more comfortable?
- How was the mapping for you?

**Semi structured Interview questions with Trauma experts (Based on PCES)**

1. Understanding the Client's Experience
    - How well do you feel the therapist understands your experience and perspective?
2. Emotional Support
    - When you were feeling upset or overwhelmed, how did the therapist support you?
3. Exploring Personal Experiences

- Did the therapist help you talk about specific personal experiences, or did the conversation stay more general?

4. Feeling Accepted
   - Did you feel completely accepted by the therapist, no matter what you shared? Why or why not?
5. Guiding the Conversation
   - Did the therapist follow your lead in the conversation, or did they introduce new topics and ideas?
6. Focusing on Emotions
   - How did the therapist help you explore and express your emotions?
7. Therapist's Presence
   - Did the therapist give you space to express yourself, or did they take control of the session?
8. Clear Communication
   - Did the therapist explain things in a way that was easy for you to understand?
9. Getting to the Heart of Your Experience
   - Did the therapist's responses help you feel truly understood? Why or why not?
10. Emotional Balance

- When you felt overwhelmed or disconnected, how did the therapist help you manage your emotions?

**Semi Structured Interview questions (PCE Theory experts)**

1. How did you feel about the way the client's natural tendency for growth was supported or hindered during the session?
2. How did you feel about the conditions provided for the client's growth? Were they necessary and adequate?
3. How did you feel about the level of non-directionality in the session? Did it support or limit the client's process?
4. How did you feel about the way the session supported the client's autonomy and self-determination?
5. How did you feel about the balance of equality between you and the client? Were there moments where authority played a role?

6. How did you feel about the level of non-directionality in the therapeutic relationship?
7. How did you feel about the overall therapeutic conditions? What worked well, and what could be improved?
8. How did you feel about the role of faith in the therapeutic process and the organization as a whole during the session?
9. How did you feel about how well the session stayed within the client's frame of reference?
10. How did you feel about how your own experiences or theories influenced your understanding of the client?
11. How did you feel about the level of choice the client had in using the material within the session?
12. How did you feel about any moments where your own perspective or authority influenced the session?
13. How did you feel about any interventions where the client may not have been fully aware of the purpose?