

Is person-centred experiential
psychotherapy an effective therapeutic
approach for post-traumatic stress?

A SYSTEMATIC REVIEW OF THE EXISTING LITERATURE

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Abstract

This dissertation aims to review the existing literature on the person-centred experiential approach to post-traumatic stress and post-traumatic growth to establish if it is an effective therapeutic approach. An analysis of peer-reviewed academic journal articles and book chapters will highlight the main literature on this topic. Sixty-four papers are reviewed, analysed and critically evaluated for their contribution to four main themes including theoretical perspectives, cross-cultural theoretical perspectives, quantitative studies and qualitative research.

Further analysis of sub-themes within the four main themes will be critically evaluated. Theoretical perspectives on person-centred theory of personality, post-traumatic stress and psychopathology will be explored, alongside gender and sexual orientation specific theory. Theoretical contributions from contemporary person-centred approaches to post-traumatic stress such as focusing-oriented therapy, emotion-focus therapy and existential therapy will be evaluated. Cross-cultural perspectives on post-traumatic stress and the person-centred approach will also be reviewed. Quantitative studies on the efficacy of person-centred counselling will be examined. Sub-themes include therapeutic outcomes relating to the measurement of post-traumatic growth, studies comparing person-centred therapy with other modalities in the treatment of trauma and group therapy. Themes emerging from qualitative papers include case studies on emotion focused therapies and classical client-centred therapy.

Organismic valuing theory and person-centred personality theory offers a robust contribution to the development of therapeutic approaches to trauma. The small but growing number of qualitative and quantitative studies are promising. This study identifies tension between the person-centred approach as a humanistic paradigm versus the prevailing medical paradigm, psychopathology and contemporary neurobiological approaches to treating trauma. The study also

questions the positionality of a therapeutic approach developed within a Western cultural framework and challenges the findings of empirical research.

Keywords

Person-centred, experiential, client-centred, counselling, psychotherapy, post-traumatic stress disorder, post-traumatic stress, post-traumatic growth, trauma, actualising tendency, self-actualisation, organismic valuing theory.

Introduction

This dissertation will review the existing literature on the person-centred experiential approach (PCE-A) to post-traumatic stress (PTS) and post-traumatic growth to evaluate whether it is an effective therapeutic approach. Current NICE (2018) guidelines recommend a combination of cognitive behavioural therapy (CBT), narrative exposure therapy (NET), prolonged exposure therapy (PET) and eye-movement desensitisation processing (EMDR) for post-traumatic stress disorder (PTSD). This is despite CBT based interventions for trauma via the NHS IAPT (Improving Access to Psychological Therapies) service, returning a recovery success rate of only 36.4%, the second lowest recovery rate of all conditions treated by IAPT (Baker, 2021). Furthermore, Murphy et al (2013), in their survey of UK based trauma services, established that over a third (38%) were offering person-centred psychotherapy to their clients.

The phenomenon of PTS and PTG is largely understood through the medical paradigm with the NHS offering brief, manualised, target-driven therapeutic treatments. The PCE-A inhabits a humanistic paradigm and therefore rejects illness ideology, manualised therapeutic approaches and the language of disorder. Joseph (2021) identifies a robust, theoretical framework to support a person-centred approach to PTS and PTG but laments the primacy of the medical model in interpreting current research and the lack of empirical, humanistic research to support the effectiveness of the PCE-A. This dissertation aims to review the existing literature on the PCE-A to PTS and PTG to establish whether it is an effective therapeutic approach.

Four main categories of peer-reviewed literature from 1940-2022 are included: theoretical papers (including a separate section on cultural perspectives on PTS & PTG); qualitative studies and quantitative studies. The papers are sourced systematically, as evidenced in the PRISMA diagram in the 'Methods' chapter (Page et al, 2019), from the following databases and with the addition of ten papers from my academic book collection:

- EBSCOhost
- APA PsycInfo
- LjMU (Liverpool John Moores University) Discover

This study provides an analysis of the main themes found within these four categories. The themes are then organised systematically into the chapters and sections outlined in this dissertation.

Chapter two provides a detailed overview of PTSD, how it is categorised by the DSM-V (APA, 2013) and ICD-11 (World Health Organisation, 2021) and outlines the current treatment recommendations. Additionally, chapter two outlines the historical background to the PCE-A and how it accounts for the process of psychological maladjustment and therapeutic change within a humanistic paradigm.

Chapter three discusses the methodology & method chosen for the study and illustrates the results of the literature review in a PRISMA diagram (Page et al, 2019). Chapter four presents the findings of the study in a series of pie-charts which illustrate the analysis of the main themes and sub-themes identified which are:

- **Theoretical papers:** Person-centred theory of personality and post-traumatic stress; Person-centred psychopathology; Focusing-oriented theory; Experiential theory; Emotion-focused theory; Gender specific; Sexual orientation specific.
- **Cross-cultural perspectives.**
- **Quantitative studies:** Comparison of person-centred therapy with alternative modality; Post-traumatic growth; Group therapy; Survey.
- **Qualitative studies:** Emotion-focused therapy; Classical Client-Centred Therapy.

Chapter Four also provides an analysis of the theoretical papers and those exploring cross-cultural perspectives. Due to the large amount of data and limitations regarding word count, narrative analysis of the quantitative and qualitative studies is presented in this chapter alongside a tabular analysis in Appendix Three.

Chapter five will draw together the literature reviewed across the theoretical papers, quantitative and qualitative studies discussed in chapter four. This chapter will analyse the existing evidence to establish whether the PCE-A to PTS and PTG is an effective therapeutic approach. Finally, chapter six provides a conclusion, limitations of the study and recommendations for further research.

Background

This chapter will facilitate an understanding of PTSD and highlight the current therapeutic treatment recommendations in the UK. It will explain the theory of the PCA, outline how person-centred theory of personality (Rogers, 1951; 1957; 1959) is understood to account for psychological disturbance and provide a brief overview of contemporary person-centred approaches. Finally, some context for the PCA as a humanistic paradigm and its positionality in relation to the prevailing medical model will be covered.

Post-Traumatic Stress Disorder

The term 'post-traumatic stress disorder' (PTSD) originally appeared in the 1980s in reference to war veterans (Humphreys & Joseph, 2004), was first included in DSM-III (APA, 1980), and continues in the most current edition, DSM-V (APA, 2013). The first criteria for PTSD listed in the DSM-V (APA, 309.81, F43.10, 2013) is "*exposure to one or more traumatic event(s), defined as one involving death or threatened death, actual or threatened serious injury, or actual or threatened sexual violence.*"

"Exposure means:

- *Witnessing the event as it occurred to someone else.*
- *Learning about an event where a close friend or relative experienced an actual or threatened violent or accidental death.*
- *Repeated exposure to distressing details of an event.*

A diagnosis of PTSD requires:

- *Exposure to the traumatic event.*
- *One (or more) intrusion symptom(s).*
- *One (or more) symptom(s) of avoidance.*

- *Two (or more) symptoms of negative changes in feelings and mood.*
- *Two (or more) symptoms of changes in arousal or reactivity.*

Symptoms must:

- *Last longer than one month.*
- *Cause considerable distress and/or interfere significantly with a number of different areas of life.*
- *Not be due to a medical condition or substance use.”*

(DSM V, APA, 2013, 309.81, F43.10)

Complex Post Traumatic Stress Disorder

The DSM-V (APA, 2013) does not include a separate diagnostic category for ‘Complex-PTSD.’ However, the ICD-11 (World Health Organisation, 2021) differentiates C-PTSD from PTSD. C-PTSD is described as a condition that develops in response to exposure to an incident or incidents which are exceptionally distressing and harrowing. Most typically protracted or repeated situations from which escape is hopeless and complicated such as *“torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse.”* ICD-11, (2021, 6B41).

All diagnostic parameters for PTSD must be met alongside:

- *“Problems in affect regulation*
- *Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event &*

- *Difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.” ICD-11, (2021, 6B41)*

National Institute of Health & Care Excellence recommendations for PTSD

In the UK, the most recent guidelines from NICE (national institute of health & care excellence, 2018) recommend the following for individuals who have received a PTSD diagnosis or are showing clinical symptoms of PTSD more than one month after a traumatic event:

- *“Cognitive Processing Therapy*
- *Cognitive Therapy for PTSD*
- *Narrative Exposure Therapy*
- *Prolonged Exposure Therapy*
- *Trauma-Focused Computerised Cognitive Behavioural Therapy”*

NICE (2018, NG116)

NICE (2018) also recommends EMDR for individuals continuing to experience trauma symptoms or having received a PTSD diagnosis for up to 3 months after the traumatic event. 8-12 sessions are recommended for all therapies.

Additionally, NICE (2018) recommends the following drug treatments:

- *“Venlafaxine (off-label for PTSD)*
- *Sertraline*
- *Paroxetine*
- *Risperidone (anti-psychotic medication) for individuals experiencing psychosis or severe hyperarousal & have not responded to the milder medications.”*

NICE (2018, NG116)

In the UK, the 'Adult Psychiatry Morbidity Survey' of 2014 found 5.1% of women and 3.7% of men had a positive screening for PTSD (Baker, 2021). Following CBT based interventions via the NHS IAPT (Improving Access to Psychological Therapies) service, only 36.4% of people were recovered from PTSD. This constitutes the second lowest recovery rate of all conditions treated by IAPT (Baker, 2021). Murphy et al (2013) conducted a survey to determine the types of therapy offered by specialised trauma services in the UK. Of the 13 services surveyed, 3 were non-statutory whilst ten were NHS based. The top five results showed the following:

- *"CBT 92%*
- *EMDR 77%*
- *Cognitive Therapy 69%*
- *Behaviour Therapy 61%*
- *Client-Centred Therapy 38%"*

(Murphy et al, 2013, p.438)

At the time of conducting the survey, Murphy et al (2013) cite earlier NICE guidelines to support the relevance of the study. CBT was the preferred psychological intervention at the time and remains so in the most recent guidelines (NICE, 2018). Despite this, trauma services in the UK, were offering a far broader range of therapies than recommended by NICE with person-centred therapy accounting for 38%.

Person-centred psychotherapy

The Psychologist Dr Carl Rogers developed the PCA to psychotherapy from the 1940's onwards. Prior to this, Freudian psychoanalytical psychotherapy was the most common and widely acknowledged modality (Feltham, 2013). Hergenhahn & Henley (2014, p.555) pronounce that person-centred (PC) psychotherapy was "the first major alternative to psychoanalysis" alongside others in the disciplines of psychology and psychotherapy, including Malim & Birch (1998) & Webb (2018).

Rogers' later work (1951, 1957, 1959) which sets out the framework for client-centred therapy predates the advent of post-traumatic stress disorder (PTSD) related literature. However, Roger's earlier work '*Counselling and Psychotherapy: Newer concepts in practice*' (1942) and '*Counselling with returned servicemen*' (1946) coincides with his counselling of World War II veterans which may have deepened his appreciation of the psychological effects of trauma.

Theory of person-centred psychotherapy

The PCA is based on the idea that individuals have an innate tendency to move towards self-actualization and that this process can be facilitated by creating a supportive and empathetic therapeutic environment. The core belief of person-centred counselling is that people can direct their own growth and healing. The therapist's role is to provide a non-judgmental & empathic space for the individual to explore their feelings & experiences. The approach emphasises the importance of the therapeutic relationship & seeks to understand the client's experience from their perspective. It is a non-directive approach that places the individual at the centre of the therapeutic process. The PCA seeks to create an accepting therapeutic experience in which the client can explore their inner world, increase self-awareness & move towards self-actualization.

The actualising tendency

Rogers (1959) believed that all living organisms have an innate tendency to grow and develop in ways that are consistent with their unique nature. In humans, this tendency is expressed as the 'actualizing tendency,' which refers to the natural inclination to fulfil one's potential and become the best version of oneself. This is known as 'self-actualization.' Rogers (1959) believed that in a supportive and nurturing environment, individuals would naturally self-actualise (Merry, 2012).

According to Rogers (1961), the environment and relationships play a vital role in determining how individuals grow, build a self-concept and gain self-esteem. The process of actualisation in humans is not seen as a conscious decision-making process but as a process in which

both conscious and nonconscious levels of the organism are engaged. It involves an individual's behaviour, values, feelings & attitudes, all of which are subject to modification and reformulation in light of organismic experience (Merry, 2012).

The 'self-concept'

Individuals have their own unique self-concept, which consists of their perceptions of their own thoughts, feelings and experiences. Rogers (1951, 1959, 1961) believed the self-concept is central to psychological health. In a healthy social environment and in the presence of positive, nurturing relationships, the construction of the self-concept and actualisation of the self will result in the individual being open to experience. When this happens, the self-concept is in accordance with the individual's organismic experiencing and congruence exists. In contrast, an adverse social environment and/or the presence of unhealthy, abusive, neglectful relationships may lead to the actualisation of a self in opposition with organismic experience. This conflict or 'incongruence' is the cause of psychological distress (Merry, 2012; Mearns et al 2013).

The 'nineteen propositions.'

Rogers (1951) sets out his theory of personality in a series of assertions he calls the 'nineteen propositions.' This describes how individuals grow and develop their self-concept, ascribing value and meaning to their experiences. Individuals may either positively or negatively value experiences. When valued positively, a person perceives their experience accurately and incorporates it into their self-concept. This is called the '**organismic valuing process**' (OVP) (Merry, 2012). At other times, experiences are entirely disregarded because an individual cannot discern any link between the experience and their self-concept. The individual may confuse or reject the experience since it conflicts with the self-concept and threatens to destabilise it.

Conditions of worth

The 'organismic valuing process' mentioned above consists of experiences valued directly by an individual or via the intrusion of 'others.' Merry (2012) remarks that when this occurs, values can be assimilated both inaccurately & negatively & can become confused with direct experience. This happens when conditions of worth are imposed on a person, disrupting their OVP & leading them to ascribe value to experiences not aligned with their authentic self. These 'introjects' (Merry, 2012) are internalised conditions of worth.

Initially, conditions of worth are externally imposed via 'others.' However, once introjected, individuals can feel like these conditions are self-inflicted & necessary to feel worthy or deserving of love, approval, or acceptance from others. These conditions are shaped by external factors such as interpersonal relationships & the social environment (Mearns et al, 2013). Thus, individuals behave in accordance with the conditioning of 'others' & not with their organismic experiencing. This leads to psychological maladjustment & incongruence. Individuals experience disconnection from their authentic self, as they sacrifice their own values & desires to meet external expectations. This can also contribute to low self-esteem & feelings of inadequacy, as individuals may feel that they are only worthy of love and acceptance if they meet certain conditions.

Classical client-centred therapy & the six necessary & sufficient conditions

'The Necessary and Sufficient Conditions of Therapeutic Personality Change,' (Rogers, 1957) serve as the foundation for the PCA. Rogers (1957) proposed that if all six conditions are met during counselling, then a change in personality would occur adding that psychological change was impossible even in the absence of a single condition.

1. *"...Psychological contact.*
2. *The client is ... incongruent.*
3. *The therapist is ... congruent.*
4. *The therapist experiences unconditional positive regard for the client.*

5. *The therapist experiences (and demonstrates) an empathic understanding of the client's internal frame of reference.*
6. *The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved."* (Rogers, 1957, p.97-99)

Classical client-centred therapy (CCT) focuses purely on 'conditions' theory (Merry, 2012). The conditions represent a set of values and attitudes that are necessary for the therapist to internalise and reflect during the therapeutic encounter. The therapeutic 'climate' created by the six necessary and sufficient conditions provides a corrective psychological experience for the client, re-establishing self-actualisation and congruence between the self-concept and organismic experiencing.

PC psychotherapists believe psychological disturbance stems from introjected conditions of worth and believe these introjects are dismantled by offering the core conditions of empathy, unconditional positive regard (UPR) and congruence. The intention is to mobilise the actualising tendency, collapse the conditioned self-structure, achieving congruence between self and experience to form a new self-structure (Joseph, 2004). Joseph (2004) and Joseph & Linley (2005, 2006) argue traumatised clients will often have already experienced a breakdown of the conditioned self-structure. The fundamental function of PC counsellors is to aid the client in reconstructing their self-structure by integrating self and experience to develop into what Rogers (1967, p.183) refers to as a "fully functioning person."

Contemporary person-centred psychotherapy

Various contemporary approaches have evolved out of classical CCT:

- Focusing-oriented therapy
- Emotion-focused therapy
- Experiential person-centred therapy
- Encounter-oriented therapy (relational depth)

- Existentially informed person-centred therapy (Sanders, 2012)

These newer 'tribes' of the PCA (Sanders, 2012) present some substantial changes to the classical approach. Most significantly, to non-directivity & 'intervention levels' (Warner, 2000). The literature reviewed for this dissertation contains a range of papers from both the classical & contemporary approaches.

The humanistic paradigm versus the medical paradigm

An understanding of the PCA's contrasting positionality to the prevailing medical model of distress is essential. The background to both PTSD and the PCA as outlined in this chapter demonstrate two conflicting paradigms. The PCA understands the phenomenon of post-traumatic stress (PTS) through a humanistic paradigm. However, the prevailing and dominant discourse which exists understands it via a medical paradigm, as a 'disorder' or 'illness' to be 'cured.' Not only does this impact the way the PCA seeks to engage therapeutically with people impacted by PTS but also how research understands the phenomenon of PTS and post-traumatic growth (PTG) (Joseph, 2021).

Joseph (2021) argues research findings on PTG have raised what appear to be difficult theoretical problems and identifies issues where mainstream research struggles to account for key questions around PTG. He posits there is a lack of understanding about the connection between PTS & PTG, whether PTG is simply resilience, a normal process, imagined, adaptive or a type of personality change. Most importantly, Joseph (2021) positions these contentious debates as only appearing puzzling or contradictory when seen through the lens of the medical model of distress. He argues there are significant contrasts between how illness ideology and humanistic psychology handle the concept of PTG. Humanistic psychology understands PTS and PTG as part of the same psychological process. The medical model, in framing PTS as a disorder (PTSD or post-traumatic stress disorder) fails to account for the inclusion of PTG as a normative part of this process. This presents deeper issues for empirical research on PTS and PTG as it is unfeasible to concurrently

frame a research study from these two opposing paradigms (Joseph, 2021). Joseph (2021) argues both PTG and PTS must be understood through the lens of the humanistic paradigm via organismic valuing process theory (OVPT) (Joseph, 2004) to be appreciated as a normal, human response to trauma as opposed to a 'disorder.'

The PCA's theoretical perspective on trauma represents a radical, non-conformist view of psychological distress. It opposes the dominant medical discourse which characterises PTS as disordered and dysfunctional. The humanistic paradigm is inherently oppositional to the prevailing 'illness' paradigm. It is important to preface the rest of this dissertation with an appreciation of this before assessing the literature. The significance of this is reflected in the dominant theoretical themes identified during the review process, person-centred (PC) theory of personality (to include OVPT) and person-centred views on psychopathology accounted for 22 out of 40 papers. 13 papers are representative of contemporary PC approaches such as focusing-oriented theory, experiential theory, emotion focus theory & existential theory. 4 papers are client specific, including gendered perspectives & positionality to sexual orientation.

Methodology & Method

Methodology

This review aims to establish whether the person-centred experiential approach to post-traumatic stress is an effective therapeutic approach. To answer this question, a systematic literature review of existing theoretical literature, quantitative studies and qualitative studies is conducted. Systematic reviews were initially used in the fields of medicine, information and engineering from 1990's onwards before entering the fields of humanities, social sciences and psychology (Boell et al, 2010). They have also been dominated by meta-analyses of statistical data from controlled trials to inform health and social policy (Gough et al, 2012). The highly structured nature of a systematic review should render it reproducible and minimise bias in search and selection (Xiao & Wtason, 2019) and preferably utilise an infrastructure reporting system such as PRISMA (Gough et al, 2012). This dissertation has attempted to minimise potential bias, maximise replicability and present a comprehensive account of the search and selection procedures as evidenced in the 'Method' section. However, Boell et al (2010) challenge the idea of reproducibility in systematic reviews, claiming databases often yield inexact results and search terms can vary in an indefinite manner. For this reason, three different databases were accessed alongside twelve different search terms as evidenced in the 'Method.' Boell et al (2010) further argue for a 'hermeneutic' (Heidegger, 2002) approach to systematic literature reviews outside of the medical field, suggesting the back and forth, iterative process of searching and refining for deeper meaning is better suited to the philosophical foundations of qualitative research. The initial literature search of this dissertation returned 1,137 results. However, the iterative process of reading and understanding the relevance of individual papers in relation to the intrinsic meaning of the research question reduced this number to 64.

Gough et al (2012, p.2) remark that systematic reviews vary greatly in their "ontological, epistemological, ideological, and theoretical stance, their research paradigm, and the issues that

they aim to address.” This is further complicated by the fact the primary research being reviewed is often of a different paradigm and theoretical/epistemological position to the systematic review itself. This was a challenging aspect of the dissertation as it aims to review theory, quantitative and qualitative studies in a qualitative manner. Despite the fact there are some colourful pie charts reflecting the number of studies under each theme, the study is not quantitative. These were included to demonstrate the systematic nature of the selection process and subsequent refining and bracketing of the literature into emergent themes using a thematic analysis approach (Braun & Clarke, 2006). This represented a more hermeneutic approach to refining meaning in the context of the larger body of literature than any kind of quantitative analysis.

This study deviates from the standard systematic review which is more suited to aggregative as opposed to interpretive syntheses (Dixon-Woods et al, 2006). This review is not conventional in its approach as it attempts to analyse theoretical literature and literature from different research paradigms (qualitative and quantitative). Booth & Carroll (2015) remark on the rarity of systematic reviews of theory but suggest they can be useful in informing best practice for interventions. The study makes links in the ‘Discussion’ chapter between the nature of theoretical inquiry observed in the review and subsequent studies conducted. Furthermore, the type of literature review conducted, whilst systematic in its method, provides critical and thematic analysis throughout (Braun & Clarke, 2006); (Dixon-Woods et al, 2006). The review is inductive and analytical in nature borrowing from both the ‘thematic synthesis’ (Thomas & Harden, 2008) and ‘critical interpretive synthesis’ (Dixon-Woods et al, 2006) approaches to literature reviews. Theory building forms part of interpretive synthesis, the study demonstrates an existing body of theoretical papers which offer a robust theoretical foundation for the person-centred approach to trauma. However, certain themes emerging from the data would suggest a more experiential rather than classical client-centred approach to trauma is effective. Dixon-Woods et al (2006) suggest that a ‘critical interpretive synthesis’ is better conducted within a team setting to offset potential bias and enhance

transparency. The very nature of such a review renders it open to interpretation and therefore not as well suited to an individual researcher with the risk of subjective bias this entails.

The epistemological foundations of the study are located in a constructivist-interpretivist paradigm (Timulak, 2015). The issue of subjective bias is ontologically inherent in this paradigm. I, as the researcher, review and analyse the findings through a particular lens and as a person-centred experiential psychotherapist this is undoubtedly a humanistic one. This is further complicated by the fact much of the primary research and theoretical papers are grounded in a humanistic paradigm which is seeking to distinguish itself from the dominant, reductionist, medical paradigm which currently dictates therapeutic recommendations for PTSD (NICE, 2018). My analysis of the quantitative studies included in this review yields some unfavourable results for the classical client-centred approach to trauma. These are critically evaluated in the 'Discussion' chapter as objectively as possible. Additionally, I selected ten articles from my personal academic book collection, a process in which subjective bias is inherent. Ontologically, I was flirting with the 'critical theory' paradigm which seeks to address power relations and believes that reality is constructed by medical, cultural, socio-economic, political, ethnic and gender values (Scotland, 2012). In many ways, the study is critical of the dominant medical paradigm which occupies the power to dictate the therapies offered for PTS and whilst I and person-centred therapy inhabit a humanistic paradigm, my intention is to remain as reflexive and objective as possible for the purposes of this study.

Method

In order to examine whether the PCA is an effective therapeutic approach for PTS, this study has reviewed literature from 1940 to 2022. The PCA began in the 1940's with the advent of Carl Rogers' *'Counselling and Psychotherapy: Newer concepts in practice'* (1942). PTSD was first included in DSM-III in 1980 (APA, 1980) and as a subsequence the majority of person-centred academic research on PTS began in the early 2000's with Stephen Joseph (2004). PC academic research into PTSD is in its infancy and Joseph (2004) attributes this to the PCA's unwillingness historically and as a humanistic paradigm, to engage with illness ideology & the language of 'disorder.'

Traditionally, systematic reviews may focus on one area of research, for example a meta-analysis of quantitative studies or a narrative synthesis of qualitative studies (Grant & Booth, 2009). Literature reviews of theoretical papers are less common (Booth & Carroll, 2015). Due to the infancy of this field and the limited amount of literature available on the PCA to PTS & PTG, the searches conducted included all three types of academic literature:

- Theoretical Papers
- Qualitative Studies
- Quantitative Studies

A further reason for this is to establish a more comprehensive picture of the existing evidence to illustrate whether the PCA is an effective therapeutic approach for PTS. This needs to include the theoretical basis for the PCA to PTS & PTG and of course any existing empirical research. To obtain search results three databases were accessed:

- EBSCOhost
- APA PsycInfo
- LJMU (Liverpool John Moore's University) Discover

Gusenbauer & Haddaway (2019) examined 28 academic search systems & concluded that only 14 were appropriate for systematic reviews. The results included both APA PsycInfo and EBSCOhost. LJMU Discover is the online library database used within my university & provides a rich source of journals & academic books. The search parameters included a date range of 1940-2022 and specified 'academic books' & 'peer reviewed journals' only. Grey literature was not included in the study due to the importance of demonstrating the existence of high quality, peer-reviewed, academic research to examine the efficacy of the PCA to PTS & PTG. The following search terms were used identically across all three databases:

- Person-centred psychotherapy AND Trauma
- Person-centred psychotherapy AND PTSD
- Person-centred counselling AND Trauma
- Person-centred counselling AND PTSD
- Person-centred therapy AND Trauma
- Person-centred therapy AND PTSD

Additionally:

- Client-centred psychotherapy AND Trauma
- Client-centred psychotherapy AND PTSD
- Client-centred counselling AND Trauma
- Client-centred counselling AND PTSD
- Client-centred therapy AND Trauma
- Client-centred therapy AND PTSD

It is important to acknowledge the changing terminology and the reasons for searching for both 'person-centred' and 'client-centred.' Initially, Rogers (1942) chose to call his approach to

counselling the 'non-directive' method but also began using the term 'client' as opposed to 'patient' to symbolise an anti-medical model stance. With a shift in focus towards centring the clients' experience over the therapist's expertise, Rogers (1951) then changed to 'client-centred.' In 1963, after leaving academia, Rogers co-founded the 'Center for Studies of the Person' where he then started to use 'person-centred' to describe his work (Kirschenbaum, 2004, 2007). Currently, both 'client-centred' and 'person-centred' are used interchangeably.

Furthermore, there are variances in referencing what is most widely acknowledged as post-traumatic stress disorder (PTSD). The PCA is a humanistic paradigm and thus rejects illness ideology (Joseph, 2021). The inclusion of 'Disorder' in the term 'PTSD' characterises it as a pathological process as opposed to a normal emotional/cognitive reaction to both extreme and abnormal human experiencing (Joseph & Williams, 2005). This dissertation prefers to use 'Post-traumatic stress' for this reason except when it is directly referencing literature that has used 'PTSD.' Joseph & Williams (2005) attest to the preferred use of 'Post-traumatic stress.' Van der Kolk (2000) refers to PTSD as simply 'trauma' or 'psychological trauma' as early as 2000. For these reasons, the search terms 'PTSD' and 'Trauma' were both used across all three databases.

Figure 1 below shows a 'PRISMA' diagram (Page et al, 2021). This demonstrates the systematic search process undertaken across EBSCOhost, APA PsycInfo and LJMU Discover. A total of 1,137 search results were returned. 465 duplicate records were removed and 434 excluded after reading abstracts and establishing that they did not meet quality criteria and/or have any focus on the PCA to PTSD/trauma. A total of 899 records were not retrieved. Finally, 238 records were read in full & assessed for eligibility. 130 records were then excluded for not having sufficient focus on person-centred psychotherapy and 44 were excluded for not adequately focusing on PTSD/trauma. This left a remaining 64 records which have been included in this review, 10 of which were sourced from my personal book collection. Appendix four contains the 'PRISMA' checklist for systematic reviews

Appendix one provides a breakdown of every paper included in the review in order of database and categorises them under theory/quantitative/qualitative. 7 studies were included from EBSCOhost, 1 study from APA PsycInfo, 46 studies from LJMU Discover and 10 from my personal book collection. It appears that the majority of eligible search results returned were from LJMU Discover. The 'PCEP' journal (Person-centred experiential psychotherapy) held on the LJMU Discover database returned a rich source of eligible records unlike EBSCOhost & APA PsycInfo. Appendix two breaks the literature down by theme and sub-themes and appendix three presents the quantitative/qualitative studies in tabular form as well as by theme and sub-theme.

PRISMA 2020 flow diagram for new systematic reviews which includes searches of databases, registers & other sources which for the purposes of this study includes academic books.

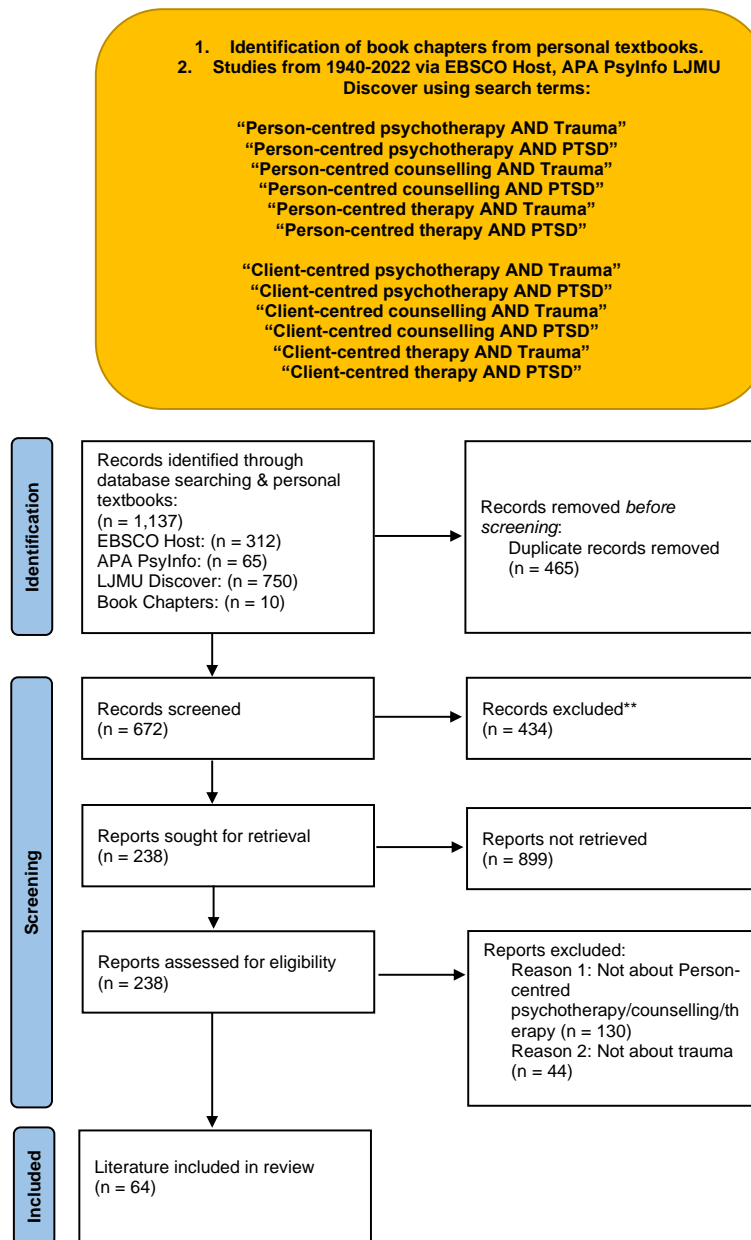


Figure 1 ‘PRISMA’ diagram showing the search & exclusion process (Page et al, 2021)

Presentation of findings

The following pie charts illustrate the themes identified in the literature review. Figure 2 below demonstrates the breakdown of studies and their primary focus:

1. Forty theoretical papers
2. Four theoretical papers exploring the person-centred approach to post-traumatic stress through a cultural lens.
3. Thirteen quantitative studies
4. Seven qualitative studies

The ensuing pie charts provide a more detailed breakdown of the themes identified within each of the above 4 categories.

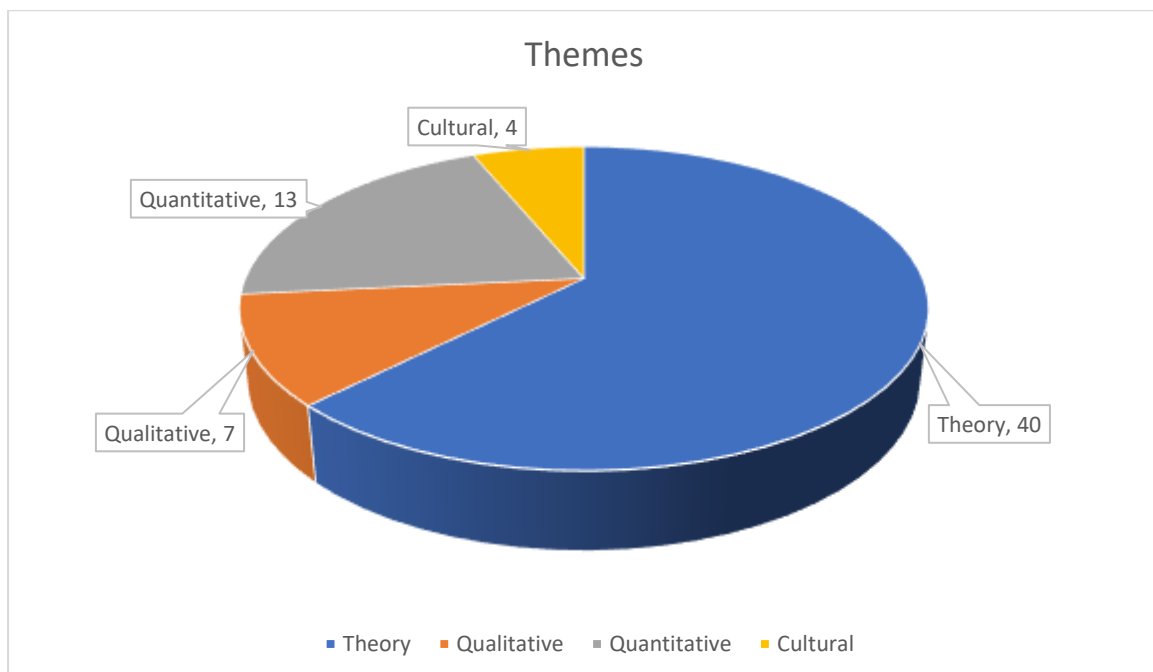


Figure 2

Theoretical papers: breakdown of sub-themes

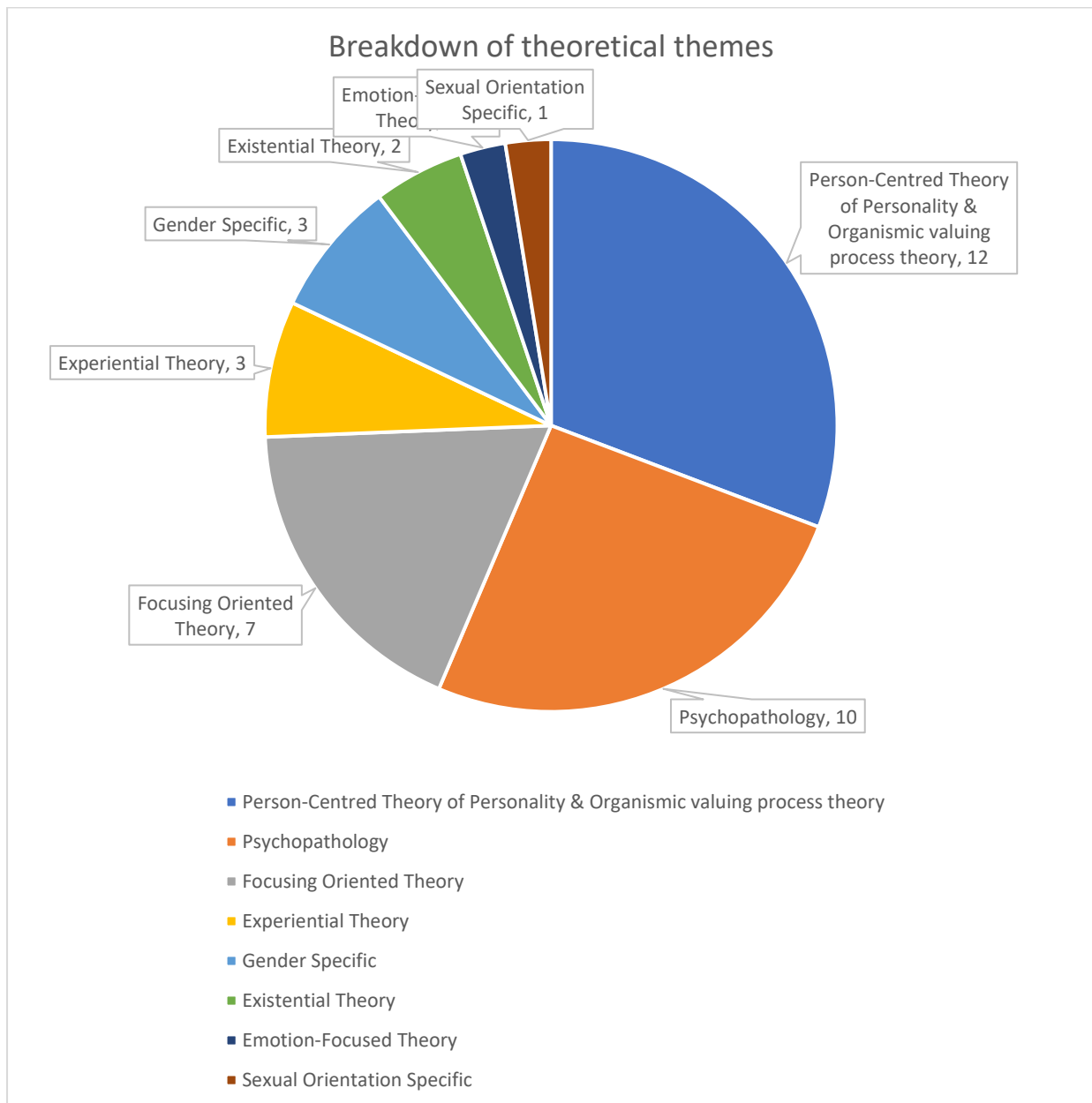


Figure 3

Quantitative studies: breakdown of sub-themes

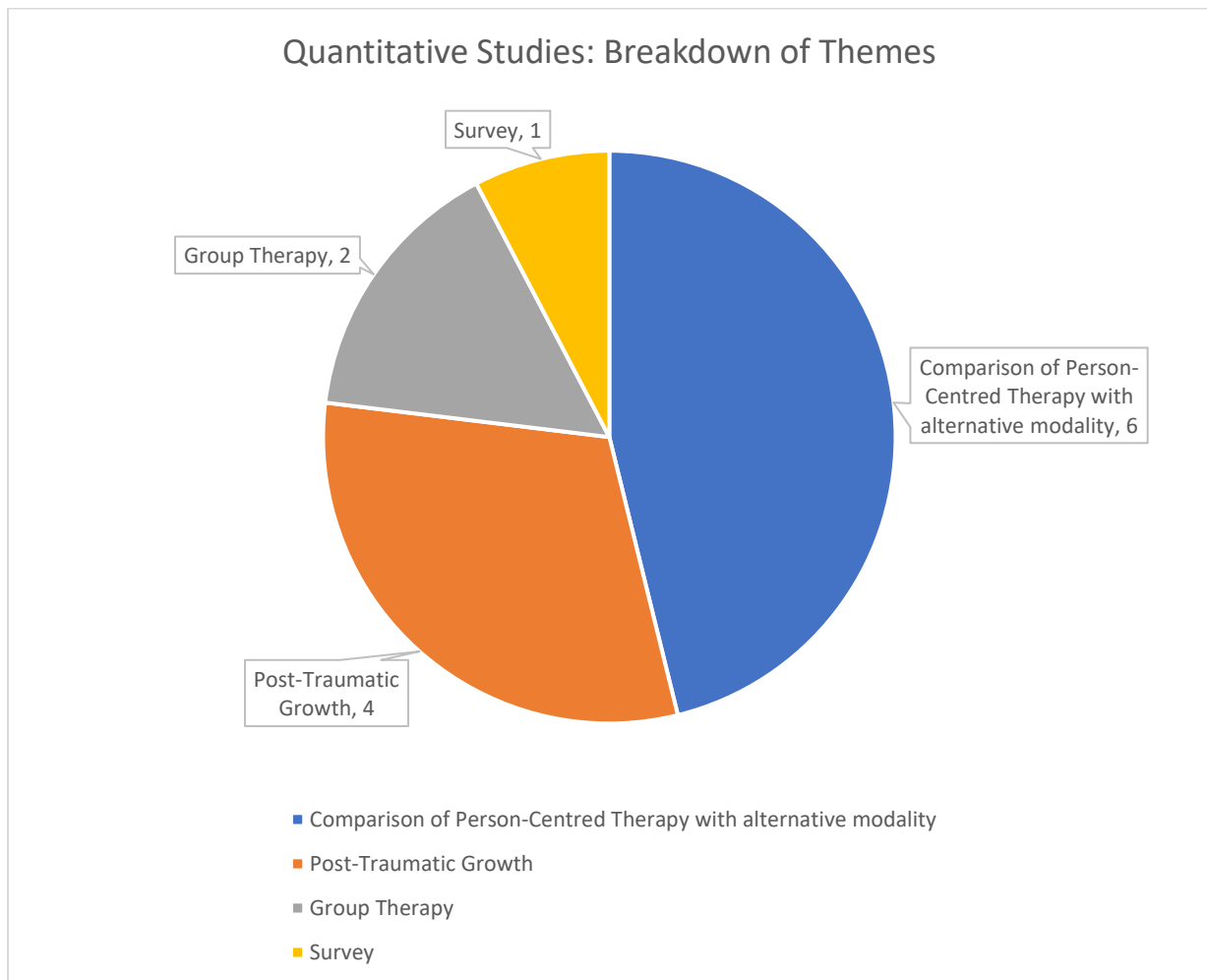


Figure 4

Qualitative studies: breakdown of sub-themes

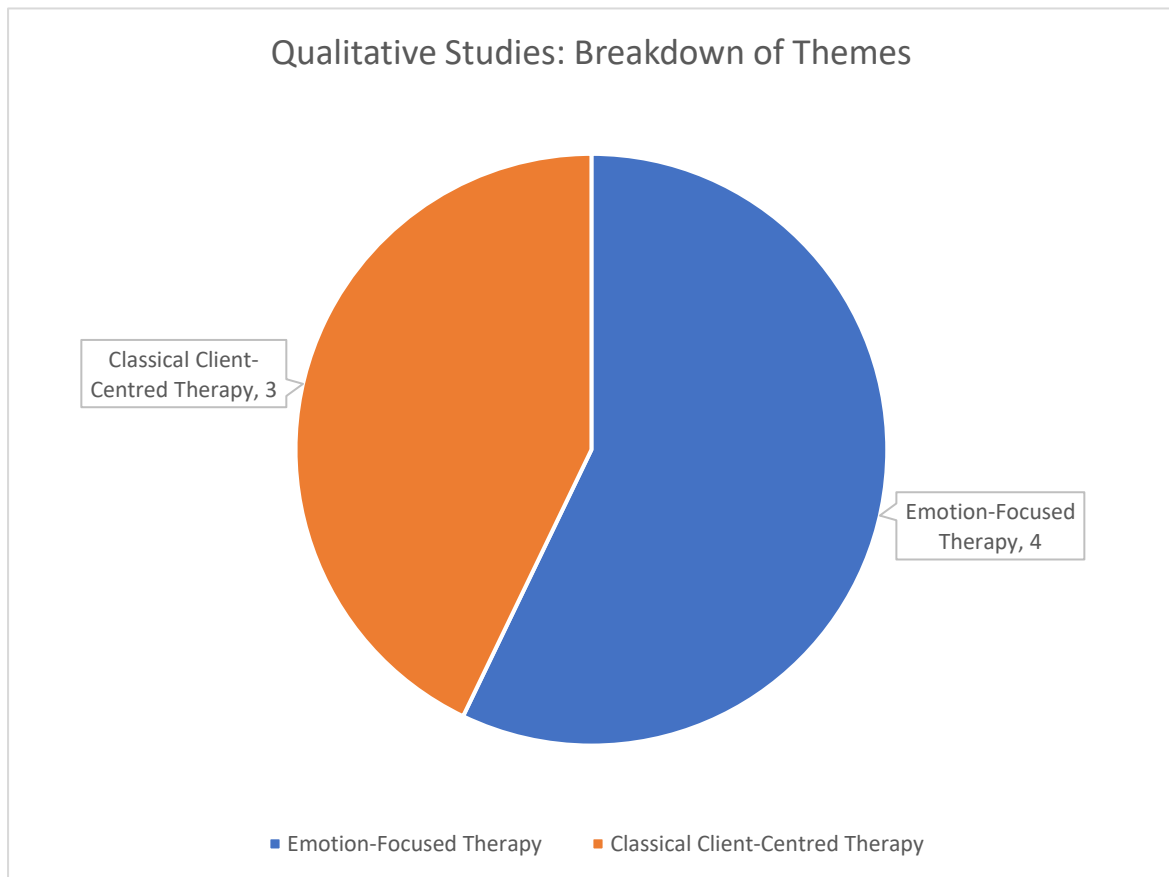


Figure 5

Cultural perspectives on post-traumatic growth theory: breakdown of sub-themes

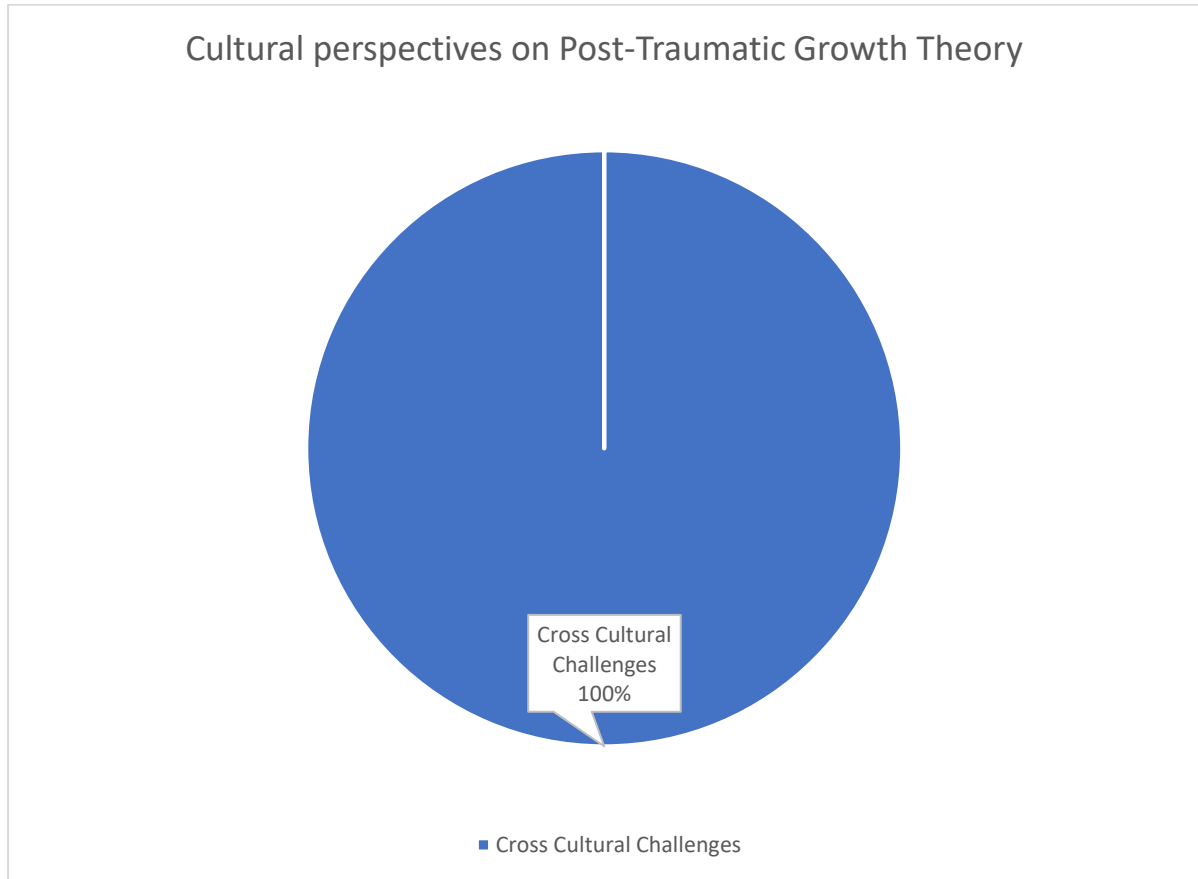


Figure 6

Theoretical perspectives on the person-centred approach to post-traumatic stress

The systematic literature review identified forty papers discussing theoretical perspectives on the person-centred approach (PCA) to post-traumatic stress (PTS). Analysis of theory can be important when reviewing the efficacy of a therapeutic approach. Certainly, other domains such as public health policy and social care are often typified using complicated interventions. In turn, use of one or more theories or models will likely guide the design of complicated treatments (Dieppe et al, 2008).

Each of the following sub-themes are reviewed separately to assess their effectiveness for the PCE-A to PTS & PTG:

- Person-centred theory of personality and organismic valuing process theory
- Person-centred psychopathology
- The theory of focusing-oriented therapy
- The theory of person-centred experiential therapy
- The theory of existentially informed person-centred therapy
- The theory of emotion-focused therapy for complex trauma
- Person-centred theory on gender specific trauma
- Person-centred theory on sexual orientation specific trauma

Please refer to Appendix Two for a reference list of all papers reviewed in each section.

Person-centred theory of personality & organismic valuing process theory

12 papers were identified under this theme, 7 of which were in peer-reviewed journals with the remainder from my personal collection of academic books.

Joseph's (2004, 2005, 2006) characterization of Rogers' (1957, 1959) organismic valuing process and actualizing tendency as a growth model demonstrates that it explains traumatic stress processes in a manner compatible with contemporary trauma theories (Carrick & Joseph, 2013). Joseph (2004) draws on Rogers' (1959) paper to account for the disintegration and disorganisation of the self-structure that occurs because of trauma. At times, experiences which are 'subceived' as threatening to the self-structure are denied to awareness to maintain the illusion of congruence, this can be understood as a defence mechanism. Of course, true congruence occurs when experiences are admitted to awareness and accurately symbolised to the self, resulting in a process of change in a person. However, when an experience is too threatening for the illusion of congruence to be maintained and defence mechanisms fail then breakdown of the self-structure begins (Rogers, 1959).

Joseph (2004) highlights the social-cognitive theories of Horowitz (1986) and Janoff-Bulman (1989; 1992) to illustrate the resemblance between their ideas on PTS and Rogers' (1959) OVPT, linking Rogers' (1959) theories on the breakdown of the self-structure to their theories on the fragmentation of an individual's assumptive world. Joseph (2004, p.106) continues by comparing Horowitz's (1986) definition of "intrusive and avoidant states" as a consequence of the impulse to re-integrate traumatic experience, known as the "completion tendency," to Roger's beliefs on organismic valuing. Organismic valuing theory (OVT) claims that fragmentation of the self-structure happens when a person simultaneously attempts to reject their experiences to maintain their pre-existing self-structure whilst accurately symbolising it in conscious awareness. Joseph (2004, p.106) clarifies this, "*The person is on the one hand attempting to accurately symbolize in awareness their experience and on the other to deny their experiences.*" The result of this fragmentation is incongruence. Joseph (2004) illustrates the similarities between the PCA to PTS and social-cognitive theories:

“Person-centred and social-cognitive conceptualization of post-traumatic stress and growth

PERSON-CENTRED MODEL	SOCIAL COGNITIVE TERMS
<i>EVENT WHICH IS SUDDEN, OBVIOUS AND DEMONSTRATES INCONGRUENCE BETWEEN SELF AND EXPERIENCE.</i>	<i>TRAUMATIC EVENT WHICH SHATTERS BASIC ASSUMPTIONS ABOUT THE SELF AND WORLD.</i>
↓	↓
<i>BREAKDOWN AND DISORGANISATION OF SELF-STRUCTURE MANIFESTED IN AWARENESS AND AT OTHER TIMES AS DEFENCE.</i>	<i>PHENOMENOLOGY TYPICAL OF POST-TRAUMATIC STRESS (INTRUSIVE AND AVOIDANT EXPERIENCES).</i>
↓	↓
<i>PERSON CENTRED THERAPY LEADS CLIENT TO ACCURATELY SYMBOLISE THEIR EXPERIENCE IN AWARENESS.</i>	<i>EXPOSURE BASED TECHNIQUES LEAD TO RE-EXPERIENCING.</i>
↓	↓
<i>REINTEGRATION OF SELF AND EXPERIENCE IN A WAY CONSISTENT WITH ACTUALISING TENDENCY.</i>	<i>PTSD SYMPTOMS DIMINISH.</i>
↓	↓
<i>BECOME MORE FULLY FUNCTIONING.</i>	<i>PHENOMENOLOGY TYPICAL OF POST TRAUMATIC GROWTH.”</i>

Joseph (2004, p.119)

Joseph & Williams (2005) propose a three phase ‘psycho-social’ framework for understanding the differences in how individuals process trauma. Drawing on Rachman’s (1980) theories on emotional processing alongside the cognitive processing theories of Beck (1976), Horowitz (1986) and Janoff-Bulman (1985, 1989, 1992) they develop three theoretical principles to account for PTS as a normative process as opposed to a disordered one:

1. Subjective appraisal: everybody has different reactions to trauma.
2. Normal process: it is a normal reaction as opposed to abnormal.
3. Personality and social psychology factors: cognitive-emotional processing of trauma is impacted by an individual’s personality and their social environment.

(Joseph & Williams, 2005)

Joseph & Williams (2004) suggest that their 'psycho-social' model is compatible with OVT which underpins the PCA to trauma. Furthermore, they believe OVT accounts for individual differences in the subjective appraisal process and accommodation (as opposed to just assimilation) of the traumatic experience. They propose three outcomes, the third of which is the most preferable and consistent with the PCA to trauma:

1. *"Experiences can be assimilated (i.e. return to pre-trauma baseline)*
2. *Experiences can be accommodated in a negative direction (i.e. psychopathology)*
3. *Experiences can be accommodated in a positive direction (i.e. growth)"*

(Joseph & Williams, 2005, p.435)

Joseph (2021) argues that PTS & PTG should be thought of as part of the same psychological process. Joseph & Linley (2006) provide greater focus on how the PCA to PTG offers an effective and unique therapeutic model. They propose that there are three main growth models:

1. The functional-descriptive model of Tedeschi and Calhoun (1995, 1996, 1998a, 1998b, 1999, 2004a, 2004b)
2. The meta-theoretical perspective of person-centred theory and organismic valuing theory (Rogers, 1959) (Joseph, 2004)
3. The biopsychosocial-evolutionary model of Christopher (2004)
(Joseph & Linley, 2006)

These three complimentary theories provide valuable insight into PTG processes. However, Joseph & Linley (2006) remark that organismic valuing theory is the only model to assist with how a person integrates their traumatic experience and accommodates for it in a positive direction (Joseph & Williams, 2005). It is an actual component of OVT. Whereas they argue that the 'completion tendency' of the cognitive-emotional models (Tedeschi & Calhoun, 2004) does not provide a theory of how a person accommodates their traumatic experience. Joseph & Linley (2006, p.1049) believe

more client-centred, experiential, and existential therapies will prove beneficial in promoting post-traumatic growth and comment:

“The implication of person-centred theory is that although a range of therapeutic approaches might work to help alleviate the symptoms of PTSD, only those therapeutic approaches that are actively helping the person to congruently integrate self and experience will lead to growth.”

Joseph et al (2012) provide an overview of the latest developments in PTG, drawing together research findings and current measurement tools:

- Changes in Outlook Questionnaire (Joseph et al., 1993)
- Perceived Benefit Scale (McMillen & Fisher, 1998)
- Post-Traumatic Growth Inventory (Tedeschi & Calhoun, 1996)
- Stress-Related Growth Scale (Park et al., 1996)
- Thriving Scale (Abraido-Lanza et al., 1998)
- Psychological Well-Being Post-Traumatic Changes Questionnaire (Joseph et al, 2012)

Main theoretical concepts including OVT are discussed alongside the relationship between PTS and PTG. They propose a new “affective-cognitive processing model of post-traumatic growth” (Joseph et al, 2012, p.316) which advances Joseph & Williams (2005) psycho-social framework to account for the different ways a person might accommodate their traumatic experience through an ‘appraisal process.’ The model is consistent with OVT and the PCA and offers a series of suggestions on clinical interventions. Joseph (2015) builds on how the PCA to PTS and PTG offers an alternative, non-medicalising perspective with a robust theoretical foundation but admits that evidence for this is limited. Case-study research provides insight into person-centred therapeutic encounters with traumatised clients but Joseph (2015) cites the importance of conducting fresh research into the effectiveness of the PCA to PTS & PTG. Patterson (2017) elaborates on the importance of measuring

PTG following adversity, specifically referring to both the 'Changes in Outlook Questionnaire' (Joseph et al, 1993) and the newer 'Psychological Well-Being Post Traumatic Changes Questionnaire' (Joseph et al, 2012). Patterson (2017) argues that person-centred therapists and researchers should consider using measurement tools to support the effectiveness of the PCA to PTS & PTG but only provided they are consistent theoretically with the PCA.

Carrick & Joseph (2013) address the challenges faced by person-centred therapists in counselling traumatised clients, illustrating the process of breakdown and disorganisation of the self-structure via a short case-study. They offer insightful suggestions on how OVT and the core conditions of empathy, congruence and UPR assist the client in reorganising their self-structure and accurately symbolising their traumatic experience in awareness thus achieving congruence. Reference is made to the usefulness of more process-experiential approaches (Elliott et al, 2003) to enhance engagement with the clients' process.

Similarly, Quinn (2008) focuses on the importance of the core conditions, particularly congruence and asks whether the PCA is effective when working with combat veterans with PTSD. Drawing on Joseph's (2004) conceptualisation of Rogers' (1959) theory of personality, he explains how PC therapy helps the veteran towards a reorganisation of their self-structure which is incongruent with their pre-trauma self. Quinn (2008, p.459) describes the PCA as an "underutilised and generally ignored therapeutic orientation in the treatment of combat PTSD." He argues that the uniqueness of the approach lies in its authentic intersubjectivity, drawing a distinction between what he refers to as the "utilitarian" and "genuine" congruence of the therapist (Quinn, 2008, p.463). Utilitarian congruence is inauthentic and technique driven with the aim of imposing an outcome on the client. Genuine congruence allows for the other two core conditions of empathy and UPR to flourish in the therapist, enabling the therapist to facilitate psychological change from within their client in a growth promoting environment (Quinn, 2008). This is essential in the treatment of combat veterans with PTSD who are suffering from extreme incongruence and

struggling to integrate their traumatic experiences. Quinn (2008) argues that genuine therapist congruence, the foundation of Rogers' prerequisites for therapeutic personality change is essential in counselling war veterans.

Warner (2013) introduced the idea of 'difficult client process' to enhance the PCA to counselling traumatised clients, explaining that this offers an additional facet to the 'necessary and sufficient' conditions of personality change (Rogers, 1957). Warner (2013) believes trauma impacts an individual's processing capacities in a similar fashion to Kohut's (1984) self-object theories and advises caution in the nature of the comments, interpretations and reflections made by the therapist. Warner (2013, p.349) describes client's with 'fragile process' as having difficulty:

- *"Holding experience in attention without extreme vulnerability or shame.*
- *Modulating the intensity of experience.*
- *Starting and stopping experience.*
- *Naming phenomena in ways that fit with the totality of their experience.*
- *Taking in the experience of others without feeling that their own experience and sense of self has been annihilated."*

Warner (2013) argues that acknowledging when a client is in 'difficult process' will assist client-centred therapists in staying closely connected to the clients' experiencing during the therapeutic encounter, enhancing their ability to process traumatic material.

Hook & Murphy (2016) believe that Warner's (2013) conceptualisation of processing styles does not replace conditions of worth theory, arguing that processing theory is already implicit in classical CCT. The universal applicability of incongruence theory eliminated the requirement for the PCA to be guided by diagnosis. However, categorising experience into distinct processing styles, forces therapists to adopt a more diagnostic approach to distress (Hook & Murphy, 2016). Hook & Murphy (2016) continue to argue that processing theory asserts that people with a fragile process

will exhibit characteristics of borderline and other personality disorders (Warner, 2000b) and suggests victims of childhood abuse are more likely to experience dissociative process (Warner, 2008). The danger is that consciously adapting therapeutic responses to engage with different processing styles moves the PCA “a step closer to becoming a specificity-diagnosis-treatment model of psychotherapy” (Hook & Murphy, 2016, p.297). This is pertinent for the PCA to PTS as person-centred therapists seek to understand this phenomenon through a humanistic paradigm as opposed to a medical, diagnosis driven paradigm.

Finally, Murphy & Joseph (2016) and Joseph (2017) provide a summary of the historical foundations and theoretical developments to support the PCA to PTS and PTG. Murphy and Joseph (2016) illustrate the breakdown of the self-structure, subsequent intrusive and avoidant states and re-evaluation of meaning/integration via a short vignette. They support this with an analysis of their ‘affective-cognitive processing model of post-traumatic growth’ (Joseph et al, 2012) and demonstrate how this framework is compatible with the person-centred core conditions of empathy, congruence and UPR. Joseph (2017) and Murphy & Joseph (2016) stress the importance of the PCA to PTS and PTG as being understood as an ‘approach’ as opposed to a set of techniques. The guiding principle and philosophy of which is to “create facilitative social environment conditions that will enable the client to evaluate experiences for themselves and to find their own directions in life” (Murphy & Joseph, 2016, p.130). Joseph (2017) asserts that person-centred theory of personality is consistent with the phenomenology of PTSD and also provides a theoretical framework for understanding PTG through OVT. Joseph (2017) concludes by stressing the need for evidenced based research to support this. The next part of this dissertation will now review theoretical papers on person-centred psychopathology.

Person-centred psychopathology

10 papers were identified under this theme, 6 of which were in peer-reviewed journals with the remainder from my personal collection of academic books.

The PCA is a humanistic model and sits in direct opposition to the medical model of distress, it does not seek to classify 'distress' but rather to understand the meaning that distress holds for different people (Rundle, 2017). Crisp (2018, p.82) comments that Rogers' PCA offers a "radical alternative to the dominant objectivist and disease-centred biomedical model of service delivery." Whilst, Hawkins (2017, p.275) in writing about the PCA to historical child-abuse, seeks to encourage a more collaborative understanding between those who view "human distress in pathological terms and those who see it in more adaptive terms." Historically, PTS has been understood from a pathological perspective, as an 'illness' or 'disorder.' However, huge developments have been made in our understanding of how trauma impacts the brain and body and in how therapists can integrate this knowledge into their practice (Van der Kolk, 2015, Spring, 2018; 2019).

This creates tension within the PCA to PTS. Additionally, criticism exists regarding the efficacy of the PCA, alongside claims that the PCA does not have a theory of personality (Wheeler, 1995). Joseph (2004) argues that whilst the PCA has been criticised (Purton, 2002) for not providing a comprehensive enough account of psychological disturbance beyond 'conditions of worth' (Rogers 1959) theory, this is due to a simplistic understanding of person-centred theory. Wilkins (2017) supports Joseph's (2004) sentiment, illustrating how Rogers (1959) paper, *"A theory of therapy, personality and interpersonal relationships, as developed in the client-centred framework,"* demonstrates a theory of child development, both 'healthy' and 'dysfunctional' development, conditions of worth theory and incongruence theory. Rogers (1959) paper presents the foundation upon which person-centred psychopathology is understood.

Furthermore, Joseph (2021) argues mainstream research on PTS and PTG has raised theoretical dilemmas and identifies how a reliance on medical model discourse has obscured our understanding of the link between PTS & PTG. Joseph (2021) explores the idea of PTG as simply resilience, a normal process, imagined, adaptive or a type of personality change asserting that such theoretical dilemmas only present themselves when we try to understand PTS and PTG through the medical model of distress. Humanistic psychology understands PTS & PTG as part of the same psychological process and as a normal, human response to trauma as opposed to a 'disorder' (Joseph, 2021).

The previous section of this dissertation discussed how incongruence between organismic experiencing and the self-concept leads to a breakdown in the self-structure following (a) traumatic event(s). From a PC perspective, this is how PTS is understood to occur and also accounts for how incongruence leads to other types of psychological maladjustment that may be referred to as mental illness, disease, personality disorder, psychoses and neuroses in other models (Wilkins, 2017). Holdstock & Rogers (1977, p.136) describe psychological maladjustment from the person-centred perspective:

"...the continuing estrangement between self-concept and experience leads to increasingly rigid perceptions and behaviour. If experiences are extremely incongruent with the self-concept, the defence system will be inadequate to prevent the experiences from overwhelming the self-concept. When this happens the self-concept will break down, resulting in disorganisation of behaviour. This is conventionally classed as psychosis when the disorganisation is considerable."

Wilkins (2017, p.39) states that four person-centred theories on psychopathology currently exist:

-Psychological Contact: Prouty (1990; 2002a; 2002b; 2002c; 2002d) developed the idea of pre-therapy which can be described as a variation of Roger's (1957) first 'necessary and sufficient'

condition of 'psychological contact.' Prouty believed mentally impaired and/or psychotic individuals experienced difficulty in achieving psychological contact with the therapist, a pre-requisite of the therapeutic encounter. Prouty (2002a, 2002c) provides evidence-based research for conceptualising 'contact' across three levels: reflections, functions and behaviours.

Rutherford (2007, p.160) describes her profound and unique experience of counselling a dissociated client with a diagnosis of PTSD, saying they presented in a "state of abject terror" and "shell shock." The account demonstrates Rutherford's use of Prouty's (1990) contact reflections to connect with the clients' internal experience and external reality, enabling them to connect to themselves in the present moment. Rutherford (2007, p.161) comments that "This connection and orientation was in stark contrast to her potentially annihilating experience of being frozen in time in relation to the traumatic event." Rundle (2017) also refers to the use of 'pre-therapy' (Prouty, 1990) in working with psychotic clients to create an anchor to external reality.

-Styles of processing: This has been covered briefly in the previous section of this dissertation with reference to Warner (2000a; 2000b; 2008; 2013; 2017) and the different 'processing' styles of clients. These are 'fragile process,' dissociated process' and 'psychotic process.' Rundle (2017) references how individuals with a 'psychotic process' (Warner, 2002) may struggle to process their experience of hallucinations and delusions within cultural norms, people with 'dissociated process' separate themselves from their traumatic experience whilst 'fragile process' means individuals struggle to process emotion on both an intra and interpersonal level.

Opposition to the idea of processing styles exists (Hook & Murphy, 2016) due to the fact it sits closer to a diagnostic-led approach to which the humanistic paradigm is opposed. However, Wilkins (2017) offers some reasonable person-centred contributions to support Warner's (2017) assertions. Notably, that Rogers (1967) refers consistently to the idea of a person being in 'process' as opposed to a fixed or rigid state of being. Warner's (2017) notion of a person's unique way of

cognitively and emotionally processing their experience of the world is very different to diagnosed 'personality types and/or disorders.'

Tarnowska et al (2020, p.292) expand on Warner's (2017) theory of processing styles by exploring how the therapeutic relationship can "repair safe other experiences" needed for "normal neurodevelopment." They attribute lack of access to a responsive caregiver in infancy as leading to issues with cognition, emotion regulation, impulse control or as difficulty processing experience and refer to this as 'early adversity.' Tarnowska et al (2020, p.303) stress the importance of understanding the impact this has from a neurobiological perspective describing the "atypical development of subcortical structures, especially the amygdala and its connections to the cortical areas of the brain, including the orbitalfrontal cortex – a structure important for affect regulation." Warner's (2017) theory of 'difficult process' and Rogers' (1957) 'necessary and sufficient' conditions of therapeutic personality change are referred to as a way to recreate the stable, secure, empathic relationship that was lacking in early infancy. Tarnowska et al (2020, p.306) focus specifically on the importance of the therapists' congruence in entering an intensely emotional encounter whilst maintaining autonomy and boundaries, commenting that this "serves as a model for the client, presenting behaviours that enable him/her to be noticed and taken into consideration without destroying the relationship." Furthermore, from a neuroscientific perspective, they state the therapeutic environment alters brain neuroplasticity, providing clients with difficult process, the opportunity to find healthier ways of adapting to themselves and their social environment. Rutherford (2007) also emphasises the importance of therapists understanding the neurophysiological responses we have to trauma to enhance empathic attunement. Hawkins (2017) cites Warner (2000) in describing the dissociative 'process' as a survival strategy for victims of childhood abuse.

-Issues of power: This idea of psychopathology departs from the notion that psychological disturbance is intra-personal but is rooted in the cultural and social environment (Wilkins, 2017). A

latter part of this dissertation will discuss the cultural challenges of the PCA to PTS and explore how inequality leads to a greater likelihood of being diagnosed with a 'disorder.' Wilkins (2017) and Rutherford (2012) argue that the PCA faces a problem culturally, politically, and philosophically, as it seeks to understand a person's experience phenomenologically while inhabiting a social environment ruled by Western thinking. Only, Wilkins (2017), Rutherford (2012) and Rundle (2017) consider the cultural and societal impact on an individual and the relationship this has to PTS. Rundle (2017) refers to this as "alienation and authenticity" when describing psychotic experience. Rundle (2017) explains how western society regards psychosis as a disorder, views it negatively and therefore finds it understandable this would lead to feelings of judgement and alienation in a person. The idea of attempting to comply with societal and cultural demands to achieve congruence with the self-concept is central to how incongruence is established. When attempts to distort and/or deny experience fail and false congruence becomes unsustainable then psychological distress occurs (Rundle, 2017).

Rutherford (2012) draws on contributions by Summerfield (2004, p.241) who has explored cross-cultural perspectives on the medical model of distress and believes "The medicalisation of distress entails a missed identification between the individual and the social world." Rutherford (2012) believes the true meaning of a person's traumatic experience cannot be understood if not considered within its cultural context. Rutherford (2012) cites Mearns & Cooper's (2018) existential perspective on PTS which criticises the medical model for neglecting experiential specificity and also Sanders (2017) who is vehemently opposed to the medical model. Rutherford (2012, p.156) argues that it is necessary to understand 'psychological contact' within a socio-economic and cultural context, adding that such "cultur(al) specificity . . . decentralises the influence of dominant systems of thought."

-Incongruence theory: As discussed in the previous section, introjected conditions of worth lead to incongruence between the organismic experience and the self-concept. This creates incongruence

and subsequent psychological disturbance. Kalmthout (2002) remarks that this breakdown between internal and external reality can in some cases lead to psychopathology (Wilkins, 2017). Simms (2011) and Speierer (2013) have attempted to position incongruence within frameworks that outline a PCA to diagnosis. Tudor & Worrall (2006) and Tudor (2011, p.176) propose a "process conception" of incongruence that communicates a sense of impermanence on the client's "state." Biermann-Ratjen (1998) also makes the link between incongruence and psychopathology believing that PTS is a 'symptom' of incongruence. Incongruence theory offers the most comprehensive explanation for the psychopathology of post-traumatic stress. Wilkins (2017, p.49) comments:

"Post-traumatic stress has been one of the psychiatric disorders most extensively explored from the perspective of person-centred theory. Joseph has shown how person-centred theory offers an almost identical model for how post-traumatic stress arises as contemporary social-cognitive theories."

Rutherford (2012); Crisp (2018); Lee (2018); Hawkins (2017); Rundle (2017) & Wilkins (2017) all specifically reference incongruence theory across a range of issues. Rutherford (2012) references Biermann-Ratjen (1998) to describe post-traumatic stress as a symptom of incongruence. Crisp (2018) remarks on the incongruence experienced by individuals with traumatic brain injury (Goldstein, 1995). Hawkins (2017, p.277) refers to the "incongruent infancy" experienced by adult survivors of childhood abuse, describing that when the organismic needs of the infant are neglected, they are susceptible to believing their needs are unimportant. Hawkins (2017, p.277) continues to describe how increased vulnerability results from internalised conditions of worth which "teach the child they are only acceptable if they meet an adult's needs." Rundle (2017) references incongruence theory in the context of understanding psychotic experience and Wilkins (2017) remarks that PC theory has been refined by Joseph & Linley (2005) to provide a theoretical framework for understanding PTS and PTG. Lee (2018, p.2) posits that PC therapists could

understand the construct of PTSD as just “one incongruence amongst many rather than a psychopathology” requiring ‘expert’ intervention.

The biological impact of trauma

There have been significant developments in how we understand the neurobiological impact of trauma on a person (Bales & Carter, 2009); (Fonagy et al 2010); (Grossmann, 2015); (Reeb et al, 2009); (Van der Kolk, 2000, 2015); Spring (2018, 2019). This theme was presented in Rutherford (2012); Warner (2017); Rundle (2017); Hawkins (2017); Lee (2018); Crisp (2018); & Tarnowska et al (2020). The argument that understanding the neuroscience behind trauma to assist in ‘normalising’ people's physical responses to it exists. The frequency of this in the papers reviewed is apparent. If it is not employed in a reductionist fashion but kept within a PC framework of reacting to a client's experience then integration with therapeutic practice is possible. Spring (2018, p.20) remarks it was the "single most useful thing" that helped her recovery. Sanders (2017, p. 11) warns against a propensity to become "totalizing and dismissive of other opinions as the medical model is itself" in our common goal to alleviate human suffering. The PCA's holistic approach to trauma, which takes into consideration "the physical, somatic, cognitive, affective, and spiritual domains of human existence," is not reductive (Sanders, 2017, p.25). Bullock (2020) discusses the safety and efficacy of the PCA to trauma more generally and in contrast to current NICE (2018) guidelines. Bullock (2020, p.1) promotes the use of the traditional ‘tri-phased’ approach of “emotional regulation, trauma memory processing and integration” and suggests this should be integrated with person-centred practice. Additionally, Bullock (2020) encourages the use of psychoeducation regarding the biological impact of trauma to help clients understand what has happened to them as opposed to what is wrong with them.

However, Lee (2018) is critical of the pathologizing nature of current PTSD discourse and cautions against the way in which the PCA is evolving with the medical paradigm. Lee (2018, p.1) rejects the idea of “faulty brains” being the cause of PTSD and envisages a similar deterioration in

the discourse to that which has occurred with BPD (borderline personality disorder). Lee (2018, p.2) continues to argue that PC therapists have entered psychopathology discourse on “its terms rather than person-centred terms” and suggests that PC therapists need to become more person-centred if progress is to be made. I would suggest that changes in brain function are a result of trauma, not a cause of it. Additionally, the papers reviewed in this chapter demonstrate PC alternatives to understanding psychopathology and illustrate that PC therapists are entering PTSD discourse on ‘their terms.’

Focusing-oriented theory

Seven papers were identified under this theme all of which were in peer-reviewed journals.

Eugene Gendlin (1962; 1974), a close colleague of Carl Rogers', developed focusing-oriented psychotherapy. A less non-directive approach than classical client-centred therapy, it is concerned with how we express the meaning of our experience through understanding of 'felt-sense' (Purton, 2012). Of all the contemporary person-centred approaches to trauma, focusing-oriented therapy (FOT) appears to have received the most attention.

Coffeng (2004) describes how the use of imagery is integrated into FOT for three clients who have experienced trauma and makes the distinction between how to approach type one (single traumatic event) and type two trauma (repeated traumatic events) therapeutically. Coffeng (2004, p.279) comments that FOT "takes a middle position between confrontation and relaxation . . . to stay with the anxiety producing problem . . . attend to the . . . 'felt sense'" until the anxiety dissipates and there is a shift or change. Coffeng (2004) believes this process is enhanced when images or words are matched with the felt sense. There are six steps to 'focusing:'

1. Clearing a space (CAS): asking oneself what the problem is? Creating space between oneself and the problem until this emotional distance is genuinely felt.
2. Finding the 'felt sense:' establishing where the feeling resides in the body.
3. Finding a 'handle:' finding images or words that define the 'felt-sense.'
4. Resonating: checking the 'felt sense' against the 'handle.' Does this feel right/accurate?
5. Experiential felt 'shift:' a shift in 'felt-sense' is experienced.
6. Receiving: acknowledging the process and welcoming what has transpired.

(Coffeng, 2004)

Coffeng (2004) explains how the above process is integrated into therapeutic work with a refugee who was experiencing PTS after living in a war zone, a client experiencing a traumatic loss and a

client who had received a diagnosis of PTSD following an emergency caesarean section. Coffeng (2004) expands on the first step of FOT 'clearing a space' (CAS) with reference to a variation of this developed by McGuire (1982; 1983; 1984a; 1984b) for clients in a state of extreme crisis and emotional overwhelm. Instead of simply creating 'space' or emotional distance, McGuire (1982; 1983; 1984a; 1984b) asked her clients to imagine a positive experience, think about it and relay it in detail and 'invite the therapist' to this space with them. The 'problem' is then placed at the edge of this 'positive place' to enable the client to consider it at a distance and from a place of safety. Coffeng (2004) describes using this step of focusing in greater detail with some success via vignettes.

Coffeng (2005) explores the phases of therapy when working with severely traumatised and dissociated clients. The standard three phase approach involves stabilisation, processing trauma and reintegration and is therapist-led (van der Hart, van der Kolk & Boon, 1998). However, Coffeng (2005) draws on Roy (1991) to develop a more client led approach and breaks this down into two main phases. The first phase involves using Prouty's (1994) slow, literal and deliberate contact reflections to achieve the first 'necessary and sufficient' condition of 'psychological contact.' Coffeng (2005) comments that dissociated clients are similar to Prouty's observations on psychotic clients who are pre-expressive with little access to feelings and calls this first phase 'pre-symbolic' or 'pre-experiential' therapy. Clients demonstrate less dissociation after 'pre-experiential' therapy, the slow, literal contact reflections create trust and ground clients in the present. Coffeng (2005, p.94) remarks on the importance of supporting the client at this stage as traumatic memories and emotions resurface, calling it the "critical episode." Coffeng (2005, p.94) suggests the use of McGuire's (1982; 1983, 1984a; 1984b) adapted version of CAS to help clients "feel space and recover, while the traumatic experience is placed at the edge of the positive image." The second phase proposed by Coffeng (2005) moves the client from the 'pre-experiential' to 'experiential' stage of processing at which point it is suggested that Gendlin's (1996) focusing steps are followed. This helps clients to:

“focus on the vague felt sense, which contains all aspects of their traumatic experience . . . when clients have contact with their body, they have access to the body’s healing capacity. Their felt sense can be consulted to repair or reconstruct the traumatic experience.” (Coffeng, 2005, p.95)

Santen (2018) also refers to the importance of appropriate engagement with dissociated clients who are at the pre-experiential stage of the therapeutic process. Drawing on a series of sessions with an adolescent client who is traumatised and dissociated, Santen (2018) explains how ‘experiential body-mapping’ helps to rebuild reality when the undistorted version of reality is intolerable. Santen (2018, p.75) explains that “This focusing-oriented therapy is based on the assumption that trauma once struck straight into the body, and that it should be processed in the same bodily way that it came in.” Santen (2018) illustrates how this approach led to the client’s processing of trauma and helped her to reconnect with reality.

Scharwachter (2005) similarly explores how FOT can be integrated with the traditional three phase model (Van der Hart et al, 1989); (Herman, 1992) for PTSD commenting that its structured approach sits comfortably within this framework. Scharwachter (2005) illustrates how to integrate the two approaches through analysis of transcripts of counselling sessions with a client, arguing that there is significant overlap. Additionally, Scharwachter (2005) asserts that FOT enhances the traditional three-phase model with its unique orientation towards understanding the internal landscape of the felt sense. Rappaport’s (2010) research on how to integrate Herman’s (1992) three phase trauma model with Gendlin’s (1996) six focusing steps for ‘Focusing-Oriented Art Therapy’ (FOAT) corresponds with the work of Coffeng (2004; 2005) and Scharwachter (2005). Rappaport (2010) contributes thirty years of clinical experience in integrating the two approaches for a range of clients including those diagnosed with PTSD; anxiety; depression; bipolar disorder and schizophrenia. Rappaport (2010) provides a structured framework for the integrated approach and comments on the benefits of it including empathic attunement and creating a safe distance from the trauma to

avoid emotional flooding through CAS. The uniqueness of art therapy is in how it “provides materials to contain, symbolise and externalise the felt sense into the art process . . . for clients who are too distant (or dissociated) from their experience,” (Rappaport, 2010, p.140). Katonah (2010) also elaborates on the first step of focusing, CAS, presenting six characteristics which typify direct engagement with it. Katonah (2010) references the positive effect this has on a range of issues from body image to recovery from trauma. More than just the ‘preparatory’ step it was initially proposed as, CAS has been demonstrated (Coffeng, 2004; 2005, Scharwachter, 2005 & Rappaport, 2010) to help with a client’s emotion regulation during counselling for trauma. Rappaport (2010, p.160) comments that “CAS is an experiential way of enabling the body to discern which issue wants to be explored in *this* therapy session and allows a felt sense of the issue to form freshly.”

Young (2013) explores the different approaches to congruence as formulated by Rogers (1959) and Gendlin (1981) and uses examples of how we can understand the impact of trauma on a person. Young (2013) calls trauma an extreme form of incongruence and presents a framework for clinical practice which incorporates and redefines both Rogers ‘incongruence’ (1959) as ‘blocking-incongruencing’ and Gendlin’s ‘incongruence’ (1981) as ‘opening-incongruencing.’ Young (2013) believes that trauma involves both types of incongruence (blocking and opening). In ‘Blocking-incongruencing’ Young (2013, p.241) states that trauma “can block and distort our world, selves and values” through hypervigilance and flashbacks and “our world, self and values can also block trauma . . . through feeling like a coward or a failure.” Whereas, “Opening-incongruencing can be understood as an embodied process that is trying – but is not yet able – to integrate self, values and the world,” (Young, 2013, p.242). Young (2013) has used this approach in working with diverse client populations including, children; adults; those with complex PTSD; autism spectrum disorders; borderline personality disorder and clients at end -of-life as well as suffering from chronic pain and illness.

Experiential person-centred theory

Three papers were identified under this theme all of which were in peer-reviewed journals.

Experiential person-centred theory was initially influenced by Gendlin (1996) and then further developed by Rice (1974) and Greenberg (1997). It is a process-driven approach with far less emphasis on the non-directivity of the therapist than classical CCT and can include interventionist techniques. The approach is relational, guided by radical trust, empathic responding and attending to felt sense (Westwell, 2016).

Vanaerschot (2013) outlines a PC experiential approach to counselling clients struggling with attachment and interpersonal trauma. With the therapist's empathically attuned, supportive presence, traumatised clients begin to explore their traumatic experience and begin to experiment with seeking closeness and connection to feel comforted. Consequently, their sense of self-strengthens, their ability for self-soothing increases, and they begin to feel safer in relation to themselves and others. Vanaerschot (2013) uses a series of vignettes to illustrate the approach focusing on three areas: content, manner, and way-of-being-with – which provide a variety of therapeutic options for clients with interpersonal trauma. Empathic relating and emotion processing are focused on to help the client internalise a safe, accepting 'other' transforming the therapeutic encounter into a corrective experience in and of itself. Vanaerschot (2013) demonstrates how a range of PC approaches are integrated into the sessions, referring to Rogers (1957) necessary and sufficient conditions, Gendlin's (1996) focusing on felt sense, Greenberg, Rice & Elliott's (2003) emotion processing, Prouty's (1998) pre-symbolic contact reflections and Warner's (2000b) fragile process. This combination provides a valuable insight into the integratedness of the PCE-A.

Snijder (2013, p.100) offers a different approach to how traumatised clients can process their experience, drawing on Elliot, Watson, Goldman & Greenberg's (2003) theory on "evocative unfolding, trauma retelling, and meaning creation." Focusing purely on the factual context of an

experience, a narrative is constructed without confronting the traumatic injury in order to minimise potential negative consequences such as re-traumatization, mnemonic distortion or fabrications (Snijder, 2013). A short case study with transcriptions of a session is used to illustrate how narrative reconstruction of the trauma is conducted in such a manner that the path towards (re)experiencing is undertaken only after the factual narrative has been established. Snijder (2013, p.111) comments that this functions “as an intermediate step between retelling and meaning creation, thus creating room for meaning assignment.” Importantly, Snijder (2013) comments that this technique should only be considered once the client has established a safe, trusting relationship with the therapist.

Welling & Ofer (2022) propose a new way of understanding different types of emotional pain and suggest that different experiential techniques should be adopted to ensure therapeutic change occurs. Three types of emotional pain are identified as “basic emotional pain, relational pain and self-pain” (Welling & Ofer, 2022, p.1). ‘Basic emotional pain’ is proposed as the type of pain that results from trauma. Trauma refers to powerful emotional experiences that are experienced as too overwhelming for the organism to process and are retained as traumatic memories in the body. Some situations might serve as triggers that allow these memories to be re-experienced in an overpowering manner, obscuring normal brain functioning. Welling & Ofer (2022) suggest that therapies focused on the bodily experience such as the experiential approach are a way to achieve emotion regulation and reprocess traumatic memories.

Existentially informed person-centred theory

Two papers were identified under this theme both of which were in peer-reviewed journals.

Cooper (2012) describes the existential approach to therapy as intersecting with classical CCT in a complicated manner. Nevertheless, the philosophical roots of each approach share commonalities, particularly from a phenomenological perspective which views the lived experience of the client as more important than the medical paradigm (Cooper, 2012). Less technique driven than focusing-oriented therapy (Gendlin, 1996) and the experiential approach (Rice, 1994), (Greenberg, 1997), the emphasis is more focused on the authenticity of the human encounter.

Cameron (2019, p.1) explores the meaning of 'trauma-focused presence' through an existential-humanistic lens, emphasising the limitations of the medical model. A relationally driven approach, centred on confrontation with the assumptive world and the meaning of existence is put forth. Intra and interpersonal growth and grounded presence are considered alongside the importance of meaning-making for clients by focusing his or her whole attention and effort on a specified direction or prioritised objective in life. Cameron (2019) suggests that the content driven, linear, one size fits all approach of manualised trauma therapy is insufficient to capture the relational depth required to help clients process trauma.

Shumaker & Kelsey (2020, p.22) concur with this in their exploration of the "existential impact of high-conflict divorce on children," suggesting a combination of existential-integrative and person-centred therapy due to the high risk of psychological maladjustment in this client population. Shumaker & Kelsey (2020) contend that whilst anxiety is regarded as a typical component of incongruence from an existential-humanistic perspective, it has the potential to be both overwhelming and incapacitating for certain children, leading to significant trauma. The authors draw on Schneider (2008, 2016) who believes some formative events might lead to enough fear, dread and anxiety to cause trauma. Schneider (2008) suggests that three types of trauma can occur,

the first is an 'acute trauma' which is sudden, shocking and challenges the assumptive world the child inhabits. The second is 'chronic trauma' which may result from an inability to deny the reality of the divorce, leaving the child in a state of depressed resignation and third, implicit trauma which is absorbed via parental conflict. Shumaker & Kelsey (2020) believe manualised trauma therapy is insufficient in such cases and a combination of person-centred, existential-integrative therapy is better placed to create empathic attunement, genuine presence and meaning-making. The authors illustrate this through a brief case-study.

Emotion-focused theory

One paper was identified under this theme which was in a peer-reviewed journal.

Emotion-focused therapy (EFT) integrates the work of Rogers (1951, 1957, 1959), Gendlin (1974, 1981, 1996) and Rice (1974) and has been further developed and evolved through the work of Greenberg et al (1993) and Elliott et al (2004). It combines therapeutic techniques from gestalt therapy and focusing-oriented therapy (FOT) whilst observing the relational aspects of the person-centred approach (PCA) (Elliott, 2012).

Mlotek & Paivio (2017) present an overview of the different types of trauma and disturbance and the long-term impact of complex trauma, they then demonstrate EFT through a case study from a video recording and transcript of a session. The authors refer to EFT for trauma as 'EFTT' and declare that EFTT draws on complex trauma theory (Courtois & Ford, 2015) and attachment theory (Bowlby, 1979). Additionally, EFTT is a short-term (16-20 sessions), experiential, evidence-based therapeutic approach derived from traditional EFT. Mlotek & Paivio (2017) remark that EFTT has similarities with other trauma based therapeutic approaches such as:

- Safe and trusting relationship.
- Coping mechanisms for emotional regulation.
- Exposure based techniques to support cognitive and emotional processing of trauma.
- Meaning making through narrative restructuring.
- Phased based.

Mlotek & Paivio (2017) suggest that EFTT is unique in including the following:

- Processes inhibited emotions to create new meanings.
- Promotes the client's experience of exploring the meaning of feelings, for example, 'felt-sense' (Gendlin, 1996). As opposed to therapist-led interventions such as interpretation, challenge and psychoeducation.

- Promote emotion regulation through empathic responding as opposed to therapist-led interventions such as mindfulness and breathing techniques.
- EFTT's primary focus is on accessing the feelings associated with significant 'past others' with whom there are unresolved attachment issues.
- Using the 'empty-chair method' (Greenberg & Foerster, 1996) where the client imagines they are speaking directly to the perpetrator of their childhood abuse.

Mlotek & Paivio (2017, pp.205-210) suggest a four-phase approach across 16-20 sessions which includes the following:

- *"Phase One: Cultivating the alliance.*
- *Phase Two: Reducing fear, avoidance and shame.*
- *Phase Three: Resolving issues with perpetrators.*
- *Phase Four: Termination."*

The authors suggest that this results in psychological change in two main ways:

1. The therapeutic relationship provides a safe and secure environment in which to process trauma and is in itself a corrective emotional experience for insecure attachment.
2. Maladaptive emotions are transformed into adaptive feelings through new meaning making and expression of previously inhibited emotions (via the 'empty chair method').

Person-centred theory on gender-specific trauma

Three papers were identified under this theme, all of which were in peer-reviewed journals.

Edwards & Lambie (2009) present a case for women who have experienced childhood sexual abuse (CSA) to have PC counselling. They note the experience of CSA is strongly related to an increased incidence of PTSD (Randolf & Reedy, 2006). The authors argue that the six necessary and sufficient conditions (Rogers, 1957) provide the safe environment required to process the client's traumatic experience. Additionally, the non-directive nature of the therapy enables a sense of control over the therapeutic process for women who have been denied such control during the abuse. Howard & Arbaugh (2019) concur with Edwards & Lambie (2009) regarding the strength of the PCA in empowering survivors of domestic violence (DV) to control their own recovery and narrative through self-actualisation. However, Howard & Arbaugh (2019) present a more feminist perspective on the PCA, stressing the need for PC therapists to recognise the cultural, socio-economic circumstances of their clients' lives. Additionally, they recommend a more directive approach than is traditionally expected of the PCA when working with survivors of DV, emphasising the need for safety planning, safeguarding and self-care. Marijke (2011) explores the impact of childhood abuse on men specifically and suggests an approach which combines the PCA with art therapy. Drawing on Rogers (1957), theories on post-traumatic growth (PTG), Gendlin (1996) & Rappaport (2010), the author promotes a tailor made, art-focused therapeutic approach for male survivors of childhood abuse. Marijke (2011) explains how the approach supports the emotional processing of aggression and anger, helping to express internal emotions through the creation of external art.

Person-centred theory on sexual orientation-specific trauma

One paper was identified under this theme, which was in a peer-reviewed journal.

Brice (2011) explores the PCA to working with traumatised clients who have been the target of homophobic hatred. This issue is examined via a case study of a homosexual male client who endured a violent experience which was life threatening. Brice (2011) explores his own views throughout the case study, drawing on the theoretical contributions of Proctor (2006) and Sanders (2006) in reflecting on politics in the therapy room when confronted with alienation and sexuality. Brice (2011) demonstrates the challenges of working intensively with traumatised people, referencing the contribution of neuroscience in enhancing our understanding of the impact of trauma and the importance of empathy (Warner, 1997).

Cross-cultural perspectives on the person-centred approach to post-traumatic stress and post-traumatic growth

Four papers were identified under this theme. Three of which were in peer-reviewed journals with the fourth sourced from my academic book collection.

OVT is challenged by the cultural, ethnic, and socioeconomic situations of clients who have been impacted by trauma, whether because of racism, abuse, war, immigration or other factors. It is essential to explore the positionality of the PCA to PTS & PTG in relation to these factors (Splevins et al, 2010). The organismic valuing theory of PTG (Linley & Joseph, 2004; 2005) was developed in a western society (Rogers, 1959) in which cultural biases will exist. OVT may explain PTS & PTG from a metaphysical perspective but it limits our appreciation of how people from different cultures, specifically non-western, understand self-actualisation in the context of their unique culture. Splevins et al (2010) refer to this specifically in the context of individualistic versus collectivist cultures and the implicit but very different social codes adhered to. More qualitative research into the cultural bias inherent in therapeutic approaches to PTS and PTG is required (Splevins et al, 2010). Additionally, acknowledgement is needed that cultural variance is standard in research as opposed to the pursuit of one 'Eurocentric' universal truth which creates further power imbalance (Splevins et al, 2010).

Kashyap & Hussain (2018) believe self-actualisation is influenced by the cultural environment but note there may be some similarities between Western and Eastern cultural ideas regarding personal growth. Kashyap & Hussain (2018) cite self-reliance, autonomy and self-determination as defining characteristics of Carl Rogers' (1959) version of the self-actualized individual but argue such qualities are more aligned with western, individualistic culture. Kashyap & Hussain (2018, p.61) comment that "traits like self-criticism, self-correction, and self-examination, which lead to personal sacrifice for the sake of the group harmony, are more valued in collectivist

cultures.” The authors explore different types of socio-cultural power, proposing that “proximate” is the influence of interpersonal relationships on a person whilst “distal” is via secondary sources such as media, suggesting that PC theory only accounts for “proximate” (Kashyap & Hussan, 2018, p.56) or what Rogers (1957; 1959) would refer to as the conditioning imposed by ‘significant others.’. The authors suggest that socio-cultural factors are crucial in determining PTG in an individual.

However, Lago (2017, p.168) believes that a more contemporary understanding of PC theory accounts for such socio-cultural contexts, asserts they do function as a “conditioning agent” and refers to them as “culture-specific conditions of worth” (2017, p.168). Ortega-Williams et al. (2021) explore historical group traumas through a collectivist lens, suggesting the scarcity of research on the collective trauma of minoritized groups highlights the need to explore cultural positionality. Simply focusing on “proximate” (Kashyap & Hussain, 2018) influences or those from significant others (Rogers, 1957; 1959) is ‘necessary’ but perhaps not ‘sufficient enough’ for the PCA to trauma.

Quantitative studies

The systematic literature review identified thirteen quantitative studies. They are reviewed under the following themes:

- Comparison of person-centred therapy with alternative modality
- Post-traumatic growth
- Group therapy
- Survey

****Appendix Three presents an overview of all the studies in this section. They are presented in tabular form and categorised by Author; Population; Design; Outcomes and Discussion/Limitations.***

Comparison of person-centred therapy with alternative modality

Six studies were identified under this theme.*

Two studies from Mclean et al (2015) and Capaldi et al (2016) provide a secondary analysis of Foa et al (2013) and one study by Mills et al (2020) is not yet completed. All the studies compare classical client-centred therapy (CCT) with an alternative therapy.

Cottraux et al (2008) compare cognitive behavioural therapy (CBT) with Rogerian Supportive Therapy (RST) for a combination of sixty males and females meeting the DSM IV criteria for PTSD. The authors found that whilst CBT and RST showed equal results in those who completed the study, CBT had a better retention rate. Notably, the therapists used to administer the study were CBT qualified but not trained in RST and described RST as ineffective. No information on ethnicity of participants was provided. Foa et al (2013) conducted a study comparing Prolonged Exposure Therapy for Adolescents (PE-A) and CCT on 61 adolescent females with sex-abuse related PTSD. Patients in the PE-A group showed greater improvement across all measures. The therapists

administering the study held Master's degree in Psychology and Social Work with three of a client-centred orientation and one eclectic. McLean et al (2015) conducted a secondary analysis of Foa et al (2013) exploring how a reduction in negative thinking aids recovery from PTSD. The authors found that changes in negative cognition were equal across both therapies but with a greater incidence for PE-A. Capaldi et al (2016) also provide a secondary analysis of Foa et al (2013) exploring the impact therapeutic alliance has on PTSD symptoms. Whilst both therapies showed a reduction in PTSD symptoms, PE-A showed lower symptom severity and better therapeutic alliance. Ghafoori et al (2009) compare trauma-informed CBT (TF-CBT) with child-centred therapy across 128 male and female young people aged 4-17 years. The study is retrospective, exploring initiation and completion of each therapy. TF-CBT shows higher completion rates than CCT. However, no initial or follow up assessments were conducted, no analysis of reasons for drop-out and the training and education level of the therapists is unclear. Finally, Mills et al (2020) are conducting a study comparing integrated trauma-focused CBT (COPE-A) and CCT for trauma and substance using adolescents. The authors hypothesis that COPE-A will outperform CCT, showing greater reductions in PTSD symptoms and substance use. The research protocol is unclear on the theoretical orientation of the therapists simply saying 'Project Psychologists' will deliver the therapy.

The above studies demonstrate that CCT is consistently outperformed. However, they only compare classical CCT with alternative modalities, there are no comparison studies on experiential PC approaches approaches and apart from Ghafoori et al (2009), all offer short-term therapy up to a maximum of 16 sessions. Additionally, it appears to be a consistent problem that the therapists administering these studies are not trained in CCT but have been provided with a 'manual' on CCT to follow which is ironic considering the person-centred approach (PCA) is not a manualised therapy.

Post-traumatic growth

Four studies were identified under this theme.*

Linley & Joseph (2011) conducted a survey to assess what changes in the 'search for' and 'presence of' 'meaning in life' were experienced by a combination of male and female participants following a traumatic event. Results showed that the 'search for' meaning is correlated with negative change whilst the 'presence of' meaning is correlated with positive change. The authors argue that whilst the 'search for' meaning is an inescapable pre-requisite of ensuing positive change, it is not 'seen' like this by people. The authors further comment that the cross-sectional study is generic with no focus on content of meaning, limited in value and requires further longitudinal studies. Flanagan et al (2015) conducted a longitudinal study over a 3-month period with 2 assessments, to examine the correlation between unconditional positive self-regard (UPSR) and post-traumatic growth (PTG). 76 participants who had experienced a traumatic life event, completed the study which showed that higher UPSR at phase 1 correlated with both a greater 'perception' and 'actual' PTG at phase 2. The authors argue that therapeutic approaches such the PCA which encourage UPSR are likely to promote PTG. No information on sex, age, race of participants was provided. Similarly, Murphy et al (2015) conducted a cross-sectional study on males and females who were asked to identify their most traumatic experience to date. The study explored the correlation between UPSR and PTG and whether it is impacted by 'intrinsic aspiration.' The authors found that UPSR is highly correlated with PTG and that this is impacted by 'intrinsic aspirations.' The authors argue the findings are consistent with organismic valuing process (OVP) and support a PCA to PTS and PTG. Zwiercan & Joseph (2018) conducted a cross-sectional study with a combination of male and female participants who had experienced a stressful event in the past 6 months, to examine the relationship between Gendlin's (1996) 'focusing' and PTG. Greater scores on 'focusing' on felt sense were associated with lower PTS and higher PTG. The authors argue this shows

Gendlin's (1996) 'focusing' on felt sense is associated with PTG but more practice based research is required. No information on ethnicity of participants.

Group therapy

Two studies were identified under this theme.*

Payne et al (2007) examined the efficacy of PC group therapy for males and females experiencing C-PTSD. The authors found participants who experienced empathic listening showed less PTS symptoms, less negativity and greater positivity. However, unconditionality was poorly perceived leading the authors to conclude the groups were not genuinely PC. The authors comment that the group facilitators were Clinical Psychologists and not PC trained therapists, observing this is a common theme as demonstrated in the therapy comparison studies above.

Cowden et al (2021) examined the efficacy of group experiential therapy using psychodrama for ex-military males and females reporting M-PTSD. The study was longitudinal with three phases, over 6 months. Recovery status for PTSD was 69.23%. The authors argue that the results are clinically significant and show a reduction in psychological distress due to experiential therapy but more practice-based research is needed.

Survey

One study was identified under this theme.*

Murphy et al (2013) surveyed 13 UK based trauma services to assess the types of therapies offered.

The results showed that CBT and EMDR were most frequently used with CCT being the fifth most widely used (38%). The authors argue that trauma services are offering a broader range of therapies than those recommended by NICE (2018) which are CBT and EMDR.

Qualitative studies

The systematic literature review identified seven qualitative studies. They are reviewed under the following themes:

- Emotion-Focused Therapy
- Classical Client-Centred Therapy

****Appendix Three presents an overview of all the studies in this section. They are presented in tabular form and categorised by Author; Population; Design; Outcomes and Discussion/Limitations.***

Emotion-Focused Therapy (EFT)

Four studies were identified under this theme.*

Murphy et al (2018) present an inductive analysis of 4 retrospective case studies (clients all met DSM IV criteria for PTSD) to establish the key person-centred and emotion-focused therapeutic principles regarded as facilitative for early-stage trauma work. The authors suggest that a PCE-A to early stage trauma therapy is guided by 1) therapeutic alliance, 2) accurate awareness & symbolisation of past trauma in self-concept, 3) experiential specificity of trauma & 4) empathic responding to enhance client autonomy and self-actualisation. Similarly, Harte et al (2020a, 2020b) conduct a theory building analysis of how EFT incorporates Gendlin's 'focusing' approach to help clients who have experienced an emotional/traumatic injury. The authors propose a three phase model which integrates EFT with FOT to assist clients with bringing repressed traumatic memories back into awareness so they can be processed and integrated. Pillai et al (2022) present 3 case studies of female clients who are experiencing depression, anxiety and trauma due to breast cancer. The authors examine the clients' experience of distress through the lens of emotion-focused theory and

identify emergent themes such as shame, hypervigilance, fear, past childhood trauma. They suggest that EFT for people suffering from cancer should be trauma informed.

Classical Client-Centred Therapy (CCT)

Three studies were identified under this theme.*

Murphy (2009) presents a case study of one male client who is experiencing C-PTSD due to childhood abuse with the aim of demonstrating how psychological change is achieved in CCT. The author conducts a phenomenological analysis of therapy notes from 160 sessions and focuses on four emergent themes: 1) PTS, 2) acceptance & understanding, 3) meaning making and 4) growth. Murphy (2009) argues the themes demonstrate the client experienced a reduction in PTS as a result of CCT and that it is an effective therapeutic approach. Tickle & Murphy (2014) present a case study of one female client experiencing interpersonal trauma and identify three therapeutic processes indicative of the client's and therapist's mutual experience of the therapeutic conditions. The authors argue that mutuality is created naturally through the PC core conditions and highlight mutual empathy, disconnection and client agency as new knowledge to contribute to the understanding of it. Jones (2020) applies interpretative phenomenological analysis to the experiences of 4 female participants impacted by bullying at school. Semi-structured interviews are analysed for themes including the participants' perceptions of PC counselling. The author concludes some participants found PC therapy useful whilst others wanted a more technique driven approach.

Discussion

This dissertation aims to answer the question: 'Is person-centred experiential psychotherapy an effective therapeutic approach for post-traumatic stress?'. The systematic literature search identified 64 papers which were evaluated as relevant to this question. The papers were categorised into four main themes:

1. Theory
2. Cross-cultural perspectives
3. Quantitative studies
4. Qualitative studies

Further sub-themes emerged within three of the main themes. The papers were analysed sequentially by theme with ongoing critical analysis throughout:

Theory

- Person-centred theory of personality and organismic valuing process theory **12 papers**
- Person-centred psychopathology **10 papers**
- The theory of focusing-oriented therapy **7 papers**
- The theory of person-centred experiential therapy **3 papers**
- The theory of existentially informed person-centred therapy **2 papers**
- The theory of emotion-focused therapy for complex trauma **1 paper**
- Person-centred theory on gender specific trauma **3 papers**
- Person-centred theory on sexual orientation specific trauma **1 paper**

Cross-cultural perspectives

- Regarded as one theme with no sub-themes **4 papers**

Quantitative Studies

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- Comparison of person-centred therapy with alternative modality **6 papers**
- Post-traumatic growth **4 papers**
- Group therapy **2 papers**
- Survey **1 paper**

Qualitative Studies

- Emotion focused therapy **4 papers**
- Classical client-centred Therapy **3 papers**

Due to word count limitations together with the fact critical analysis has been provided throughout the study, this chapter will focus on the papers which best answer the research question.

From a theoretical perspective, the study has established that the PCA offers a robust theoretical foundation from which to understand the psychological processes involved in PTS & PTG (Joseph, 2004, 2015, 2017; Joseph et al, 2005, 2006, 2012; Carrick & Joseph, 2013; Murphy & Joseph, 2016). Organismic valuing process theory has been reformulated by Joseph (2004; 2005; 2006) to account for both the breakdown in self-structure caused by psychological trauma and potential post-traumatic growth. In this respect PC theory of trauma is more thorough and comprehensive than the functional-descriptive model of Tedeschi and Calhoun (1995, 1996, 1998a, 1998b, 1999, 2004a, 2004b) and the biopsychosocial-evolutionary model of Christopher (2004) (Joseph & Linley, 2006), neither of which account for the phenomenon of post-traumatic growth. Joseph & Williams (2005) propose a three phase 'psycho-social' framework for understanding the differences in how individuals process trauma which they suggest is compatible with organismic valuing theory. Joseph et al (2012) build further on this framework with the addition of their 'affective-cognitive processing model of post-traumatic growth' and demonstrate how it is compatible with the person-centred core conditions of empathy, congruence and UPR. The study has also demonstrated that the PCA

accounts for the psychopathology of PTS through four main theories: psychological contact (Prouty, 2002a); styles of processing (Warner, 2017); incongruence theory and issues of power (Rutherford, 2007; Hawkins, 2017; Wilkins, 2017; Rundle, 2017).

The study has demonstrated that a range of contemporary PC approaches have made contributions to the development of person-centred trauma theory and to some specific client populations. However, focusing-oriented theory, experiential and emotion focus theory appear to have offered possible frameworks and phased approaches to the therapeutic treatment of trauma. Coffeng (2004, 2005); Scharwachter (2005); Rappaport (2011) & Katonah (2010) integrate Gendlin's (1996) 'focusing' steps into their trauma focused practice and show how it is consistent with the traditional three phase model of trauma treatment (Herman, 1992). A variety of experiential approaches are used in sessions such as body-mapping (Santen, 2018), use of imagery and art. Vanaerschot (2013) & Snijder (2013) integrate several PC approaches into their experiential orientation, demonstrating the use of narrative re-structuring, meaning making and safe attachment in trauma therapy. Welling & Ofer (2022) differentiate types of emotional pain, suggesting a tailored, experiential approach to the processing of the 'basic, emotional pain' concomitant with trauma. Finally, Mlotek & Paivio (2017) suggest a four phased experiential approach to the treatment of complex trauma for emotion-focused therapy 'EFTT' draws on complex trauma theory (Courtois & Ford, 2015) and attachment theory (Bowlby, 1979). The effectiveness of the aforementioned theories and approaches are illustrated through case studies and vignettes.

Analysis of cross-cultural perspectives (Splevins et al, 2010; Kashyap & Hussain, 2018), gender (Howard & Arbaugh, 2019) and sexual orientation specific theory (Brice, 2011) present some challenges for the PCA to trauma. Howard & Arbaugh (2019) argue the PCA needs to adopt a more directive approach to safety planning & safeguarding at risk clients. Splevins et al (2010) argue that organismic valuing theory and self-actualisation are understood through the lens of a Western paradigm which is not always translatable to other cultures. Kashyap & Hussain (2018) offer some

perspective on the cultural influences impacting post-traumatic growth, suggesting that theories on PTG need to account for more than just the psychological impact of inter/intra-personal relationships. Lago (2017) proposes a way of doing this through a PC lens by reframing conditions of worth as 'culture-specific' to account for socio-cultural conditioning.

Analysis of both the qualitative and quantitative studies in the study reflects the lack of cross-cultural perspectives inherent in primary research. Out of twenty studies, 8 contained no information on the ethnic status of participants nor was there much attempt to include meaningful analysis of cultural positionality in the studies that included ethnic status. More generally, the primary research reviewed presented a fragmented lens with which to view the effectiveness of the PCE-A to PTS. The main focus of quantitative studies was to compare classical CCT with an alternative modality (Cottraux et al, (2008); Foa et al, (2013); McLean et al, (2015); Capaldi et al, (2016); Ghafoori et al, (2009)). CCT was 'out-performed' in these studies but interesting themes arose from the analysis which I will cover:

- Only classical CCT was used as a comparison. There was no inclusion of PCE approaches such as focusing-oriented therapy; experiential therapy; emotion-focused therapy which this study has shown to have robust phased approaches and frameworks for trauma therapy.
- The therapists used to administer the studies/therapy are not trained in person-centred experiential psychotherapy with some studies showing (Cottraux et al (2008); Foa et al (2013); Ghafoori et al (2009)) little to no experience in the approach aside from a few days of manualised training.
- The therapy is short-term with a variance of between 14 & 16 sessions in each study apart from Ghafoori et al (2009) which is less.

Nevertheless, the structured approach of Prolonged Exposure Therapy & Cognitive Behavioural Therapy returned better results in these studies. Traditional trauma therapy recommends a

phased/structured approach (Herman, 1992) which person-centred experiential approaches are evidencing efforts to evolve with

The quantitative studies on post-traumatic growth are either cross-sectional or longitudinal and focus on the association between meaning in life and PTG (Linley & Joseph, 2011), unconditional positive-self-regard and PTG (Murphy et al, (2015); Flanagan et al, (2015)) and awareness of 'felt-sense'/ability to 'focus' (Gendlin, 1996) and PTG (Zwiercan & Joseph, (2018)). These studies offer a much more targeted examination of the theories relevant to the effectiveness of the PCA to trauma and are positive in their findings which demonstrate higher UPSR and awareness of 'felt-sense' is correlated with PTG. The authors argue the findings support a person-centred approach to trauma.

There are mixed results from the quantitative studies on person-centred group therapy. Payne et al (2007) report a reduction in PTS for participants who experienced empathic listening but due to low scores on unconditionality suggest the group was not genuinely person-centred. The authors comment on the fact the group facilitators were Clinical Psychologists and not PC therapists as an issue and also reference this as a larger issue across PC research which is consistent with the findings in this study.

Finally, the quantitative studies provide a range of analyses on different client populations. Emotion-focused therapy is well represented which is consistent with the greater focus from experiential therapies in the theory analysis. Murphy et al (2018) propose a series of principles for early stage trauma therapy through an inductive case study analysis of PC/emotion focused therapy sessions. Harte et al (2020a, 2020b) suggest a three phase model for experiential therapeutic approaches to processing emotional pain as a result of trauma, informed by their qualitative analysis of therapy sessions. Classical CCT is explored through case study and interpretative phenomenological analysis (Murphy, (2009); Tickle & Murphy (2014); Jones, (2020)) with a greater focus on the effects of the therapeutic relationship.

Conclusion, Limitations & Future Research

Conclusion

This study has demonstrated through a systematic review of existing theoretical, qualitative and quantitative literature that person-centred psychotherapy is an effective therapeutic approach for post-traumatic stress. The PCA has established itself as one of three main theoretical models through which to understand post-traumatic stress and post-traumatic growth. Person-centred experiential approaches offer contemporary phase-based approaches, consistent with traditional trauma therapies for the therapeutic treatment of post-traumatic stress. This is evidenced through the analysis of theoretical papers and qualitative studies in the review. Whilst quantitative research demonstrates classical client centred therapy is outperformed by manualised approaches, there is a lack of comparative research on experiential approaches and issues around the theoretical orientation of the therapists administering these studies. Additionally, the PCA understands PTS through a humanistic lens, providing a less pathologizing stance than the dominant medical paradigm which categorises the phenomenon as a disorder.

Limitations & Future Research

Systematic literature reviews benefit from a team-based approach with multiple researchers to minimise bias and subjectivity (Dixon-Woods et al, 2006). As one researcher has conducted this study through a constructivist-interpretivist paradigm with a humanistic positionality this increases the risk of bias. Additionally, a very small amount of primary research exists on the effectiveness of the PCA to trauma.

Future research should involve more qualitative and quantitative studies to test the person-centred experiential theories presented in this study. More practice based research is needed as evidenced by the recommendations in the studies reviewed. Additionally, a greater focus on cross-cultural perspectives is required to test organismic valuing theory and its relevance to other socio-

cultural contexts. Lastly, it is essential that primary research into the effectiveness of the PCA to trauma is conducted and administered by person-centred trained therapists with a thorough understanding and appreciation of the modality.

16,523 words.

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APPENDICES

Glossary

PCA	Person-centred approach
PCC	Person-centred counselling
PCT	Person-centred theory
PCE	Person-centred experiential
PCE-A	Person-centred experiential approach
CCT	Client-centred therapy
RST	Rogerian Supportive Therapy
UPR	Unconditional Positive Regard
UPSR	Unconditional Positive Self Regard
PTS	Post-traumatic stress
PTSD	Post-traumatic stress disorder
C-PTSD	Complex Post Traumatic Stress Disorder
M-PTSD	Military Post Traumatic Stress Disorder
PTG	Post-traumatic growth
EFT	Emotion-focused therapy
FOT	Focusing-oriented therapy
OVP	Organismic Valuing Process
OVPT	Organismic Valuing Process Theory
CAS	Clearing a Space
NICE	National Institute Clinical Excellence
CBT	Cognitive Behavioural Therapy
TF-CBT	Trauma Informed Cognitive Behavioural Therapy
NET	Narrative Exposure Therapy

PET	Prolonged Exposure Therapy
PE-A	Prolonged Exposure Therapy for Adolescents
COPE-A	Integrated Trauma Focused CBT for trauma and substance abuse in adolescents
EMDR	Eye Movement Desensitisation Processing

Appendix One

Table of studies included in review organised by database and type

Papers retrieved from EBSCOhost

Author(s), year of publication & journal	Title	Type
Bullock, P. (2020) <i>Therapy Today</i> , 31(3), 30–33. Available at: https://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=142490530&site=ehost-live (Accessed: 13 November 2022).	'Is counselling enough to treat trauma? Penny Bullock asks whether person-centred counselling is safe and effective for trauma work.'	Theory
Jones, C. (2020) <i>Counselling & Psychotherapy Research</i> , 20(4), pp. 657–665.	'Is person-centred counselling effective when assisting young people who have experience bullying in schools.'	Qualitative
Joseph, S. (2004) <i>Psychology and psychotherapy</i> , 77(1), pp.101–119.	'Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications.'	Theory
Murphy, D. (2009) <i>Counselling and Psychotherapy Research</i> , 9(1), 3-10.	'Client-centred therapy for severe childhood abuse: A case study.'	Quantitative
Murphy, D. et al. (2013) <i>Journal of Psychiatric & Mental Health Nursing</i> , 20(5), pp. 433–441.	'A survey of specialized traumatic stress services in the United Kingdom.'	Quantitative
Murphy, D., Elliott, R., & Carrick, L. (2019) <i>Counselling and Psychotherapy Research</i> , 19(4), 497–507.	'Identifying and Developing Therapeutic Principles for Trauma-Focused Work in Person-Centred and Emotion-Focused Therapies.'	Mixed Methods
Payne A, Liebling-Kalifani, H. & Joseph S. (2007) <i>Counselling & Psychotherapy Research</i> , 7(2), 100–105.	'Client-centred group therapy for survivors of interpersonal trauma: a pilot investigation.'	Quantitative
Total	7	

Papers retrieved from APA PsycInfo

Author(s), year of publication & journal	Title	
Mills, K.L., Barrett, E., Back, S.E., Cobham, V.E., Bendall, S., Perrin, S., Brady, K.T., Ross, J., Peach, N., Kihlas, I., Cassar, J., Schollar-Root, O. Teesson, M. (2020) <i>BMJ Open</i> , 10(11)	'Randomised controlled trial of integrated trauma-focused psychotherapy for traumatic stress and substance use among adolescents: trial protocol.'	Quantitative
Total	1	

Papers retrieved from LJM Discover

Author(s), year of publication & journal	Title	
Baljon, Marijke C.L. (2011) <i>Person-Centred & Experiential Psychotherapies</i> , 10(3), 151-164	'Wounded masculinity: Transformation of aggression for male survivors of childhood abuse.'	Theory
Brice, A. (2011) <i>Person-Centred & Experiential Psychotherapies</i> , 10(4), 248-259.	"'If I go back, they'll kill me..." Person-centred therapy with lesbian and gay clients.'	Theory
Cameron, A. (2019). <i>Journal of Humanistic Psychology</i> , 0(0), 1-29.	'Trauma-Focused Presence.'	Theory
Capaldi, S. et al. (2016) <i>Journal of clinical psychology</i> , 72(10), 1026-1036.	'Therapeutic Alliance during Prolonged Exposure Versus Client-Centred Therapy for Adolescent Posttraumatic Stress Disorder.'	Quantitative
Coffeng, T. (2004) <i>Person-Centred and Experiential Psychotherapies</i> , 3, 277-290.	'Trauma, imagery and focusing.'	Theory
Coffeng, T. (2005) <i>Person-Centred & Experiential Psychotherapies</i> , 4(2), 90-105.	'The Therapy of Dissociation: Its phases and problems.'	Theory
Cottraux, J. et al. (2008) <i>Psychotherapy and psychosomatics</i> , 77(2), 101-110.	'Randomized Controlled Comparison of Cognitive Behaviour Therapy with Rogerian Supportive	Quantitative

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<p>Cowden, R.G., Chapman, I.M., Houghtaling, A. & Worthington Jr. A.L. (2021) <i>Person-Centred & Experiential Psychotherapies</i>, 20(2), 119-138.</p>	<p>Therapy in Chronic Post-Traumatic Stress Disorder.'</p> <p>'Effects of a group experiential therapy program on the psychological health of military veterans: a preliminary investigation.'</p>	<p>Quantitative</p>
<p>Crisp, R. (2018) <i>Person-Centred & Experiential Psychotherapies</i>, 17(1), 70-85.</p>	<p>'Rogers and Goldstein redux: the actualizing person responding to trauma and loss.'</p>	<p>Theory</p>
<p>Edwards, N.N. & Lambie, G.W. (2009) <i>The Journal of Humanistic Counselling, Education and Development</i>, 48, 23-35.</p>	<p>A Person-Centred Counselling Approach as a Primary Therapeutic Support for Women with a History of Childhood Sexual Abuse.</p>	<p>Theory</p>
<p>Flanagan, S. Patterson, T.G., Hume, I.R. & Joseph, S. (2015) <i>Person-Centred & Experiential Psychotherapies</i>. 14(3), 191-200.</p>	<p>'A longitudinal investigation of the relationship between unconditional positive self-regard and posttraumatic growth.'</p>	<p>Quantitative</p>
<p>Foa, E.B., McLean, C.P., Capaldi, S. & Rosenfield, D. (2013) <i>Journal of the American Medical Association</i>. 10, 2650-2657.</p>	<p>'Prolonged Exposure vs Supportive Counseling for Sexual Abuse-Related PTSD in Adolescent Girls A Randomized Clinical Trial.'</p>	<p>Quantitative</p>
<p>Ghafoori, B., Garfin, D.R., Ramirez, J. & Khoo, S.F. (2019) <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>, 11(7), 767-774.</p>	<p>'Predictors of treatment initiation, completion, and selection among youth offered trauma-informed care.'</p>	<p>Quantitative</p>
<p>Harte, M., Strmelj, B. & Theiler, S. (2020) <i>Person-Centred & Experiential Psychotherapies</i>, 19(1), 38-65.</p>	<p>'Expanding the emotion focused therapy task of focusing to process emotional injury.'</p>	<p>Qualitative</p>
<p>Harte, M., Strmelj, B. & Theiler, S. (2020) <i>Person-Centred & Experiential Psychotherapies</i>, 19(1), 66-93.</p>	<p>'Processing emotional pain using the expanded Emotion Focused Therapy task of Focusing: A single session case study.'</p>	<p>Qualitative</p>
<p>Hook, L. Murphy, D. (2016) <i>Person-Centred & Experiential Psychotherapies</i>, 15(4), 285-299.</p>	<p>'Related but not replaceable: a response to Warner's reworking of person-centred personality theory.'</p>	<p>Theory</p>

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Howard, S. & Arbaugh, D.K. (2019) <i>Social Work in Mental Health</i> , 17(6), 703-722.	'Counselling survivors of domestic violence: theoretically integrated approaches.'	Theory
Joseph, S. (2015). <i>Person-Centered & Experiential Psychotherapies</i> , 14(3), 178–190.	'A person-centred perspective on working with people who have experienced psychological trauma and helping them move forward to posttraumatic growth.'	Theory
Joseph, S., (2021) <i>The Humanistic Psychologist</i> , 49(2), 219-239.	'Posttraumatic growth as a process and an outcome: Vexing problems and paradoxes seen from the perspective of humanistic psychology.'	Theory
Joseph, S. & Linley, P.A. (2005) <i>Counselling and Psychotherapy Research</i> , 5(1), 5–10.	'Positive Psychological Approaches to Therapy.'	Theory
Joseph, S. & Linley, P. A. (2006) <i>Clinical Psychology Review</i> , 26(8), 1041–1053.	'Growth Following Adversity: Theoretical Perspectives and Implications for Clinical Practice.'	Theory
Joseph, S., Murphy, D. & Regel, S. (2012) <i>Clinical psychology and psychotherapy</i> , 19(4), 316–325.	'An Affective–Cognitive Processing Model of Post- Traumatic Growth.'	Theory
Joseph, S. & Williams, R. (2005) <i>Behavioural and cognitive psychotherapy</i> , 33(4), 423–441.	Understanding Posttraumatic Stress: Theory, Reflections, Context and Future.'	Theory
Kashyap, S. & Hussain, D. (2018). <i>Journal of loss & trauma</i> , 23(1), 51–69.	'Cross-Cultural Challenges to the Construct 'Posttraumatic Growth.'"	Theory
Katonah, D.G. (2010) <i>Person-Centred & Experiential Psychotherapies</i> , 9(2), 157-168.	'Direct Engagement with the Cleared Space in Psychotherapy.'	Theory
Lee, D.A. (2017) <i>Psychotherapy and politics international</i> , 15(2), 1-10.	'A person-centred political critique of current discourses in post-traumatic stress disorder and post traumatic growth.'	Theory
Linley, A.P. & Joseph, S. (2011)	'Meaning in Life and Posttraumatic Growth.'	

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Journal of Loss and Trauma, 16(2), 150-159.		Theory
McLean, C.P., Yeh, R., Rosenfield, D. & Foa, E.B. (2015) <i>Behaviour Research and Therapy</i>, 68, 64-69.	'Changes in negative cognitions mediate PTSD symptom reductions during client-centred therapy and prolonged exposure for adolescents.'	Quantitative
Mlotek, A. E. & Paivio, S.C. (2017) <i>Person-Centred & Experiential Psychotherapies</i>, 16(3), 198-214.	'Emotion-focused therapy for complex trauma.'	Theory
Murphy, D. Demetriou, E. Joseph, S. (2015) <i>Person-Centred & Experiential Psychotherapies</i>, 14(3), 201-213.	'A cross-sectional study to explore the mediating effect of intrinsic aspiration on the association between unconditional positive self-regard and posttraumatic growth.'	Quantitative
Ortega-Williams, A. et al. (2021) <i>Journal of trauma & dissociation</i>, 1–21.	'An Integrated Historical Trauma and Posttraumatic Growth Framework: a Cross-Cultural Exploration.'	Theory
Pillai, S., Connolly, A., Hession, N. & Timulak, L. (2022) <i>Person-Centred & Experiential Psychotherapies</i>, Vol. (ahead-of-print), 1-22.	'Why Mutilate Me Before I Die': An Emotion-Focused Conceptualization of Breast Cancer Clients' Experiences of Anxiety and Depression.'	Qualitative
Quinn, A. (2008) <i>Journal of Humanistic Psychology</i>, 48(4), 458–476.	'A Person-Centred Approach to the Treatment of Combat Veterans With Posttraumatic Stress Disorder.'	Theory
Rappaport, L. (2011) <i>Person-Centred and Experiential Psychotherapies</i>, 9, 128-142.	'Focusing-oriented art therapy: Working with trauma.'	Theory
Splevins, K. et al. (2010) <i>Journal of loss & trauma</i>, 15(3), 259–277.	'Theories of Posttraumatic Growth: Cross-Cultural Perspectives.'	Theory
Rutherford, M. C. (2007) <i>Person-Centred & Experiential Psychotherapies</i>, 6(3), 153–168.	'Bearing Witness: Working with Clients Who Have Experienced Trauma—Considerations for a Person-Centred Approach to Counselling.'	Theory

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Santen, A. (2014) <i>Person-Centred & Experiential Psychotherapies</i> , 13(2), 75-93.	'Into the fear-factory: connecting with the traumatic core.'	Theory
Scharwächter, P. (2005) <i>Person-Centred & Experiential Psychotherapies</i> , 4(1), 4-19.	'The Integration of Focusing-oriented Psychotherapy into the Three-phase Model for the Treatment of Post-traumatic Stress Disorder.'	Theory
Shumaker, D. & Kelsey, C. (2020) <i>Person-Centred & Experiential Psychotherapies</i> , 19(1), 22-37.	'The existential impact of high conflict divorce on children.'	Theory
Snijder, A. (2013) <i>Person-Centred & Experiential Psychotherapies</i> , 12(2), 100-111.	'Trauma in context. Working with traumatic experiences and recollections from the factual and immediate context.'	Theory
Tarnowska, M., Osińska-Owczarska, A., Sowicka, M. & Supel-Szczerbic, G. (2020) <i>Person-Centred & Experiential Psychotherapies</i> , 19(4), 292-309.	'How the therapeutic relationship can repair failures in 'safe other' experiences required for normal neurodevelopment of capacities for human intimacy and autonomy.'	Theory
Tickle, E. & Murphy, D. (2014) <i>Person-Centred & Experiential Psychotherapies</i> , 13(4), 337-351.	'A journey to client and therapist mutuality in person-centred psychotherapy: a case study.'	Qualitative
Vanaerschot, G. (2013) <i>Person-Centred & Experiential Psychotherapies</i> , 12(1), 3-15.	'Working with interpersonal and intrapsychic anxiety through the empathically attuned therapeutic relationship.'	Theory
Welling, H. & Ofer, N. (2022) <i>Person-Centred & Experiential Psychotherapies</i> , Vol. (ahead-of-print), 1-26.	'Pain dynamics: an integrative roadmap for navigating through the experiential process.'	Theory
Young, D.C. (2013) <i>Person-Centred & Experiential Psychotherapies</i> , 12(3), 237-255.	'Incongruencing. A Focusing-Oriented Approach.'	Theory
Zwiercan, A. Joseph, S. (2018) <i>Person-Centred & Experiential Psychotherapies</i> , 17(3), 191-200.	'Focusing manner and posttraumatic growth.'	Quantitative
Total	46	

Studies retrieved from academic books

Author(s), year of publication & book	Title	
Carrick, L. & Joseph, S. (2013) In: Cooper, M., O'Hara, M., Schmid, P.F. and Bohart, A.C. <i>The handbook of person-centred psychotherapy & counselling</i> . 2 nd ed. Basingstoke, Hampshire: Palgrave Macmillan.	'Working with traumatized clients and clients in crisis.'	Theory
Hawkins, J. (2017) In: Joseph, S. <i>The handbook of person-centred therapy and mental health: theory, research and practice</i> . Monmouth: PCCS Books.	'Living with pain: mental health and the legacy of childhood abuse.'	Theory
Joseph, S. (2017) In: Joseph, S. <i>The handbook of person-centred therapy and mental health: theory, research and practice</i> . Monmouth: PCCS Books.	'Understanding post-traumatic stress from the person-centred perspective.'	Theory
Lago, C. (2017) In: Joseph, S. <i>The handbook of person-centred therapy and mental health: theory, research and practice</i> . Monmouth: PCCS Books.	'A person-centred perspective on diagnosis and psychopathology in relation to minority identity, culture and ethnicity.'	Theory
Murphy, D. & Joseph, S. (2016) In: Wilkins, P. <i>Person-centred and experiential therapies: contemporary approaches and issues in practice</i> . London: Sage.	'Client-centred therapy and post-traumatic growth.'	Theory
Patterson, T. G. (2017) In: Joseph, S. <i>The handbook of person-centred therapy and mental health: theory, research and practice</i> . Monmouth: PCCS Books.	'Assessing efficacy and effectiveness in person-centred therapy: challenges and opportunities.'	Theory
Rundle, K. (2017) In: Joseph, S. <i>The handbook of person-centred therapy and mental health: theory, research and practice</i> . Monmouth: PCCS Books.	'From patient to person: how person-centred theory values and understands unusual experiences.'	Theory
Warner, M. S. (2013) In: Cooper, M., O'Hara, M., Schmid, P.F. and Bohart, A.C. <i>The handbook of person-centred psychotherapy & counselling</i> . 2 nd ed. Basingstoke, Hampshire: Palgrave Macmillan.	'Difficult client process.'	Theory
Warner, M. S. (2017) In: Joseph, S. <i>The handbook of person-centred therapy and mental health: theory, research and practice</i> .		Theory

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<p>Monmouth: PCCS Books.</p> <p>Wilkins, P. (2017) In: Joseph, S. <i>The handbook of person-centred therapy and mental health: theory, research and practice.</i> Monmouth: PCCS Books.</p>	<p>'A person-centred view of human nature, wellness and psychopathology.'</p> <p>'Person-centred theory and 'mental illness.'"</p>	<p>Theory</p>
<p>Total</p>	<p>10</p>	

Figure 2: Table of studies included in review organized sequentially by database

Appendix Two

Person-centred theory of personality & organismic valuing process theory: chronological list of papers reviewed

1. Joseph, S., (2004) Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications. *Psychology and psychotherapy*, 77(1), pp.101–119.
2. Joseph, Stephen & Williams, Ruth, (2005) Understanding Posttraumatic Stress: Theory, Reflections, Context and Future. *Behavioural and cognitive psychotherapy*, 33(4), pp.423–441.
3. Joseph, Stephen, and Linley, P. Alex. (2006) “Growth Following Adversity: Theoretical Perspectives and Implications for Clinical Practice.” *Clinical Psychology Review*, 26(8), 1041–1053.
4. Quinn, A. (2008). A Person-Centred Approach to the Treatment of Combat Veterans With Posttraumatic Stress Disorder. *Journal of Humanistic Psychology*, 48(4), 458–476.
5. Joseph, S., Murphy, D. & Regel, S. (2012) An Affective–Cognitive Processing Model of Post-Traumatic Growth. *Clinical psychology and psychotherapy*, 19(4), 316–325.
6. Warner, M. S. (2013) Difficult client process. In: Cooper, M., O'Hara, M., Schmid, P.F. and Bohart, A.C. *The handbook of person-centred psychotherapy & counselling*. 2nd ed. Basingstoke, Hampshire: Palgrave Macmillan.
7. Carrick, L. & Joseph, S. (2013) Working with traumatized clients and clients in crisis. In: Cooper, M., O'Hara, M., Schmid, P.F. and Bohart, A.C. *The handbook of person-centred psychotherapy & counselling*. 2nd ed. Basingstoke, Hampshire: Palgrave Macmillan.
8. Joseph, S. (2015) A person-centred perspective on working with people who have experienced psychological trauma and helping them move forward to posttraumatic growth. *Person-Centred & Experiential Psychotherapies*, 14(3), 178–190.
9. Hook, L. Murphy, D. (2016) Related but not replaceable: a response to Warner's reworking of person-centred personality theory. *Person-Centred & Experiential Psychotherapies*, 15(4), 285-299.
10. Murphy, D. & Joseph, S. (2016) Client-centred therapy and post-traumatic growth. In: Wilkins, P. *Person-centred and experiential therapies: contemporary approaches and issues in practice*. London: Sage.
11. Joseph, S. (2017) Understanding post-traumatic stress from the person-centred perspective. In: Joseph, S. *The handbook of person-centred therapy and mental health: theory, research and practice*. Monmouth: PCCS Books.
12. Patterson, T. G. (2017) Assessing efficacy and effectiveness in person-centred therapy: challenges and opportunities. In: Joseph, S. *The handbook of person-centred therapy and mental health: theory, research and practice*. Monmouth: PCCS Books.

Person-centred psychopathology: chronological list of papers reviewed

1. Rutherford, M. C. (2007) Bearing Witness: Working with Clients Who Have Experienced Trauma—Considerations for a Person-Centred Approach to Counselling. *Person-Centred & Experiential Psychotherapies*, 6(3), 153–168.
2. Hawkins, J. (2017) Living with pain: mental health and the legacy of childhood abuse. In: Joseph, S. *The handbook of person-centred therapy and mental health: theory, research and practice*. Monmouth: PCCS Books.
3. Rundle, K. (2017) From patient to person: how person-centred theory values and understands unusual experiences. In: Joseph, S. *The handbook of person-centred therapy and mental health: theory, research and practice*. Monmouth: PCCS Books.
4. Warner, M. S. (2017) A person-centred view of human nature, wellness and psychopathology. In: Joseph, S. *The handbook of person-centred therapy and mental health: theory, research and practice*. Monmouth: PCCS Books.
5. Wilkins, P. (2017) Person-centred theory and ‘mental illness’ In: Joseph, S. *The handbook of person-centred therapy and mental health: theory, research and practice*. Monmouth: PCCS Books.
6. Lee, D.A. (2017) A person-centred political critique of current discourses in post-traumatic stress disorder and post traumatic growth. *Psychotherapy and politics international*, 15(2), 1-10.
7. Crisp, R. (2018) Rogers and Goldstein redux: the actualizing person responding to trauma and loss, *Person-Centred & Experiential Psychotherapies*, 17(1), 70-85.
8. Bullock, P. (2020) ‘Is counselling enough to treat trauma? Penny Bullock asks whether person-centred counselling is safe and effective for trauma work’, *Therapy Today*, 31(3), pp. 30–33. Available at: <https://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=142490530&site=ehost-live> (Accessed: 13 November 2022).
9. Tarnowska, M., Osińska-Owczarska, A., Sowicka, M. & Supel-Szczerbic, G. (2020) How the therapeutic relationship can repair failures in ‘safe other’ experiences required for normal neurodevelopment of capacities for human intimacy and autonomy. *Person-Centred & Experiential Psychotherapies*, 19(4), 292-309.
10. Joseph, S. (2021) Posttraumatic growth as a process and an outcome: Vexing problems and paradoxes seen from the perspective of humanistic psychology. *The Humanistic Psychologist*, 49(2), 219-239.

Focusing-oriented theory: chronological list of papers reviewed

1. Coffeng, T. (2004) Trauma, imagery and focusing. *Person-Centred and Experiential Psychotherapies*, 3, 277–290.
2. Coffeng, T. (2005) The Therapy of Dissociation: Its phases and problems. *Person-Centred & Experiential Psychotherapies*, 4:2, 90-105.
3. Scharwächter, P. (2005) The Integration of Focusing-oriented Psychotherapy into the Three-phase Model for the Treatment of Post-traumatic Stress Disorder. *Person-Centred & Experiential Psychotherapies*, 4(1), 4-19.
4. Katonah, D.G. (2010) Direct Engagement with the Cleared Space in Psychotherapy. *Person-Centred & Experiential Psychotherapies*, 9(2), 157-168.

5. Rappaport, L. (2011) Focusing-oriented art therapy: Working with trauma. *Person-Centred and Experiential Psychotherapies*, 9, 128-142.
6. Young, D.C. (2013) Incongruencing. A Focusing-Oriented Approach. *Person-Centred & Experiential Psychotherapies*, 12(3), 237-255.
7. Santen, A. (2014) Into the fear-factory: connecting with the traumatic core. *Person-Centred & Experiential Psychotherapies*, 13(2), 75-93.

Experiential theory: chronological list of papers reviewed

1. Vanaerschot, G. (2013) Working with interpersonal and intrapsychic anxiety through the empathically attuned therapeutic relationship. *Person-Centred & Experiential Psychotherapies*, 12(1), 3-15.
2. Snijder, A. (2013) Trauma in context. Working with traumatic experiences and recollections from the factual and immediate context, *Person-Centred & Experiential Psychotherapies*, 12(2), 100-111.
3. Welling, H. & Ofer, N. (2022) Pain dynamics: an integrative roadmap for navigating through the experiential process. *Person-Centred & Experiential Psychotherapies*, 2022, Vol. (ahead-of-print), 1-26.

Existentially-informed person-centred theory: chronological list of papers reviewed

1. Cameron, A. (2019). Trauma-Focused Presence. *Journal of Humanistic Psychology*, 0(0), 1-29.
2. Shumaker, D. & Kelsey, C. (2020) The existential impact of high conflict divorce on children. *Person-Centred & Experiential Psychotherapies*, 19(1), 22-37.

Emotion-focused theory: chronological list of papers reviewed

1. Mlotek, A. E. & Paivio, S.C. (2017) Emotion-focused therapy for complex trauma, *Person-Centred & Experiential Psychotherapies*, 16(3), 198-214.

Gender-specific theory: chronological list of papers reviewed

1. Edwards, N.N. & Lambie, G.W. (2009) A Person-Centred Counselling Approach as a Primary Therapeutic Support for Women With a History of Childhood Sexual Abuse. *The Journal of Humanistic Counselling, Education and Development*, 48, 23-35.
2. Baljon, Marijke C.L. (2011) Wounded masculinity: Transformation of aggression for male survivors of childhood abuse. *Person-Centred & Experiential Psychotherapies*, 10(3), 151-164.
3. Howard, S. & Arbaugh, D.K. (2019) Counseling survivors of domestic violence: theoretically integrated approaches. *Social Work in Mental Health*, 17(6), 703-722.

Sexual-orientation specific theory: chronological list of papers reviewed

1. Brice, A. (2011) "If I go back, they'll kill me..." Person-centred therapy with lesbian and gay clients. *Person-Centred & Experiential Psychotherapies*, 10(4), 248-259.

Cultural perspectives on the PCA to PTS & PTG: chronological list of papers reviewed

1. Splevins, K., Cohen, K., Bowley, J. & Joseph, S. (2010) Theories of Posttraumatic Growth: Cross-Cultural Perspectives. *Journal of loss & trauma*, 15(3), 259–277.
2. Kashyap, S. & Hussain, D. (2018) Cross-Cultural Challenges to the Construct "Posttraumatic Growth". *Journal of loss & trauma*, 23(1), 51–69.
3. Ortega-Williams, A., Beltran, R., Schultz, K., Ruglo Henderson, Z., Colon, L., Teyra, C. (2021) An Integrated Historical Trauma and Posttraumatic Growth Framework: a Cross-Cultural Exploration. *Journal of trauma & dissociation*, 1–21.
4. Lago, C. (2017) A person-centred perspective on diagnosis and psychopathology in relation to minority identity, culture and ethnicity. In: Joseph, S. 2017. *The handbook of person-centred therapy and mental health: theory, research and practice*. Monmouth: PCCS Books.

Appendix Three

Quantitative Studies included in review

Comparison of person-centred therapy with alternative modality

Six studies were identified under this theme and are presented below.

Authors & Location	Population	Design	Outcomes	Discussion & Limitations
-Cottraux et al (2008). -France.	-60 participants. -18 Male. -42 Female. -18-65 years. -All met DSM IV criteria for PTSD.	-Comparison study between cognitive behavioural therapy (CBT) & Rogerian supportive therapy (RST). -Randomised. -16 weekly sessions. -Measures: Post Traumatic Disorder Checklist, Hamilton Anxiety Scale, Beck Depression Inventory and Quality of Life.	-42 patients completed the study. 27 in CBT group & 15 in RST group. -3 CBT patients withdrew before 16 weeks & 13 in the RST group. -CBT had 87% retention rate with RST at 52%. -CBT & RST 'completers' fared equally well but CBT had a better retention rate.	-The same therapists were used in each group. They were psychiatrists or senior psychologists with CBT training and judged the use of RST as 'non-effective.' -Manuals were provided on 'how to administer' RST. -Checklists of techniques used in RST were reported weekly. -Impossible to replicate this study in France where therapists are either CBT or psychodynamically trained. -No information on ethnicity.
-Foa et al. -USA.	-61 adolescent females. -13-18 years. -34 Black, 11 White, 10 Hispanic, 2 Biracial, 4 no response. -Seeking support at a rape crisis centre. -DSM-IV PTSD diagnosis.	-Comparison study between Prolonged Exposure Therapy for Adolescents (PE-A) & Client-Centred Therapy (CCT). -Randomised. -14 weekly sessions at 60-90 minutes. -Measures: Child PTSD Symptom Scale, PTSD diagnosis assessed by the DSM-IV, Children's Global Assessment Scale, Children's Depression Inventory.	-61 patients in study. -31 in PE-A group & 30 in CCT group. -Patients in the PE-A showed greater improvement than those in the CCT group across all report measurements.	-Specific study population impacts generalizability. -Self-report measures open to bias. -Four female therapists with Master's degrees. One in Psychology and 3 in Social Work. -Three therapists with a client-centred orientation and one eclectic. -Small sample size.
-McLean et al (2015). -USA.	-Secondary analysis of above Foa et al study (2013). -Exact population as above.	-Comparison study between Prolonged Exposure Therapy for Adolescents (PE-A) & Client-Centred Therapy (CCT) to show how reduction in negative thinking aids recovery from PTSD. -Randomised. -14 weekly sessions at 60-90 minutes. -Measures: Child PTSD Symptom Scale, Child Post-Trauma Attitudes Scale, The	-61 patients in study. -31 in PE-A group & 30 in CCT group. -Data obtained from 225 out of 244 possible assessments, pre, mid & post therapy. -3 month post therapy outcomes better in PE-A than CCT, across all 3 measures. -Changes in cognition were equivalent in each	-Therapy delivered by therapists trained to MA level who completed 4 days of PE-A training & 4 days of CCT. Does not specify their core modality. -Specific study population impacts potential generalizability. -Small sample size. -Self-report measures open to bias.

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		Children's Depression Inventory.	therapy but with greater incidence for PE-A.	
-Capaldi et al (2016). -USA.	-Secondary analysis of above Foa et al study (2013). -Exact population as above.	-Comparison study between Prolonged Exposure Therapy for Adolescents (PE-A) & Client-Centred Therapy (CCT) to explore therapeutic alliance & impact on PTSD symptoms. -Randomised. -14 weekly sessions at 60-90 minutes. -Measures: Child PTSD Symptom Scale Interview, Working alliance inventory short version.	-61 patients in study. -31 in PE-A group & 30 in CCT group. -8 did not complete the study. 3 from PE-A & 5 from CCT. -Both therapies showed reduction in PTSD symptoms. -PE-A showed lower symptom severity & better therapeutic alliance.	-Four female therapists with Master's degrees. One in Psychology and 3 in Social Work. -Three therapists with a client-centred orientation and one eclectic. -Therapists had 4 days of PE-A training & 4 in CCT. -Small sample size. -Limited amount of assessments.
-Ghafoori et al (2009). -USA.	-128 patients. -51 Male. -27 Female. -79 Latinx, 20 Other, 17 White, 12 Black. -4-17 years.	-Compares trauma-informed (TF) CBT & Child-centred therapy (CCT) regarding initiation & completion. - Received either trauma-informed CBT or CCT. -Measures: Retrospective review of existing clinical records.	-55 out of 128 completed therapy. -69% initiated therapy. -61% completed therapy. -70.6% of patients completed TF-CBT -50.0% completed TF-CCT.	-Retrospective. -No initial assessment. -No follow-up assessments. -No analysis of reasons for drop-out. -Unclear on levels of training & education of therapists. -Some TF-CBT & CCT training offered on-site but no detail on quality or length. -Results preliminary, not definitive.
-Mills et al (2020). -Australia.	-100 patients. -Male & female. -12-18 years.	-Comparison of integrated trauma-focused CBT for trauma & substance use among adolescents (COPE-A) versus supportive counselling control condition (Person-Centred Therapy (PCT)). -16 sessions of 60-90 minutes. -Research protocol only. -Study in development.	-The authors hypothesise that COPE-A will outperform PCT and show greater reductions in PTSD symptoms & substance use.	-Study not yet completed. -Unclear on theoretical orientation of therapists providing treatment. - 'Project Psychologists' will deliver the therapy to both groups. - 'Project Psychologists' will receive training on COPE-A & PCT. -Unclear on ethnic background of participants.

Post-traumatic Growth

Four studies were identified under this theme and are presented below.

Authors & Location	Population	Design	Outcomes	Discussion & Limitations
-Linley & Joseph (2011). -UK.	-158 churchgoers (59 Male, 108 Female, 96% White Caucasian). -128 members of public (41 Male, 77 Female, 94% White Caucasian). -84 funeral directors	-Survey -To assess changes following adversity & both <i>search for</i> & <i>presence</i> of meaning in life. -Schematic analysis. -Measures: Changes in Outlook Questionnaire, Meaning in Life Questionnaire.	-All three survey samples showed that <i>presence</i> of meaning in life is correlated with positive change. -All three samples showed <i>search</i> for meaning is correlated with negative change.	-The authors argue that whilst searching for meaning is a prerequisite of positive change, it is not 'seen' as being so and rather is an inescapable cognitive undertaking. -Survey questions are very generic with no attention to 'content' of meaning. -Cross-sectional study limited in value. -Longitudinal study would better demonstrate changes over a period of time.

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	(64 Male, 19 Female, 1 no gender, 99% White Caucasian).			
-Murphy et al. (2015) -Cyprus.	-99 participants -44 Male -55 Female. -16-74 years -96% White/Caucasian, 3% Black, 1% Other. -Cypriot.	-Cross-sectional study. -Aim one: To explore the correlation between unconditional positive self-regard (UPSR) & post-traumatic growth (PTG) -Aim two: To explore whether the correlate between UPSR & PTG is impacted by intrinsic aspiration. -Participants asked to identify most traumatic experience to date. -Measures: PTG growth inventory, UPSR scale, The Aspiration Index.	-UPSR highly correlated with PTG. -Intrinsic aspirations are to some degree a mediating factor between UPSR & PTG.	-The authors argue that the findings support the person-centred approach (PCA) to trauma & PTG. -Findings consistent with organismic valuing process theory (OVP). -Question raised regarding how conditions of worth theory intersects with OVP. -Possible revision of OVP model of PTG. -Participants all white/Caucasian. -Longitudinal study required.
-Flanagan et al. (2015) -UK.	-143 participants -No info. on male/female. -No info. on age. -Online	-Longitudinal study. -Online questionnaire. -Participants experienced traumatic life event. -Conducted over 3 months. -To examine the correlation between UPSR & PTG. -Measures: Checklist of life events, Impact of Event Scale-Revised, UPSR Scale, Warwick Edinburgh Mental Well-being Scale, Changes in Outlook Questionnaire, PTG Inventory.	-143 participants completed initial phase. -76 completed second phase at month three. -Higher UPSR at phase 1 was correlated with greater perception of PTG at phase 2. -Individual variances in growth were also assessed at phases one & two. -Higher UPSR at phase one is correlated with greater 'actual' PTG at phase two.	-The authors argue that the findings support the PCA to trauma & PTG. -Study shows that UPSR is succeeded by PTG after a traumatic experience. -Therapeutic approaches such as the PCA which encourage UPSR are likely to promote PTG. -Measure of growth taken after traumatic experience, before would be better. -No information on sex, age or race of participants.
-Zwiercan & Joseph (2018) -UK.	-87 participants -75 Female -8 Male -4 Non-binary -Online	-Cross-sectional. -Online questionnaire -To examine the relationship between Gendlin's (1996) 'Focusing' & PTG. -Participants had a significantly stressful experience in past 6 months. -Measures: The Impact of Event Scale, PTG Inventory, Changes in Outlook Questionnaire, Focusing Manner Scale.	-Great scores on focusing attitudes correlated with lower scores on post-traumatic stress (PTS) & greater scores on PTG.	-The authors argue that the findings show Gendlin's (1996) focusing on felt sense is associated with PTG. -More women than men in study. -More practice based research studies required in a therapy context. -Longitudinal studies required. -No information on ethnicity of participants.

Group Therapy

Two studies were identified under this theme and are presented below.

Authors & Location	Population	Design	Outcomes	Discussion & Limitations
-Payne et al (2007).	-6 participants. -2 Male.	-Group therapy setting.	-Participants who experienced empathic	-The authors state there were low scores for unconditionality alongside poor

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-UK.	-4 Female. -20-54 years. -83.3% white ethnic origin. -Experiencing Complex PTSD.	-Questionnaires pre & post group therapy. -To assess the efficacy of person-centred group therapy for people who have experienced interpersonal trauma. -Measures: Changes in Outlook Questionnaire, Clinical Outcomes in Routine Evaluation, Impact of Event Scale, Barrett-Lennard Relationship Inventory.	listening reported positive changes such as: -Less PTS symptoms. -Greater positivity. -Less negativity.	perceptions of it & therefore the groups cannot be described as genuinely person-centred. -Group facilitators were trained Clinical psychologists and not person-centred therapists. -Lack of clinical expertise in person-centred therapy/theory is a common theme in studies involving the PCA.
-Cowden et al (2021) -USA.	-72 participants. -54 Male. -18 Female. -26-75 years. -66 White, 2 Black, 1 Asian, 1 Middle Eastern, 2 Mixed Race. -Self reported Military-PTSD, anxiety & depression.	-Group experiential therapy. -Longitudinal -To assess efficacy of group experiential therapy using psychodrama for military veterans. -Assessments over three phases from 0-6 months. -Measures: Mississippi Scale for Combat-Related PTSD, Combat Exposure Scale, Generalised Anxiety Disorder 7, Patient Health Questionnaire 9, EUROHIS-QOL 8 item index, Acceptability & Satisfaction.	-Recovery status: -69.23% for PTSD -94.29% for Anxiety -79.49% for Depression.	-The authors argue that the findings show a reduction in psychological distress because of group experiential therapy. -Results are clinically significant. -Participants reported high satisfaction & engagement. -Focused solely on outcome data. -Further research on process of therapeutic change in experiential therapy required.

Survey

On study was identified under this theme and is presented below.

-Murphy et al (2013) -UK.	-Trauma services in the UK. -23 services identified. -13 included in study (10 NHS services & 3 non-statutory).	-Survey -To assess the type of therapies offered in UK trauma services. -5 specific questions asked covering staffing, referrals, type of therapies offered and number of sessions, other forms of social support.	-13 services returned complete data. Top five therapies offered: -CBT 92% -EMDR 77% -Cognitive Therapy 69% -Behaviour Therapy 61% -Client-Centred Therapy 38%	-The authors argue the findings show that despite CMT & EMDR being the therapies recommended by NICE (2018), services are offering a far broader range of therapies.
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Qualitative Studies included in review

Emotion-Focused Therapy

Four studies were identified under this theme and are presented below.

Authors & Location	Population	Design	Outcomes	Discussion & Limitations
-Murphy et al (2018). -UK.	-4 case studies selected retrospectively from existing archive. -2 person-centred with 1 good & 1 poor outcome. -2 emotion-focused therapy with 1 good & 1 poor outcome. -Each case met DSM IV criteria for PTSD.	-Aim: to establish therapeutic principles regarded as facilitative from both EFT & PCT to assist in early stage therapy with clients who are traumatised. -Measures: Personal Questionnaire, CORE Outcome Measure, Social Phobia Inventory, Inventory of Interpersonal Problems, The Strathclyde Inventory, The Working Alliance Inventory, The Therapeutic Relationship Scale, The Helpful Aspects of Therapy Form. -Sessions transcribed and analysed.	-Four key principles identified as effective for PCE therapy: 1. Therapeutic alliance 2. Acknowledging past trauma & accurately symbolising in the self-concept. -Experiential specificity of traumatic events. -Focused empathic responding to enhance clients' autonomy and self-actualisation.	-Inductive: theory guided by analysis of good/bad, successful/unsuccessful therapy outcomes from real data. -Labour intensive -No clear relationship between the four principles creating psychological change. -Only first 3 sessions were analysed. -Further studies needed on middle/later stages of therapy.
-Harte et al (2020a) -Australia.	-11 Clients (8 female, 3 male) -Some clients were trainees in EFT. -Some clients were non-trainees, already engaged in therapy and reported experiencing an emotional injury causing pain.	-Aim: To demonstrate that EFT using 'focusing' can help to bring repressed traumatic memories back into awareness for processing & integration. -Measures: Working Alliance Inventory, Helpful Aspects of therapy. -Observer measures: Experiencing Scales, Client Emotional Arousal Scale III, Client Emotional Productivity. -12 single sessions recorded, transcribed & analysed. -Theory building.	3 phase model illustrating the process of therapeutic change emerged: 1. Therapeutic alliance, safety, CAS, emotion regulation. 2. Felt sense, accessing memory & emotion, imaginal restructuring, felt shift, meaning, re-grounding. 3. Deeper understanding & possible resolution	-Combines EFT with FOT -Empirically driven results -Provides a therapeutic framework for experiential therapeutic approaches to processing emotional pain as a result of trauma. -Limited case-studies but point of study is to build theory not generalise.
-Harte et al (2020b) -Australia.	-Single session case-study between therapist & client. -Client had to recall unresolved, traumatic experience from childhood.	-Aim: To demonstrate that EFT using 'focusing' can help to bring repressed traumatic memories back into awareness for processing & integration. -Measures: Working Alliance Inventory, Helpful Aspects of therapy.	-Client returned positive scores on measures. -Building on the larger study undertaken by Harte (2017) and the findings from this, a 3 phase model illustrating the process of therapeutic change emerged:	-Combines EFT with FOT -Empirically driven results -Provides a therapeutic framework for experiential therapeutic approaches to processing emotional pain as a result of trauma. -Only one case study -Client and therapist were trainees of EFT so more familiar with the approach than non-trainees.

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	-Case study extracted from larger study.	-Observer measures: Experiencing Scales, Client Emotional Arousal Scale III, Client Emotional Productivity. -Session was recorded, transcribed & analysed. -Phenomenological	1. Therapeutic alliance, safety, CAS, emotion regulation. 2. Felt sense, accessing memory & emotion, imaginal restructuring, felt shift, meaning, re-grounding. 3. Deeper understanding & possible resolution.	
-Pillai et al (2022) -Ireland.	-3 case-studies of women. -Clients met criteria for depression and anxiety and were experiencing ongoing trauma.	Aim: To study how clients with breast cancer experienced distress. Examined through a lens of emotion-focused theory. -15 recorded therapy sessions across the three case-studies. -Recorded, transcribed and analysed. -Interpretative	Descriptions of the types of distress suffered by these clients is included: -Shame -Self-blame -Hypervigilance -Fear -Past adversities such as childhood trauma & attachment issues were triggered. -Unmet needs	-The authors suggest that emotion-focused therapy for people suffering from cancer should be trauma informed. -Future studies should be focused on people from different socio-economic, cultural backgrounds.

Classical Client-Centred Therapy

Three studies were identified under this theme and are presented below.

Authors & Location	Population	Design	Outcomes	Discussion & Limitations
-Murphy (2009) -UK.	-Case study of one male client. -Experiencing C-PTSD as a result of childhood abuse.	-Aim: To demonstrate psychological change in CCT and show how C-PTSD in encountered in the therapy -Data retrieved from notes of 160 therapy sessions. -Phenomenological analysis. -Focus on themes emerging.	Four main themes emerged: 1. Post traumatic 'distress.' 2. Acceptance & understanding. 3. Meaning making 4. Growth -The themes demonstrate the client experienced a reduction in PTS as a result of CCT.	-The author argues that CCT is effective in reducing PTS in clients who have experienced childhood abuse. -The client experienced growth and new meanings as a result of an empathic, accepting therapeutic relationship.
-Murphy & Tickle (2014) UK.	-Case study of one female client. -Experiencing interpersonal trauma.	-Aim: To develop theory on the therapist's & client's mutual experiences of the therapeutic conditions. -Data retrieved from 13 sessions through a combination if therapy notes, recordings & transcriptions of sessions, therapist interviewed by 2 nd author, client & therapist reviewed findings together. -Collaborative and reflective -Theory building	Three therapeutic processes emerged: -Mutual empathy -Disconnection -Client agency	-The authors argue that mutuality is created naturally through the core conditions. -Mutuality is a key principle of the PCA. -A framework of existing knowledge on mutuality together with identified gaps and new knowledge created by this study is presented. -Further studies required.
-Jones (2020) -UK.	-4 Females -Experienced bullying in school.	-Aim: To examine how PC therapy can help people who have experienced bullying at school. -Semi-structured interviews. -Interpretative Phenomenological Analysis. -Data analysed for themes.	Four themes emerged: -Lack of support leads to trauma. -The experience & emotional communication of bullying. -Adult mental health related to childhood bullying. -The impact of PC therapy on participants.	-The author concludes some participants found PC therapy useful but others wanted a more technique driven approach. -PC therapy is empowering for clients who have experienced bullying. -Only female participants -Lack of cultural diversity in participants.

Appendix Four

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Y
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Y
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Y
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Y
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Y
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Y
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Y
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Y
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Y
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Y
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Y
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Y
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity,	Y

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Section and Topic	Item #	Checklist item	Location where item is reported
		and software package(s) used.	
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Y
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Y
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	
Study characteristics	17	Cite each included study and present its characteristics.	Y
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Y
	23b	Discuss any limitations of the evidence included in the review.	Y
	23c	Discuss any limitations of the review processes used.	Y
	23d	Discuss implications of the results for practice, policy, and future research.	Y
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	
Support	25	Describe sources of financial or non-financial support for the review, and	

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Section and Topic	Item #	Checklist item	Location where item is reported
		the role of the funders or sponsors in the review.	
Competing interests	26	Declare any competing interests of review authors.	
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

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