

ORIGINAL ARTICLE

Identifying and developing therapeutic principles for trauma-focused work in person-centred and emotion-focused therapies

David Murphy¹  | Robert Elliott²  | Lorna Carrick²

¹School of Education, University of Nottingham, Nottingham, UK

²University of Strathclyde, Glasgow, UK

Correspondence

David Murphy, School of Education, University of Nottingham, Nottingham, NG81BB, UK.

Email: david.murphy@nottingham.ac.uk

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Abstract

Background: The aim of this research was to identify facilitative therapeutic principles in person-centred and emotion-focused therapy for working with traumatised clients in the early stages of therapy.

Methods: Four cases were selected from the Strathclyde Experiential Therapy for Social Anxiety archive: one good and one poor outcome case from each therapeutic approach. Outcomes were considered good and poor based on quantitative outcome measures. Each case met DSM-IV-TR diagnostic criteria for both PTSD and social anxiety. We developed a new method for the identification of therapeutic principles that offers an alternative to current approaches to competency identification. Our method uses a qualitative, bottom-up inductive process analysis. The first three sessions from each case were transcribed and independently analysed by two researchers (one blinded to the outcomes); the third researcher acted as consultant. The transcripts were analysed by focusing on session episode structure and treatment principles.

Findings: Four trauma-focused therapist principles were identified: (a) support early relationship building/alliance formation; (b) facilitate client identification and recognition of past events as trauma experiences; (c) facilitate work on traumatic sources of current experiential and interpersonal difficulties; and (d) offer self-agency focused empathy.

Conclusions: We conclude that our approach identifies and provides a new method for establishing person-centred experiential therapy principles for early trauma-focused work. Further research is recommended, and limitations are discussed.

KEYWORDS

emotion-focused, person-centred, therapist principles, trauma

1 | INTRODUCTION

Traumatic events can lead people to feel anxious; consequently, it is not surprising that post-traumatic stress and social anxiety difficulties frequently co-occur in both research and naturalistic

samples (Collimore, Carleton, Hofmann, & Asmundson, 2010). Collimore et al. (2010) suggest that experiencing both post-traumatic stress and social anxiety will make clients more clinically distressed, thus potentially making them more difficult to help. In this study, we aimed to identify key principles common

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to person-centred and emotion-focused therapists working with traumatised clients in the early stages of therapy. By focusing on common key principles, we can further develop the person-centred experiential approach as a contemporary evolving therapy within the person-centred paradigm.

The existing National Institute for Health and Clinical Excellence (NICE) guidelines for the treatment of both post-traumatic stress disorder (PTSD; NICE, 2005) and social anxiety disorder (SAD; NICE, 2013) suggest that, as a first line of psychological treatment, clients should be offered cognitive behavioural therapy (CBT) with an adaptation focusing on the specific disorder (in the case of PTSD, eye movement desensitisation and reprocessing [EMDR] is also recommended). Notwithstanding the large body of evidence underpinning NICE treatment recommendations for CBT and EMDR for PTSD, research with traumatised clients within the humanistic-experiential psychotherapies (HEPs) shows promising results (Elliott et al., 2013). This is especially the case for more complex relational and interpersonal difficulties that clients are experiencing as responses to childhood abuse and trauma (Paivio, Hall, Holowaty, Jellis & Tran, 2001). However, the evidence for HEPs with anxiety difficulties is not positive (Elliott et al., 2013), although some recent promising developments within the emotion-focused therapy literature have begun to address the evidence gap (Elliott & Shahr, 2017; Watson, Chekan, & McMullen, 2017). Importantly, despite the evidence of the potential benefit of HEPs for traumatised clients, there remains a dearth of randomised control trial research in this area. Nevertheless, before randomised controlled trials can be conducted, it is necessary to identify the key therapist principles that are useful for working with a particular client population.

In this study, we aim to make both empirical and methodological contributions to the field by identifying key therapist principles for a person-centred experiential (PCE) approach to engaging in trauma-focused work in the early stages of therapy. We do this by analysing therapy sessions conducted with those clients experiencing trauma symptoms and utilising access to a convenience sample of socially anxious clients.

2 | BRIEF LITERATURE REVIEW FOR PCE THERAPIES AND TRAUMA-FOCUSED WORK

Within the NHS (specifically the Improving Access to Psychological Therapies [IAPT] initiative and in line with NICE Guidelines), clients reporting post-traumatic stress are routinely referred to specially trained CBT or EMDR therapists. However, a survey of NHS specialist trauma services suggested that a much wider range of therapeutic approaches are frequently offered to traumatised clients (Murphy, Archard, Regel, & Joseph, 2012). The need for a range of approaches to therapy for traumatised clients is largely due to the fact that trauma-focused CBT was designed specifically for the treatment of PTSD symptoms, whereas this might be less effective for clients that have trauma related to childhood abuse experiences

(Cloitre et al., 2010) and have more complex trauma presentations. It is also possible that such clients are not immediately recognised within the IAPT system as traumatised and receive other diagnoses (such as social anxiety, depression or even psychosis). Despite the lack of randomised trial evidence for traumatised and anxious clients, the evidence from practice-based research suggests large numbers of trained person-centred and experiential therapists routinely work with traumatised clients, often in the voluntary and third sector, where clients seeking therapy typically do not neatly fit the requirements for accessing IAPT; instead, they tend to find that the third sector context is more suited to their needs (Murphy & Joseph, 2013). Such therapies are often available for longer, more relationship oriented, exploratory in nature and focus more on underlying difficulties than surface level experiences associated with trauma symptoms.

Evidence suggests that emotion-focused work within therapy for traumatised clients is helpful for a range of trauma sequelae, including but not restricted to depression (Goldman, Greenberg & Angus, 2006), social anxiety (Elliott, 2013) and interpersonal problems for couples (Johnson et al, 1999). Rachman (1980) was one of the earliest advocates of the role of emotion processing in trauma therapy. Two common person-centred and experiential principles are emotion processing and emotion regulation (Freire, Elliott & Westwell, 2014). Rachman (1980) suggested that all exposure-based work in behaviour therapy is aimed at facilitating emotion processing. So rather than thinking that exposure alone was sufficient, Rachman's principle was that behavioural exposure was in the pursuit of emotion processing, which is in turn a cornerstone and strength of person-centred and experiential therapies.

A randomised controlled trial looking at the effects of emotion processing in therapy with clients who had experienced childhood abuse found that combining either skills training in emotion self-regulation or supportive counselling with exposure was better than exposure alone (Cloitre et al., 2010). Interestingly, no difference was found between the emotion regulation/exposure and the supportive counselling control for early drop out or termination; however, significant differences were found between the emotion regulation with supportive counselling and exposure control conditions with higher rates of early dropout and termination in the exposure control condition. This finding suggests that the early phases of trauma therapy are crucial and that it is probably important to focus on relationship building before exposure-based techniques are used. Importantly, this finding also suggests that therapeutic activity in the emotion regulation and the supportive counselling control conditions provided better chances of completing therapy than the exposure control condition. This research is challenging for the NICE-recommended therapies for PTSD because they strongly advocate exposure-based principles as the active ingredient. However, as exposure is intended to facilitate emotion processing, exposure without attending to emotion regulation or within a well-established counselling relationship is clearly less effective. In a time-limited and results-driven climate such as IAPT, a focus on exposure alone might increase the risk that clients with abuse-related trauma symptoms

terminate therapy early and prior to the completion of important emotion processing tasks. As the study by Cloitre et al. (2010) suggests, a well-established therapeutic relationship is required for achieving results in trauma-focused exposure work.

Emotion-focused therapy (EFT), an approach to psychotherapy grounded in the principles of the person-centred therapeutic relationship, has developed and evolved based on contemporary emotion theory and incorporated Gestalt and Focusing methods to facilitate emotion processing (Greenberg, Rice & Elliott, 1993). The approach has proven effective with clients experiencing post-traumatic stress as a result of childhood abuse (Paivio et al., 2001; Paivio & Laurent, 2001). A key factor in person-centred and experiential therapies is empathy (Elliott, Bohart, Watson & Murphy, 2018). Empathy might be particularly important for the therapeutic engagement of trauma survivors, especially those that have suffered childhood abuse and interpersonal violence, and who have therefore developed introjected images of others as either malevolent or unhelpful (Elliott, Davis & Slatick, 1998). Offering a genuinely caring, empathic relationship is crucial to long-term success, as staying in therapy is more likely to lead to more positive outcomes (Norcross & Lambert, 2011). In a study looking at the role of empathy in engagement in therapy and linking this to the reduction in trauma symptoms, Mlotek (2013) reported that empathy predicted client engagement in therapy and a reduction in traumatic stress symptoms independent of engagement, suggesting empathy has both a direct and indirect effect on outcome, and client engagement partially mediated the relation between empathy and outcome. Further work exploring the narrative and emotion integration change sequence in traumatised clients receiving EFT is also being conducted (Friedlander, Angus, Xu, Wright, & Stark, 2019).

Person-centred therapy is firmly grounded in relationship-based practices, making it potentially well placed to carry out trauma-focused work (Joseph, 2015). A randomised control trial of CBT and Rogerian Supportive Therapy found no between-group differences in PTSD symptoms at the end of therapy or at follow-up; whilst both approaches showed sustained gains at follow-up (Cottraux et al., 2008). Contrary to the finding reported by Cloitre et al (2010), Cottraux et al. (2008) found that the CBT condition had slightly better retention. This is an important finding for person-centred and experiential therapists to consider, as some therapists misconstrue the person-centred relationship as limited to a *laissez-faire* arrangement (Rogers, 1951) and might therefore be less inclined to engage in the more trauma-focused work that a client requires.

There is a small but growing body of evidence in support of trauma-focused work within person-centred therapy. Some of this evidence is based on qualitative case studies (Murphy, 2009; Tickle & Murphy, 2014) showing the benefits of person-centred therapy with clients traumatised through childhood abuse and domestic abuse. Added to this, research in the field of Focusing-Oriented Therapy (Coffeng, 2004; Rappaport, 2011; Santen, 2014) showed how a person-centred and experiential approach worked with traumatised young people.

However, there is undoubtedly a lack of randomised controlled trial research on bona fide person-centred therapy for post-traumatic

stress, and randomised controlled trial research on emotion-focused therapy for post-traumatic stress is limited to complex trauma (Paivio, Jarry, Chagigiorgis, Hall & Ralston, 2010). Despite this, it is widely known that person-centred therapists are often situated in third sector and non-governmental organisations, meaning that outside of statutory health care there are large numbers of person-centred and experiential therapists working with traumatised clients. In addition, early termination of therapy is an issue for traumatised clients. Empathy, a central concept in person-centred and experiential therapy, seems to be related to engagement and outcome in trauma-focused therapy (Mlotek, 2013) making the approach suitable for further research in this area.

Consequently, clients who access therapy experiencing traumatic stress, both inside and outside of statutory healthcare provision, will frequently receive an alternative to the NICE-recommended treatment of trauma-focused CBT. This can mean two things; first, more person-centred and experiential therapists holding positions in the third sector or charitable organisations need to be trained in trauma-focused CBT and/or EMDR to make services compliant with NICE recommendations (even though the evidence for CBT is not particularly relevant for the majority of more complex abuse-related traumatic stress presentations); or second, person-centred and experiential therapists working in either the statutory or third sectors need to have access to clear, theoretically consistent guidance for practice, based on specific, evidence-informed therapeutic principles supporting their approach. To follow the second option would provide a potentially helpful way forward for therapists already trained in a person-centred and/or experiential approach, and would maintain a wider choice of therapy for traumatised clients. Once the key therapeutic principles and guidance have been identified for working with trauma, these can subsequently be put to the test through randomised control trials to generate a firm evidence base for person-centred experiential therapy for traumatic stress.

This study aims to provide the first step towards this process. In this study, we set out to identify core and specific key therapist principles in person-centred and emotion-focused therapy to inform the development of a person-centred experiential therapy that can support engagement in the early sessions for clients with a trauma presentation, especially principles that appear to facilitate therapeutic progress. To do this, we modified Strupp's (1980) case comparison method, using a two-by-two case comparison featuring good versus poor outcome cases from person-centred versus emotion-focused therapies.

3 | METHOD

3.1 | Case selection

We identified two cases, one good and one poor outcome, in each of the two different types of therapy. All four cases met our inclusion criteria: That is, each case met DSM-IV-TR diagnostic criteria for PTSD and was selected from the Strathclyde Social Anxiety Experiential Therapy data set at the University of Strathclyde Research Clinic.

All participants had given signed informed consent and permissions for outside research teams to use their data under the supervision of the chief investigator (RE). From a list of socially anxious clients with documented PTSD diagnoses, we selected two good and two poor outcome cases using mean residual gain scores. That is, for each of the outcome measures (Personal Questionnaire, CORE Outcome Measure, Strathclyde Inventory, Inventory of Personal Problems and Social Phobia Inventory), pre-test scores were first used to predict post-test scores; next, standardised differences between the actual and predicted post-test scores were calculated; finally, these standardised residual gain scores were averaged across all available outcome measures for each client. Good and poor outcome cases were identified as those with the best (negative mean residual gain) and worst (positive mean residual gain) scores in the set of available cases. This meant that poor outcome cases had outcomes about half a standard deviation worse than expected, whilst good outcome cases at least 0.9 standard deviation better than expected for the data set.

3.2 | Therapists and therapies

All therapists in the Strathclyde Social Anxiety Study were qualified to postgraduate diploma or higher degree level. Clients were offered up to 40-sessions of either person-centred or emotion-focused therapy. One therapist had a PhD in psychology and was a tutor on a postgraduate counselling course; two had MSc degrees (in counselling and clinical psychology, respectively), and one was a current MSc student with a postgraduate diploma in counselling. Two of the therapists were from South America, and the other two were Scottish.

3.3 | Data collection

Client participants completed the research protocol outcome measures prior to the first session, after session 8 and at the end of therapy. There were five outcome measures: the Personal Questionnaire (Elliott et al., 2016), an individualised weekly problem distress measure consisting of about 10 problems identified by each client as difficulties they wanted to work on in therapy; the CORE Outcome Measure (Barkham, Mellor-Clark, Connell & Cahill, 2006), which assessed general problem distress; the Social Phobia Inventory (Connor et al., 2010), a problem specific measure of social anxiety difficulties; the 26-item version of the Inventory of Interpersonal Problems (Maling, Gurtman & Howard, 1995), an interpersonal problem distress measure; and the Strathclyde Inventory (Freire, 2007), a person-centred outcome measure assessing congruence versus incongruence.

Clients also completed two measures after session 3 plus every fifth session: first, the Working Alliance Inventory-12-R (WAI; Hatcher & Gillaspay, 2006; Hovarth & Greenberg, 1989), a client self-report measure that assesses the therapeutic relationship in terms of Bordin's (1979) model of therapeutic bond, and agreement on goals and tasks (12 items rated on a 5-point scale); and, second, the Therapeutic Relationship Scale (TRS; Carrick & Elliott, 2013; Sanders & Freire, 2008), a targeted client and therapist self-report measure assessing two key person-centred therapy concepts: quality of

offered therapeutic relationship and therapist nondirectiveness; the version we used consisted of 27-items each rated on a 5-point scale (0: "never"; 1: "seldom"; 2: "sometimes"; 3: "frequently"; 5: "always"). In addition, at the end of each session, clients completed the Helpful Aspects of Therapy form (Llewelyn, 1988), a qualitative self-report about significant therapy events. The University of Strathclyde Research Ethics Committee granted ethical approval for the study.

3.4 | Data analysis

Having identified appropriate cases, we gathered all available data, for each of the four cases, for the first three therapy sessions. Audio recordings of all twelve sessions were fully transcribed by a professional transcription service. Using the transcripts and the audio recordings, two members of the research team independently made process notes of the transcribed sessions focusing on session episode structure and treatment principles or therapeutic competences (Elliott, 1993). One researcher completed this task blind to the good versus poor outcome of cases. As each researcher analysed each case independently; the third researcher acted as independent consultant on the findings. The role of the consultant was to offer theoretical accounts of the coded session episode structure and therapeutic principles. Next, each researcher checked their findings against the other's findings; the cross-checking of coded principles was then followed by regular meetings to integrate the findings into a set of key common principles. Good versus poor outcome cases were used to offer a contrast and context to one another in the various responses. Following the identification of coded principles, the Helpful Aspects of Therapy forms (HAT Form) were inspected as a source for triangulation to identify additional aspects of the therapeutic process that clients explicitly stated they found helpful that had not been identified in the process analysis by the research team or to confirm those that had been identified. The result at this stage was a set of therapist principles expressed as actions or qualities that seemed to help or hinder client engagement in the early stages of trauma-focused therapy in person-centred and EFT.

4 | RESULTS

4.1 | Quantitative case selection data

Table 1 shows the mean residual gain scores and outcome measures used for the four cases selected for analysis.

TABLE 1 Residual gain scores for good and poor outcome cases

	Poor outcome	Good outcome
Person-centred therapy	+0.49 [PQ, IIP]	-0.93 [PQ, IIP, CORE, SPIN, SI]
Emotion-focused therapy	+0.66 [PQ only]	-1.50 [PQ, IIP, CORE, SPIN]

Abbreviations: CORE: Clinical Outcomes in Routine Evaluation Outcome Measure; IIP: Inventory of Interpersonal Problems; PQ: Personal Questionnaire; SI: Strathclyde Inventory; SPIN: Social Phobia Inventory; SPIN: Social Phobia Inventory.

4.2 | Qualitative findings

Using the findings from the qualitative data analysis, we produced a set of four initial key common therapist principles for effective person-centred experiential therapy with socially anxious trauma survivors in the early phase of therapy. The therapist principles we identified were as follows: (a) support early relationship building/working alliance formation, (b) facilitate identification and recognition of past events as client trauma experiences, (c) facilitate work on traumatic sources of current experiential and interpersonal difficulties and (d) offer self-agency focused empathy.

4.2.1 | Support early relationship building/Working alliance formation

Listen for, empathise with, and work with the client to develop a therapeutic bond; collaboratively articulate the client's goals for therapy; and agree the tasks.

Consistent with the Bordin (1979) model of working alliance formation, our process analyses identified, and the clients' HAT form responses confirmed the *relationship building/working alliance formation* as a key principle concerning trauma-focused work. The relationship formed between client and therapist created a safe place for the client to explore past traumatic events that continue to impact them in their day to day life. A key feature of the relationship building capability was working alliance formation. The working alliance in the two PCT cases was more explicitly concerned with developing strong emotional bonds between the client and therapist. The goals and task collaboration aspects, on the other hand, were developed more implicitly as part of the ongoing therapeutic process. For example, the clients' goals were reflected to them through the therapist's empathic understanding responses, which also conveyed unconditional positive regard for the client's expression of therapeutic goals.

In the EFT cases, the alliance was concerned more explicitly with the goals and the tasks of therapy and the therapeutic bond component was a more implicit process. In the good outcome EFT case, the therapist identified and worked with potential ruptures as the alliance was forming and as the client became overwhelmed by traumatic memories. This enabled the client and therapist to acknowledge the importance of these early memories but also set the pace of the work and to establish "resolution" as a goal along with how this could be achieved. The excerpt below shows the identification of the goal of working on a conflict and how chair work might be used to facilitate this:

EFT good outcome case. Session 3: starts at approximately 53 min (relevant text in italics):

Client: I definitely want to talk about it again next week, because I think that we've hit on something that is pretty profound, really, and I'm really glad, because I've been looking for this for a long time. So

it is something I want to delve into more. It probably does...

XXX: I don't actually feel that bad about going into that. I actually do think that I'm strong enough to just take it. I don't want to beat myself up unnecessarily, but on the other hand I'm kind of used to it. Yes, I do want to talk about it again next week.

Therapist: *Sometimes, just talking about it, it's very common to have the different aspects of yourself, and that's really what we quite often work with. Remember I was saying about the chair? So it's quite often what we work with.*

Client: And I didn't understand-

Therapist: *In time we will do that. We will maybe put that part in the chair, and really hear it.*

Client: The bully?

Therapist: *Then maybe have a dialogue with the part that hears it and experiences it.*

XXX: *That's the sort of work that we could do, and that can help to open it out.*

XXX: *Quite often what we can be looking for is what that part is actually - where it's come from or what it's trying to do. Sometimes it's trying to be helpful, but it's got a bit distorted along the way.*

Client: Interesting.

Therapist: *Yes, so it's just there's lots that we can do in terms of working with that. That sounds a bit strange to say that, does it?*

Client: No, it doesn't. It feels right, actually. It's fascinating, isn't it? Yes, it is something I want to think about more, and some part of me is actually telling me that...

4.2.2 | Facilitate the identification and recognition of past events as client trauma experiences

Listen for and facilitate the identification of events in the client's past as traumatic and support awareness and symbolization of this.

Clients from all four cases identified the importance of therapists' ability to *facilitate the development of client awareness for past trauma experiences*. The most obvious ways that therapists were

able to evidence this principle was through the facilitation of client's narrative retelling of past trauma experiences. EFT therapists did this in a more structured way than PCT therapists. For example, the good outcome EFT therapist asks clients directly "is that something you would like to work on" when a client mentions past trauma. PCT cases were less explicit in indicating past traumas as something potentially to be worked on, but instead acknowledged these as important difficulties for the client as they were symbolised within the self-concept. These are two examples taken from the good outcome cases for both EFT and then PCT. In the EFT case, the client is recalling the impact of her brother's death but also how their own childhood traumas have permeated many aspects of their lives. In the PCT case, the client is starting to realise how her mother's jealousy of her relationship with her father was traumatic in her own childhood.

EFT good outcome case. Session 1: starts approximately 5 min into session.

Therapist: *So it's really permeated out into so many things.*

Client: *Into everything.*

Therapist: *Into everything. A particular thing that is important for you is the children and how they are, and what it's done to them.*

Client: Yes.

Therapist: *So life has just shifted very dramatically by the sounds of it since he died.*

Client: Yes. I don't know what else to say.

Therapist: *Right. Okay. But it feels as if that's an important area that we might come back to. So at the moment it's like work's really important and you want to be able to do that, you have to do that.*

Good outcome PCT case. Session: starts approximately 30 min into session

Therapist: *So it's almost like in the relationship that you and he had, he was able to behave in a particular way that was different.*

Client: Yes, and I think it was something my mother saw.

I think what he was doing was he was channelling something through me. I think she was jealous of it slightly, in retrospect. I didn't think that as a child.

Therapist: *But now you kind of wonder?*

4.2.3 | Facilitate work on traumatic sources of current experiential and interpersonal difficulties

Listen for, empathise with, and help the client explore past trauma-related experiences that may be a source of current distress (including but not restricted to social traumas during childhood or adolescence and current interpersonal difficulties).

Process analysis of transcripts enabled us to identify this principle. Therapists in both EFT and PCT cases were able to help their clients to explore the past trauma experiences that were sources of their current difficulties. There was a clear difference here between the PCT good and poor outcome cases. In the good outcome PCT case, the therapist empathically and explicitly reflected trauma experiences that were related to current psychological distress. In the poor outcome PCT case, the therapist generally did not explicitly respond to past traumas when the client referred to them. Below is an example of trauma specificity from early in the third session of the good outcome case.

PCT good outcome case. Session 3: starts approximately 2 min into session.

Client: Yes, I'm just like well, you know, "you're not the boss of me, I'm not going to do that." And then he'd be like "right, I'm going to make you do it." You know, he's make me do things like- when my parents weren't around, you know, because he was just a teenage boy, he was trying to sort of make me eat cold porridge and you know, just general sort of...

Therapist: *Just kind of really kept torturing you.*

Client: ...I think Stanley (pseudonym), he never addressed that when he was up, but then when he went away he's obviously had a good think about things *and I think what he's always done is blamed me through his- you know, if anything wasn't going right, he blamed me as a kid for kind of minor troubles. You know, if something went missing, Yvonne (pseudonym), must have lost it or picked it up.*

Therapist: *So obviously for like, him you've been an actual kind of scapegoat?*

Further on in the same session of the good outcome PCT case, the example below shows the therapist reflecting their understanding that the client is developing an appreciation about the past and how traumatic experiences within the family are currently experienced and impacting her daily life.

PCT good outcome case. Session 3: starts approximately 55 min into session.

Client: These are all big things. Because I've noticed when I came in and I started filling the form in, I

looked at the thing and I thought for a while some of these didn't seem as important, because I'd put my family so far away from me as much as I can. *When I came in today I thought actually, here it goes, I'm actually in the middle of these feelings again that I can sometimes ignore through choice.*

But when they come up, when my family came up again really strongly, it just feels like I'm back squashed down again.

Therapist: *So, what's going to happen over the next week then, is kind of the epitome of the difficulty in your life.*

Client: Yes, and I wonder, I hope that I can- I don't want to cause any conflict, I just want them to understand- accept that that I have an opinion and that my opinion is as valid as their opinion.

This principle is linked to that above of identifying and acknowledging past events as traumatic; however, whereas identifying and acknowledging is developed in terms of the identification of a particular event as being traumatic in nature, Principle 3 facilitates the next step by supporting making connections from past events to current experiential and interpersonal difficulties in the client's process orientation. Therapists in good outcome cases were specifically identifying and responding to traumatic events from the past. Helping clients to explore their past traumatic experiences is known to be an important aspect of trauma-focused work (Joseph, Regel & Murphy, 2012).

4.2.4 | Offer self-agency focused empathy

Listen for, empathise with, and engage the client's personal agency/self-directedness in processing personal responses to trauma-related experiences including emotions, images, behaviours or thoughts.

Our process analysis identified empathy as an important factor in three ways in the early stages of therapy. The first is outlined in Principle 1 referring to early relationship/alliance formation. The second is in Principle 3 where the therapist supports the processing of past trauma-related experiences to facilitate connections to present experiencing. Third is the therapist's capacity to experience and communicate self-agency focused empathic understanding for the client. These empathic responses are accurate identifications of the client's sense of personal agency as they carry forward their experiencing of trauma processing. The therapist communicates this to the client, accurately and effectively supporting the development of client autonomy. The following examples of therapist self-agency-focused empathic responses are taken from 11 to 14 min into the very first session of the good outcome PCT case. The client has been talking about the difficulty of once being homeless and how ashamed she had felt. However, the therapist's response puts into the foreground her feeling of having been powerless to being able to push away:

Client: Yes, because I felt worthless. I'd lost everything.

It wasn't everything, but everything that I'd considered a staple in my life had gone.

I felt, "Well, I must hang on to people because if I lose them, what have I got left?"

I think then when I got the flat, I just thought, "Well, people didn't really..."

They did help me, but, in my mind at the time in the way I was feeling, I thought, "Well, people helped me, but it was very conditional, and I don't need to put up with that anymore. I don't have to tolerate."

There were times you'd be sitting on somebody's couch and they'd be sitting up all night talking to you. You'd be thinking, "Please go to bed and let me go to sleep."

They'd be telling you their life story and their problems, and I'd think, "Please, please go to sleep and leave me alone."

Therapist: Yes, because they had control, they could have left the room and gone to their bed?

Client: Yes, and some people did, but there were other people, where I'd maybe get to sleep at about 5:00 in the morning and have to get up at 9:00am and leave.

It was a difficult time.

Therapist: Going from your period of those difficult relationships, *just trying to keep them going because you needed to* and to tolerate the way that you felt in amongst all of that, *to finally getting your own place and really wanting to push away?*

Client: Yes, push everyone away, even my family.

In this example, the therapist senses the client's struggle was grounded in past traumatic events manifested in interpersonal relationships (principle 3) and how she had been dependent on other people, but also the client's self-agency and desire to "push away." Supporting clients to actively process traumatic life events enables them to become more autonomous (Joseph, Regel & Murphy, 2012). Similarly, the client is accepted by the therapist as wanting to "push everyone away." As the client experiences this to be no less acceptable to the therapist than any other self-experience, the client becomes more self-accepting. Previous research has shown a connection between self-acceptance and post-traumatic growth that is related to

intrinsic motivation (Murphy, Demetriou, & Joseph, 2015). Here, the client is forging her way forward, both actively in the world and in her expressions to the therapist, and as she does so, the therapist's unconditional positive regard is expressed through the self-agency-focused empathic reflection. The result is that the client follows their intrinsic motivations.

5 | DISCUSSION

In this research, we were able to identify four, early session, key common therapist principles in good outcome cases from both EFT and PCT for traumatised clients with social anxiety. The first of these was the principle of supporting the formation of the therapeutic relationship and alliance. The second was supporting clients to identify and acknowledge past experiences as traumas and symbolise these in the self-concept. Third, therapists helped clients develop greater trauma specificity by explicitly connecting their experience of traumatic events to their current life, so that these can become the focus of therapeutic work. Lastly, therapists were able to support client self-agency through focused empathic responses that targeted the client's self-directing and self-healing potential.

In this study, we have also developed a new method for identifying key common principles that provides an alternative to the methods currently adopted for generating therapeutic competency frameworks. For example, the competences that inform and underpin the development of the original CfD manual are a refined version of Roth, Hill and Pilling's (2009) taxonomy of humanistic therapy competences, which were developed in a rather convoluted manner: First, a set of well-designed randomised clinical trials of PCT and EFT were identified. Then, the "treatment manuals" ostensibly associated with these RCTs were located, including widely read published texts (Greenberg & Watson, 2006; Mearns & Thorne, 2013). After that, humanistic therapy competences were extracted from these texts. The CfD core competency list and training curriculum took in a subset of the larger humanistic therapy taxonomy (Hill, 2011).

However, there are several difficulties with this method that the current study highlights. To begin with, there is a substantial disconnect between the RCT-based global outcome evidence and the specific elements identified in the CfD competency list. The texts analysed were large and contained literally dozens of competences, with nothing to tell us which contributed to outcome and which did not. It is even possible that some of the competences were harmful to clients but were overshadowed in the aggregate by multiple helpful competences. Furthermore, we do not even know which competences were delivered to clients in the RCT evidence base, and which were not. Thus, it is not clear whether the method used for CfD competency identification and curriculum development is effective, efficient or gives rise to a truly empirically supported approach. In the psychotherapy research field, there are several research paradigms considered to be useful for testing the effectiveness of therapeutic

change processes (for example, process–outcome correlations, retrospective client-identified helpful factors; see Elliott, 2010); however, the Roth et al. (2009) method of extracting competences from RCT-linked "treatment manuals" is not one accepted as valid or useful by psychotherapy researchers (see Elliott, 2008, for a first-person account of this approach).

In addition, even if the manual-extraction competence identification method were valid, there is not enough RCT research and treatment manual development on EFT and person-centred therapy in the field of trauma-focused therapy to provide a basis for it to be used.

The development of key common therapist principles using the method in this study offers a systematic way for developing understanding and therapist guidance based on qualitative research. This is in contrast to methods that "drawdown" what are assumed to be competent therapist actions from treatment manuals used in RCTs, the method used by Roth et al. (2009) to construct the humanistic therapy competences that form the basis of Counselling for Depression (Sanders & Hill, 2014).

Consequently, by selecting cases that are good and poor outcome we have developed an alternative method for identifying key common therapist principles from transcripts of good outcome cases. This approach is inductive and derived from the "bottom up" being grounded in and evidenced by actual therapy processes.

There are some limitations to the present study. First, the method is labour intensive, as it requires complete transcripts of counselling sessions and reviews of transcript and session recordings by multiple observers. However, using transcripts ensures that once principles are identified, it is easy to document them with illustrative transcript examples. Second, although good outcome cases are used, the method does not ensure that the therapist principles identified are actually involved in client change. To determine more specifically how these therapist principles are involved in the change process would require triangulating the principles with another research method such as client post-session or post-therapy helpful factors data, for example, using the Helpful Aspects of Therapy Form or the Change Interview. Third, we selected the terminology "good" and "poor" outcome cases in the knowledge that this language could be interpreted as being value-laden. However, we selected this terminology to represent cases that have made therapeutic progress or cases that failed to progress, according to the outcome measures used within the research clinic. The terminology was selected because it was considered the most parsimonious, whilst it is understood that some clients can experience therapy as helpful without reporting progress within measurement scales. Fourth, we only looked at the first three sessions of therapy, thus providing only an account of key principles observable early in therapy. Further research is now needed to identify principles in the middle and late sessions of PCT and EFT for trauma clients. This work is currently ongoing at two research clinics. Beyond this, we call for replication of this study with new cases identified from distinct samples of clients experiencing traumatic stress.

6 | CONCLUSION

In this study, we have been able to identify four key common therapeutic principles that are present in good outcome cases of PCT and EFT for traumatised clients. These principles relate to early relationship/alliance formation, identification and acknowledgement of past events as traumatic, facilitation of past traumatic events locating these in the client's present process orientation, and finally therapists using self-agency focused empathic responses to support the self-direction and self-healing capacities of clients. In addition, we suggest that we have identified a new method for the identification and explication of therapist principles. This new method involves a bottom-up inductive process of analysis. This method needs further development and replication but offers a significant step forward from existing methods employed that lack rigour and sophistication, and that fail to ensure that competencies are genuinely linked to therapist actions within the actual therapy under analysis and linked to good outcome cases.

In this study, we have begun the process of mapping therapeutic principles within person-centred experiential therapy for early trauma work. We suggest that further studies be carried out to replicate the current study and to broaden the range of principles that support change. We also conclude that more work needs to explore the middle and later stages of trauma therapy to see what further principles will be identified within the therapy.

ORCID

David Murphy  <https://orcid.org/0000-0003-0019-3124>

Robert Elliott  <https://orcid.org/0000-0002-3527-3397>

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BIOGRAPHIES

David Murphy, PhD., CPsychol., AFBPsS., is Associate Professor at the University of Nottingham, Course Director for the MA in Person-Centred Experiential Counselling and Psychotherapy, and on the British Psychological Society's Register of Psychologists Specializing in Psychotherapy. David is editor of the WAPCEPC international journal Person-Centered & Experiential Psychotherapies.

Robert Elliott, PhD., Clinical Psychologist Robert received his PhD from the University of California, Los Angeles. He is an internationally recognized psychologist, researcher, and trainer. He has led EFT training in the States, many parts of Europe, and Asia. He is co-author of important books in the field of Psychology, including: Facilitating emotional change, Learning emotion-focused psychotherapy, Research methods in clinical psychology; as well as author of more than 170 journal articles, and book chapters.

He has received the Distinguished Research Career Award of the Society for Psychotherapy Research, and the Carl Rogers Award from APA for his distinguished work in the field.

Lorna Carrick is the counselling courses subject leader in the counselling unit at the University of Strathclyde, Glasgow, Scotland. Lorna teaches on the Person-Centred/ Experiential MSc in Counselling & Psychotherapy. She teaches EFT with Robert Elliott and has delivered EFT Training the UK and Europe. Lorna is also involved in developing Person-Centred/ Emotion-Focused Therapy research and training for therapists at Strathclyde University's Research Clinic. Lorna began her career as a Clinical Psychologist and she has over 20 years of experience working in the Person-Centred/Experiential approach as a therapist, supervisor, trainer and developer of counselling services. Lorna has a deep commitment to extending the evidence base for Person-Centred and Emotion-Focused Therapies through focused and innovative research.