Bearing Witness: Working with clients who have experienced trauma — Considerations for a person-centered approach to counseling

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Abstract. This paper explores traumatic experience from both a cultural and neurophysiological perspective. An argument is developed to support and challenge the person-centered approach in working with clients who have experienced trauma. Through a case study, elements of theory are illustrated. Drawing from the increased knowledge base in neurophysiology, this paper aims to strengthen confidence in wider empathic attunement and brings attention to safety for both client and counselor.

***Key Words*:** Trauma, neurophysiology, cultural perspective, empathic attunement

Zeuge sein: Die Arbeit mit traumatisierten Klientinnen und Klienten. Überlegungen zu einem Personzentrierten Ansatz zur Beratung
Dieser Artikel untersucht traumatische Erfahrung aus einer kulturellen und einer neurophysiologischen Perspektive. Pro und Kontra werden erörtert, um den Personzentrierten Ansatz in der Arbeit mit Traumaopfern zu untermauern, aber auch in Frage zu stellen. Mit einer Falldarstellung werden Elemente der Theorie veranschaulicht. Mit Hilfe des inzwischen vertieften Erkenntnisstandes der Neurophysiologie beabsichtigt dieser Artikel, das Vertrauen in ein erweitertes empathisches Mitschwingen (Attunement) zu bestärken. Außerdem lenkt er die Aufmerksamkeit auf das Thema Sicherheit — sowohl für die Klientinnen und Klienten als auch für die Beraterinnen und Berater.

Ser testigo: Rabajar con consultantes que han vivenciado trauma. Consideraciones para un enfoque centrado en la persona
Este artículo explora la experiencia traumática desde una perspectiva tanto cultural como neurofisiológica. Se desarrolla un argumento para apoyar y desafiar al enfoque centrado en la persona en el trabajo con consultantes que han vivenciado trauma. A través de un estudio de caso, se ilustran componentes teóricos. Con fundamentos en una crecida base deconocimientos en neurofisiología, este artículo se propone fortalecer la confianza en una sintonización empática más amplia y hace un llamado de atención a la seguridad del consultante y del terapeuta.

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Témoignage : Le travail avec des clients ayant vécu des expériences traumatiques. Réflexion sur une approche du counselling centrée sur la personne
Cet article explore l'expérience traumatique à partir d'un double perspectif, culturel et neurophysiologique. Le développement de son argumentation à la fois appuie et questionne le travail dans l'approche centrée sur la personne avec des clients ayant eu des expériences traumatiques. Une étude de cas illustre les éléments théoriques. L'article puise dans les connaissances croissantes qui fondent la neurophysiologie pour étayer la confiance en un accordage empathique élargie et met en exergue l'importance de la sécurité pour le client comme pour le counsellor.

Testemunhas: O trabalho com clientes vítimas de experiências traumáticas. Considerações para um *counselling* centrado na pessoa
O presente artigo explora a experiência traumática, do ponto de vista cultural e neurofisiológico. Desenvolve-se argumentação que apoia a abordagem centrada na pessoa e a desafia a trabalhar com clientes vítimas de experiências traumáticas. Através de um estudo de caso ilustram-se alguns elementos teóricos. A partir de uma crescente fonte de conhecimentos de base neurofisiológica, este artigo pretende sustentar a confiança num maior afinamento empático e chama a atenção para a segurança, quer do cliente, quer do *counsellor*.

トラウマを抱えたクライアントのカウンセリング：パーソンセンタードアプローチを適用するにあたっての考察
この論文では、トラウマ体験を文化的および神経生理学的という２つの視点から検討する。トラウマを体験したクライアントとのカウンセリングにおいて、パーソンセンタードアプローチを活かして行く上での利点と課題点について論述し、事例検討を通してPCA理論を実際の事例にどのように利用したのかを分析する。近年発展が目覚ましい神経生理学の知識を援用しながら、この論文では共感のより幅広い有用性を主張し、クライアントとカウンセラー両者にとっての安全性を喚起する事を目的としている。

The experience of trauma inspires a whole range of therapeutic possibilities. There is a vast amount of literature on the subject and many intelligent therapeutic approaches based on research, wisdom and sound principles. Within this paper, it is my intention to examine the relevance of neurophysiological responses to traumatic experience and relate current understanding to the person-centered approach to counseling. I will place this discussion within an argument that culture specificity requires both appreciation and perspective in order to engage more fully the healing response. Finally, I will propose a case for the person-centered approach to counseling that emphasizes empathic attunement and an increased knowledge base as a way of promoting confidence, safety and integration of self-experience both for the client and the counselor.

LANGUAGE AND CONCEPTS

Any experience may be considered traumatic if it causes unbearable psychic pain (Kalsched, 1996). The medical model of Western culture defines trauma more particularly as an event, and the response to this event as post-traumatic stress (American Psychiatric Association, 1994). Within this model, the experience of trauma becomes a stressor if the personal response

involves intense fear, helplessness or horror. The personalization of this definition opens a door to a fairly global and recognizable experience, yet the notion that a traumatic event may create stress or disorder may not be meaningful in a culture where fate, supernatural and spiritual values predominate and determine psychic structure (Summerfield, 2004). Even within Western culture, gender-related values may emphasize emotional containment as a sign of strength, so questioning the usefulness of a diagnosis.

The medical model definition goes on to state that if the trauma is experienced as if it were not over, if there is avoidance of stimuli associated with the trauma, if there is emotional numbing and heightened arousal, an individual may be diagnosed as having post-traumatic stress disorder (PTSD). In order to qualify for this diagnosis, the symptoms must persist for at least one month and cause impairment. Inspired by experiences during the Vietnam War, this terminology is culturally specific to Western science and ideology and relates both to treatment and to forensic support. Within this culture a diagnosis may matter therapeutically or politically to a client who experiences powerlessness as a result of their experience. Related to the diagnosis is potential access to a powerful system and, thereby, a possible route towards various types of help. Furthermore, a diagnosis may provide relief, a kind of "making sense" of paralyzing symptoms. This notwithstanding, the usefulness of a diagnosis for some people contrasts the irrelevance of this medical model for others. Summerfield (2004), in his examination of cross-cultural perspectives on the medicalization of human suffering, states:

> The medicalisation of distress entails a missed identification between the individual and the social world, and a tendency to transform the social into the biological … The objectification of understandable distress or misery as a pathological entity, a technical problem to which short-term technical solutions like counselling apply, is a serious distortion. This is not, of course, to play down what people may suffer, but to emphasise that suffering is not psychopathology. For the vast majority, "post-traumatic stress" is a pseudocondition. (p. 241)

There is a challenge culturally, politically and philosophically to the person-centered approach to counseling which would seek also to determine an individual's experience in phenomenological terms and yet live in a world where the deterministic power of Western thought is omnipresent. Consideration of traumatic experience cannot be separated from cultural context. Summerfield suggests that the specificity of medical terminology, in itself, may contribute to a secondary traumatic experience through missing a human perspective.

Mearns and Cooper (2005) offer an existential perspective on trauma describing disruption to "the whole assumptive frame upon which our sense of self is founded" (p. 65). They question the relevance of diagnostic terminology due to its failure to acknowledge experiential meaning and so they add depth to the argument against the usefulness of a medical model. This challenge takes us closer to a wider perspective that may include spiritual dimensions of experience apparently neglected by the medical terminology. Summerfield (2004) notes quite simply that a diagnosis in itself does not tell us what is really wrong. This important perspective supports expansive rather than deterministic thought. Echoing this position, Sanders (2005) argues passionately against the whole concept of medicalization.

He challenges those who align themselves with the medical model.

Considering the relevance of a diagnosis *alongside,* a client begins to balance the power of medical contribution in relation to self-experience. Wider thinking considers psychological contact with the client in context, paying attention to the cultural, spiritual and socioeconomic implications. In support of this approach, Summerfield (2004) stresses the evolving meaning of language. Interestingly, he observes that denying the prevailing medical terminology may, paradoxically, seem to minimize the experience. Trauma and any concurrent interpretations of aftereffects arise from a social and cultural context, which is shaped by co-created meanings that continually evolve. For this reason, I support an appreciation of culture specificity that holds in regard the history of its evolution. At the same time, I argue for meaningful language that supports the therapeutic experience.

Within trauma work, this open-mindedness is particularly relevant. Physiological and emotional responses to trauma have their roots in primitive reactions. By decentralizing the influence of dominant systems of thought through appreciating their implication and function alongside other cultural perspectives, we move away significantly from further paralyzing influence. The freedom inherent within this attitude may more fully engage a healing response through consciousness of collective influence. This attitude of open-mindedness lies at the heart of practice and provides the foundation for the rest of this paper.

An exploration of the relevance of neuroscience to therapeutic practice can no longer be seen as a separate topic. Damasio (1994) begins to reflect on the brain's circuitry being formed by ancestry, unique history, individual circumstances and collective influence. He states that "To understand in a satisfactory manner the brain that fabricates human mind and human behavior, it is necessary to take into account its social and cultural context" (p. 260). Hence, my interest lies in a wider and more integrated knowledge base.

This discussion, however, takes us nowhere near a fuller appreciation of the experience of *continual* fear and trauma. Most of the literature explores trauma as an event which has passed, and my focus throughout this paper is on enabling healing of the traumatic injury which, although past, is still felt in the present. The experience of working with people who are continually living in traumatic circumstance, although related, is beyond the scope of this present paper.

A NEUROSCIENTIFIC PERSPECTIVE

Physiological responses to trauma involve the autonomic nervous system (ANS) within the body. There is a vast amount of neurophysiological research emphasizing the importance of ANS arousal and the limbic system in the brain. I refer the reader to some varied and excellent texts on the subject (Pert, 1997; Greenfield, 2000; Cozolino, 2002; Schore, 2003; Damasio, 2003; Gerhardt, 2004). Within my own investigation, I am interested specifically in hippocampal functioning. This small part of the limbic system appears to be relevant to healing in as much as it is involved in contextualizing memory and the time-line of an event. The hippocampus is associated with the amygdala (also situated within the limbic system),

which is our "first alert" appraiser of danger and safety. If danger is sensed, the amygdala triggers a cascade of biophysiological events. The neurotransmitter response acts as a messaging service, communicating throughout the body. The cascade releases stress hormones, ensuring the body's rapid and best functioning under the circumstances. This chemical reaction to danger shuts down the immune system, the capacity to learn, and the body's digestive and excretory functions. Energy through increased blood supply is channeled to the limbs and to sensory perception for fight or flight. The amygdala does not become overwhelmed by stress. It will continue to call alert and to function no matter what chemicals are flooding through the system. This primitive function depends on the hippocampus to process and signal to the prefrontal cortex in the brain that the event is over. Through this process of neurotransmission, chemicals are stimulated to calm the amygdaloidal stress reaction. The function of the hippocampus, however, becomes compromised if arousal is too high. This means, under overwhelming circumstances, the traumatic event cannot be processed fully, and the amygdala's stimulated function remains switched on. Over time, in this aroused state, the body adapts — neuromodulator receptors can shut down, creating an experience of disengagement or shock. Although not fully understood, this state of emotional numbness offers only partial relief. The traumatic experience is still "held" in the body's system. Without knowing an event is over, it cannot be assigned to the past (where it belongs). This appreciation is critical for an individual who is plagued by intrusive thought, flashback experiences and haunting nightmares. Furthermore, the hypervigilance attached to having experienced a traumatic event would suggest expectancy of repeated trauma with no inner security of personal resilience to avoid or overcome the adversity. Processing and learning only become possible when safety is perceived and arousal is calmed.

When a traumatic event is encountered, one of three primitive and involuntary responses will occur: fight, flight or freeze. Automatic and immediate neurophysiological assessment through the amygdala and cerebral cortex will determine the individual's strength relative to the event and any flight path. If there is insufficient strength to fight or no chance of flight, the best survival strategy is to freeze. In this situation, both the sympathetic and the parasympathetic nervous systems (within the ANS) become aroused together to create either a "stiff" or "floppy" immobility of the body. The individual has no voluntary control over this survival decision. In relation to recovery, this piece of information might be of use to clients who have judged themselves, or who carry shame, in relation to freezing in the face of adversity. The immobility response is automatic and not under conscious control.

If the hippocampus becomes overwhelmed and cannot provide its usual function of processing, comparing and storing information, then the cortico-hippocampal networks cannot integrate the somatic, sensory and emotional experiences within networks of autobiographical memory (Colozino, 2002). Appreciation of this basic neurophysiological theory offers insight into the critical importance of establishing safety such that arousal may become calmed. It is not possible to process traumatic experience whilst in a high state of arousal. Achieving a sense of control may enable the sympathetic nervous system to return to its pre-aroused state allowing processing through the hippocampus to take place. It is then possible to establish a *sequence* of personal experience, including a sense of distance from the

traumatic event. This sequence creates personal narrative and meaning, and gives a sense of "self becoming safe" over time, rather than a sense of "self haunted by trauma." The subsequent effect of traumatic experience on the body and brain, and the modulation of this experience through support, ritual or treatment intervention, is a topic for ongoing research. Although this system of scientific thought is part of Western orthodoxy, the importance of balance within the body and the restoration of function is a cross-cultural pursuit, observed also in Eastern and in tribal medicine.

Three basic tenets of therapeutic intent emerge from neurobiological exploration:

- To provide a safe environment
- To enable internal control
- To restore or promote resiliency

These three link well with each other. Once an individual feels in sufficient control, safety will be experienced. This sense of being safe enough seems to reduce arousal such that internal resources can be identified and a sense of resilience supported. Entering the therapeutic encounter with this intention involves purposefulness which I will discuss later.

Within the person-centered approach to counseling, Brodley (2006) argues clearly for attunement rather than goals for clients. She presents an important reminder that: "Systematic non-interference protects the client's self-determination, autonomy and sense of self — it allows and facilitates self-healing and self-development" (p. 47). Classical person-centered practice trusts attunement with, and responsiveness to, the whole organism of the client. This is sufficient for healing to take place. No understanding of biology is necessary.

My argument is that a basic understanding of neurophysiology, together with cultural sensitivity, supports an informed and finely tuned responsiveness that does not need to be directive or selective. I am interested in presenting a case that supports expansive empathic attunement with an additional knowledge base such that practice is not only enriched but also continually challenged. In discussing further the person-centered approach to working with trauma, I will explore also some general elements of trauma therapy across therapeutic modalities.

TRAUMA THERAPY AND THE PERSON-CENTERED APPROACH

Achieving a sense of safety and control are key indicators in reducing ANS arousal and offer a place for the healing process to begin. There are many different contexts for healing — counseling is only one such opportunity. People are usually resilient in the face of adversity and cultural contexts have evolved specific support mechanisms that can be more relevant than one-to-one counseling (Herbert & Sageman, 2004). The person-centered approach to counseling has evolved within Western culture. Sensitivity to the appropriateness of this therapeutic medium is an essential consideration. Given that the suitability of counseling, the therapeutic context and support for the counselor are well-considered in supervision, the question then arises of whether or not trauma therapy requires specialist experience.

The person-centered approach, with its emphasis on relational contact, may offer an important opportunity for personal control through moment-to-moment connection. For those clients who would dive into expressing their traumatic experience urgently, driven by a need to be released from their torment, care around psychological and physiological safety is important. Through attention to physiology, empathic resonance (Schmid & Mearns, 2006) and relational contact, the person-centered approach holds key contributions towards safety. I will tease these strands out a little further. Perception of ANS arousal may connect with empathic resonance such that accuracy of contact can be finely tuned. Perception may be visual, observing changes in skin coloration and tone. However, more likely, perception comes through a *subceived* sense of change in relational contact. Becoming overwhelmed suggests that internal experience overtakes the secure relational contact that underpins the therapy. If the counselor is conscious of the importance of the client not becoming overwhelmed, then *equal* attention to relational contact, the client's physiology and to their phenomenological experience becomes necessary. This involves purposeful attunement to the client's levels of arousal. The moment-by-moment internal experiencing of the counselor offers an additional and concurrent sense of distance or fluctuation in contact. This notwithstanding, achieving consistent psychological contact is a challenge for both counselor and client when the client's need to be free of the trauma creates dissociative elements. Catching the point of fluctuation, just before arousal becomes so overwhelming that the hippocampus stops functioning fully, is a sensitive skill. And, of course, expressed observation of physiological fluctuation or relational contact may interrupt the client's flow. My argument is that holding attention to the body, to relational distance and to empathic resonance, may offer sufficient *range* of contact and therapeutic presence to sustain or support the client's integration of experience.

Prouty (in Krietemeyer & Prouty, 2003) observes the importance of *contact rhythm*. "Contact moves to and fro between persons. It is important to be aware of this ebb and flow as process, and to be accepting of it rather than trying to push for steady contact" (p. 160). The sensitivity to contact rhythm supports client control in the session and is likely to offer opportunity for ANS arousal to be reduced. There is a thread of theory here that weaves the fabric of trauma therapy from a person-centered approach.

Emphasizing moment-to-moment empathic attunement with the whole of the client's experience, including physiological experience, offers a subtle yet powerful connection with the rhythm of the body. Physiological responses reveal idiosyncratic clues to hyperarousal and also to relief. Through moment-to-moment connection, the person-centered approach offers the possibility of safety and control to a client who may need to process highly charged experiences. Through a willingness to connect with the ebb and flow of the client's physiology, while, at the same time, picking up empathically on the client's experience, care and attention can be held together. Furthermore, orientation to the "here and now" emphasizes a separation from the traumatic event. Processing can take place in relative safety.

REFLECTIONS ON A CLIENT

I worked with a client once who froze. She had witnessed a horrific event that overwhelmed her previously resourceful capacity, impacted her on every level and rendered her unable to function except in the most basic way. She knew she needed help and was able eventually to approach her doctor. He recognized her need for specialized attention and referred her to me through Health Service provision. She told me she felt relieved to have a concrete recognition of her terror through a diagnosis of PTSD but was petrified in our first session, not knowing what to expect. Although also white and Scottish, her difference to me culturally was emphasized when she entered my therapy room. Our different social backgrounds were articulated through our use of language. We came from the same city, yet we were worlds apart. Her hypervigilence and discomfort were palpable and eased only when I began to tune into her accent and use some of her language.

We began to make a connection based on her willingness to see me and my respect of the cultural distance between us. She told me from the outset that I could not possibly understand her or what had happened to her. She also held the expectation that counseling would not help her. My challenge, in that first session, was to fully appreciate what she meant. In order to access my empathic resonance, I had to overcome my pride. I rated highly my capacity to grasp many different experiences. I felt humbled by her challenge and opened myself as widely as I could to the experience of *not knowing* (Schmid, 2002). I began to appreciate the importance to her of her medical diagnosis. The term PTSD offered her an anchor amidst her experience of disintegration. She felt she now had some direction — a way forwards both legally and therapeutically. I held an appreciation of her relief in finding definition. My challenge was to understand as fully as I could the ways in which she might need me to help her. I held also an openness towards her 'being' in relation to me that was beyond any definition. I was willing to hold the specific importance to her of defining terminology whilst not letting this medical approach limit my attunement. This empathic process and attitude of profound respect contributed hugely to reducing my own sense of threat within this initial therapeutic encounter. Moreover, through feeling heard, my client felt some sense of being personally effective in relation to me from the outset.

This was twelve years ago, before much was written in the field. I was interested in Judith Herman's (1992) work and understood the importance of safety. This client presented in a state of abject terror. I had not previously experienced anything so profound within my practice. Prepared by a training course on *Pre-Therapy* by Garry Prouty (1994), I made a decision to simplify some of my responses with contact reflections. Van Werde (2002) presents a model for contact work with people with a broad range of pre-expressive functioning. He suggests the value of contact reflection within mixed functioning. When contact is partially present, connection can be strengthened through simple and concrete responses. My rationale lay in *bearing witness* to the client's immediate presentation. Coffeng (1996, 2002, 2004) has since described his practice with traumatized clients in ways that emphasize this delicate contact. I was witnessing this client's "condition," her "shell shock." Through reflecting to her the ways in which I was observing her body state, I became keenly aware of her levels of

arousal. What she had witnessed was unspeakable yet she told me she needed not to be the only one who had seen it. I struggled to hold the boundary between my willingness to be fully present to her and my curiosity. I did not share this struggle with her, as it felt more like a personal challenge than information that might have been of use to her. I understood the importance of us not being overwhelmed.

Rothschild (2000) advocates various useful ways that enable clients to *apply the brakes*. Her rationale is that if a client can achieve perceptual distance from the traumatic event and orientate to a present reality that does not contain threat, then choice becomes available again to re-experience the traumatic memory or not, depending on assessment of emotional safety. This approach is echoed by Scharwachter (2005) who presents a focusing-orientated approach for the treatment of trauma. He describes the setting of boundaries combined with *making a safe space* as the basis for providing a context that the client and counselor can co-determine and control.

Looking back, I think my client and I achieved this control in yet another way. I held this client safely by observing and reflecting her immediate fluctuating body condition as she sat in front of me. This observation was twofold: it enabled her some connection with her body in the 'here and now'; and orientated her to her present situation with me in the therapy room. She was no longer alone. This connection and orientation was in stark contrast to her potentially annihilating experience of being frozen in time in relation to the traumatic event. Coffeng (2002) states how, "Contact reflections simply report the therapist's observation and refer to reality" (p. 159). These concrete observations may help a client to distinguish between inner experience and outer reality.

My client's immediate presentation to me was one of dissociation in relation to feeling, sensation, time and meaning. I reflected these fragments by literal observation as they emerged, i.e., "You're telling me you feel nothing," "You speak to me of having no sensation in your body," "You're telling me that you have no sense of time," "I'm hearing you tell me that you do not know what anything means anymore." This slow way of responding attuned to her frozen state and kept us engaged at a distance from the traumatic event. In so doing, we held also some relational contact. As she responded back to me, I was then able to attune empathically with her experience and reflect what it meant to her to be so "shut down" and "spaced out." These reflections connected with her experience and offered her tangible relief. She sighed and her breathing became deeper as she connected with her body. Powerful for her also was her perception of my lack of judgment. Within her social group she had been experiencing pressure to "get back to normal" and this lack of understanding had increased her sense of isolation. My challenge was to offer consistency of regard within my quality of presence such that the therapeutic encounter could be trusted.

Binder (1998) describes empathic contact with clients experiencing psychotic processes. She emphasizes the contact reflecting of Prouty as a means of developing self-structure, self-experience and relational reference: "In this way the patient doesn't experience himself or herself simply as part of an interpersonal relationship, but experiences his or her self through the ability to influence and control the process. This means that self-control and environmental control are reinforced" (p. 226). Empathic contact offers a key to safety with clients who have

experienced trauma. Being aware of how important it is to re-establish control helps the counselor to empathize not only with what the client is saying but with their physiological fluctuations. Once arousal feels under control and the client realizes that attention is being paid to any fluctuation, the client can experience a greater sense of safety. The counselor is acting like a midwife towards the care of the inner, the outer and the whole. To maintain empathic connection in a way that is respectful of psychological safety involves continual resonance through moment-by-moment contact with inner, outer and whole.

With my client, I used my experiencing in relation to her to try to hold her safely — *personal resonance* as described by Schmid and Mearns (2006). When I felt distance between us and was unsure of our psychological connection, or when I feared she was re-traumatizing herself through re-experiencing the traumatic circumstance, I communicated this experience to her in order to re-establish present contact. This process sometimes felt "too late," as if I had missed something. I lacked confidence. I did not know if the therapeutic experience would be able to help this client feel the possibility of her life again. This was the reason she had sought help. She felt she had lost everything. I realize now that I was ahead of myself and had lost touch with the therapeutic "ground" on which I stand. Furthermore, this ground seemed somewhat insubstantial in the face of this client's overwhelming terror. Quite apart from missing out on a range of empathic attunement that included physiological sensitivity, I had missed something very basic and simple around environmental safety.

Rothschild (2000) emphasizes *dual awareness* as a prerequisite for safe trauma therapy. This concept is about orientation to the present reality as different from the traumatic event. Individuals who experience trauma are likely to lose this discrimination, and internal sensations become associated with past events. Current reality becomes informed then by this past experience. Biermann-Ratjen (1998) describes the efforts that people make to overcome this experience of dissonance within the self-structure. There is an attempt to integrate the traumatic experience as *self*-experience. At the same time, the organism persists in defending self against experiencing this internal threat. This pressurizing process and lack of distinction creates extreme stress. Supporting dual awareness of different (and separate) experiencing emphasizes a perspective that might contribute to relief.

I noticed that my client was "on edge" (literally on the edge of her seat) during our sessions. She seemed to be under continued present threat. I reflected this with her, yet did not check how she perceived the difference between present and past reality. Rothschild (2000) suggests that if a client looks around the therapy room, they can check present reality for danger. This is a simple way of distinguishing safety and supports the experience of being in control. The hippocampal function of contextualizing information will begin to operate again when safety is experienced. The *situational reflections* of Pre-Therapy offer another concrete and nondirective way of bringing attention to outer present reality. Establishing present reality alongside the client builds a co-created affirmation of the environment. Moreover, becoming conscious of distinguishing perceptual awareness may support the client in the potentially more threatening environment beyond the therapy room.

I also missed this client's need to "ebb and flow" in relation to the quality of contact with me and with herself. I realize more fully now the vitality of shifting out of these intense

moments of experiencing in order to process or recover. Despite my lack of this knowledge at the time, my simple contact reflections still seemed to hold my client in a space within which she found a little stability — perhaps this was enough. Furthermore, my appreciation of how she survived seemed to challenge her self-judgment that she could have done more.

Biermann-Ratjen (1998), in her description of the experience of incongruence in relation to traumatic stress reaction, emphasizes the difficulty of not being able to integrate self-experience. Together with the importance of unconditional positive regard, she writes of conveying understanding of a client's symptoms within the empathic experience. She states: "the acute stress reaction is a completely intelligible and logical message conveying how the whole organism reacts to finding itself physically or psychically in danger: it makes sense" (p. 123). Physiological survival mechanisms are a vital resource. This information might well have been useful to my client. Appreciation (both from the counselor and from the client) of the neurophysiological response opens up another dimension of understanding the primitive response to trauma.

My client completed her therapeutic process after twelve sessions with a decision to work voluntarily with people in war-torn countries. Through the process of counseling and the restoration of balance in her ANS, her frozen experience slowly "thawed." She re-connected with her previous resilience and could see a future again, albeit very different from the one she imagined before the traumatic experience. She regretted that she had been "robbed of her other life."

DIVERSITY WITHIN THE PERSON-CENTERED APPROACH

A debate within the person-centered approach to counseling is that of nondirectivity versus directivity (Brodley, 2006). It is tempting to suggest that, given the prevailing wisdom of promoting safety and control with clients who have experienced trauma, a more directive line of approach would be useful but I have not reached this conclusion. I am conscious of the soothing effect of empathic attunement held with unconditional positive regard. If a client is too aroused or dissociated to perceive the responsiveness of the counselor, a question arises over the best way to re-establish contact. My argument highlights the responsiveness of the counselor during and also *before* arousal creates overwhelming experience or disengagement.

Experiential diversity within the person-centered approach such as focusing (Gendlin, 1981), process-experiential therapy (Greenberg, Rice, & Elliott, 1993), and also Pre-Therapy (Prouty, 1990), all offer distinct therapeutic rationales based on research evidence. Each of these approaches adheres to the therapeutic conditions of person-centered therapy and each of them provides evidence of working effectively with various clients who have experienced trauma (Hendricks, 2001; Elliott, et al., 1996; Krietemeyer & Prouty, 2003). The classical nondirective approach offers yet another context for the safe processing of traumatic experience (Joseph, 2005). However, despite the fact that Rogers (1963) draws on biological process in order to explain his hypothesis of the actualizing tendency, there is very little written about

neurobiology in relation to the person-centered approach to counseling. Perhaps this biological perspective is regarded as unnecessary in a phenomenological world, but my argument is that neurological function is one part of a whole system of theories that, when taking a meta-perspective, do relate in some way to each other.

Cozolino (2002) examines neurobiology in relation to psychotherapy and argues that:

> A safe *empathic relationship* establishes an emotional and neurobiological context conducive to the work of neural reorganisation. It serves as a buffer and scaffolding within which a client can better tolerate the stress required for neural reorganisation. (p. 291)

Warner (2006) offers an additional perspective. Whilst acknowledging that "any significant impairment of physiological or biochemical processes in the brain is likely to make the ordinary processing of experience difficult" (p. 13), she states that "the human organism is deeply orientated toward trying to make sense of experience and has numerous alternative ways of processing available to it" (ibid.). Levine (1997) seems to support this view and points us toward an appreciation of evolution. In his exploration of the immobility response in relation to traumatic experience, he describes how the human brain has evolved and can override some instinctive impulses.

Attention to the whole person within a cultural and historical context involves cognizance also of this person's primitive defense system relative to evolution. This fuller perspective of different, yet interconnected, systems of thought contributes toward healing the rift between body and mind that is prevalent still in Western medicine (Damasio, 1994). If this wider knowledge base offers relevant perspective to client and counselor, then confidence and hope may be enhanced. Furthermore, if both client and counselor hold hope then therapeutic potency appears to be heightened (Snyder, Michael & Cheavens, 2002). Above all, this factor seems critical within trauma therapy.

SELF-AWARENESS FOR THE COUNSELOR

As I draw this paper to a close, I return to fundamental principles that are articulated across modalities: those of safety, contact and therapist self-awareness. Bearing witness to a client also means being *able* to bear this contact. Mearns and Cooper (2005) introduce the concept of "existential touchstones" (p. 137), personal experiences from which both strength and relatedness can be drawn. These touchstones can offer profound existential connection whilst anchoring the counselor in their own survived life experience. These touchstones offer also a developmental opportunity for the counselor. Annie Rogers (1995) writes powerfully through her journey of mental anguish whilst working with a traumatized child.

> In any treatment situation, it is the therapist who is responsible for holding two stories, or two plays together. The work of sustaining a therapeutic relationship demands a two-sided or perspective in order to understand both stories. And the deepening of this relationship over time demands honesty and intimacy and sometimes

> extraordinary courage. Knowing that we are human, and therefore limited in our understanding and courage, we can be overwhelmed by these responsibilities. (pp. 319–320)

Although unique, her story offers incredible insight into the challenge of the therapeutic relationship for the therapist. As counselors, we may well think that we have paid attention to our own prejudices, assumptions, personal development and resolution of any traumatic events in our lives, yet encountering a client is a unique event for which we cannot prepare fully. Being touched and being human is part of our work (Schmid, 2002). Another aspect of relational experience is cultural, social and individual difference. However subtle, if experiencing difference, primitive defense mechanisms are awakened and our system is "on alert." Therapy is a dangerous occupation — we do not know what we may encounter within the client or within ourselves.

I am reminded of the synchronization involved in empathic attunement. I forget consistently that this work affects me profoundly. Rothschild (2006) has written about the psychophysiology of compassion fatigue and vicarious traumatization:

> We all know that empathy is the connective tissue of good therapy. It facilitates the development of trust in our clients and allows us to meet them with our feelings as well as our thoughts. Empathy also hones our tools of insight and intuition, and compliments our theoretical knowledge. But when the mechanisms of empathy are not in our awareness or under our control, we can find ourselves in real trouble … Without mastery of our own talents and tendencies toward empathy, it can mutate, twisting our compassion into compassion fatigue and our resonance into vicarious traumatization. (p. 208)

Here the warning is made explicit. Fortunately, Rothschild indicates that there are ways to avoid endangering self — self-awareness is undoubtedly a key. The concept of self-protection challenges the illusion that (as counselors) we are sufficiently resilient to encounter anything.

IN CONCLUSION

Basic neuropsychological knowledge, held within a cultural perspective, offers an additional view on process that may be a useful adjunct in appreciating and engaging the therapeutic encounter. If therapeutic process can be viewed and appreciated from different directions, then unconditional positive regard and empathy are likely to be enriched. This wider perspective implies a fuller attention to the client's process of healing and fostering of resilience. Furthermore, information regarding neurophysiological response may offer both the counselor and the client a useful way of contextualizing and integrating self-experience. The concurrent relief experienced through this process of integration may promote regulation of the client's whole system. Further research into the ways in which therapeutic contact and process influence neuropsychological mechanisms in relation to trauma is of particular interest within a medical context.

Within a Western medicalized culture, a person-centered approach to working with clients who have experienced trauma, offers an important contribution. Through emphasis on relational and moment-by-moment contact, this open-minded and skilled approach has the potential to engage a human dimension that reduces fear and promotes biophysiological and emotional integration. The aftereffects of traumatic experience and the modulation of these processes through support or treatment merits further investigation.

Attuning and responding moment by moment to cues from the client's physiology and language means that both the counselor and the client can be guided by the process of the client's self- and relational experience. We co-create the therapy. An increased knowledge base contributes to a wider and more diverse appreciation of process. This additional perspective broadens the base upon which we stand and, therefore, may offer additional strength to the connection between client and counselor through the potency of hope and confidence. Finally, a wider self-awareness may alert counselors also to ways in which we might attend sensitively to our own being within the therapeutic relationship.

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