Impact of Therapist Authentic Expression on Emotional Tolerance in Synergetic Play Therapy

Lisa Dion and Kaylin Gray
Play Therapy Institute of Colorado, Boulder, Colorado

To date, there is little research on therapist authentic expression with children. The closest explorations of this topic are studies conducted regarding therapist self-disclosure (Capobianco & Farber, 2005; Ginsberg, 2011). No published research has directly addressed the impact of expressing present thoughts, feelings, and body sensations in response to the child client’s stories and play. With new research on neurobiology, this article explores how therapist authentic expression in play therapy might be a helpful component in expanding the clients’ emotional windows of tolerance. Literature on pertinent aspects of self-disclosure, authenticity, and windows of tolerance is reviewed. This article introduces a study exploring the impact of therapist authentic expression on expanding a child’s emotional window of tolerance in Synergetic Play Therapy. Results indicated that there was a statistically significant increase in the percentage of emotionally tolerant behaviors in response to authentic therapist expressions from the first to third play therapy sessions. Also, the entire sample displayed full integration of emotions (100% emotionally tolerant behaviors) by their fifth session. Implications of these findings and for future research are outlined.

Keywords: therapist authenticity, windows of tolerance, play therapy, children, Synergetic Play Therapy

The debate about therapist authentic expression with clients has always been an important ethical and clinical question as it brings into question the topic of therapist self-disclosure. Only a few studies have been conducted examining therapist self-disclosure with children (Capobianco & Farber, 2005; Ginsberg, 2011) and although the research on this topic with adult clients is abound, it suffers from various and inconsistent definitions of self-disclosure and is therefore inconclusive (Hill, Mahalik, & Thompson, 1989). Capobianco (2005) proposes that one of the possible reasons for the inconclusiveness is that researchers have failed to distinguish between experiential disclosures about the therapeutic relationship and factual disclosures about the therapists’ personal lives.
AUTHENTICITY

Even though there is little research on therapist authentic expression with children, Winnicott (as cited in Tuber, 2008), Rogers (1966), and Gendlin (1963) all emphasized authenticity, genuineness, and congruence in their work with clients. Winnicott described authenticity as the true self, “a sense of being alive and real in one’s mind and body, having feelings that are spontaneous and unforced” (as cited in Tuber, 2008, p. 50). Rogers (1966) urged therapists to be genuine and congruent, saying that “the therapist is his actual self during his encounter with his client. Without façade, he openly has the feelings and attitudes that are flowing in him at the moment” (p. 185). Authenticity has also been described as therapists being congruent with their expressions so that they need not always appear in a good light, nor always seem understanding, wise, or strong (Gendlin, 1963).

This article uses Synergetic Play Therapy (SPT) as a framework to explore authentic expression. Authenticity, from the SPT perspective, refers to the therapist’s ability to attune to self and other with the willingness to express internal states through nonverbal and verbal expression. Authenticity in this model is not referring to disclosure of factual statements about the therapist’s personal life or opinions, but rather the therapist’s genuine and congruent experience of internal states as they relate to the child’s initiated stories or play.

Authenticity requires presence, attunement, and the ability to accurately read nonverbal communication (Siegel, 2007). The therapist’s ability to attune to the client is the foundation of all healing as it creates the opportunity for the coregulation of challenging internal states (Schore, 2011). Ogden, Pain, Minton, and Fisher (2005) explored this healing process further in 2005:

Interactive psychobiological regulation (Schore, 1994) provides the relational context under which the client can safely contact, describe, and eventually regulate inner experience . . . [It] is the patient’s experience of empowering action in the context of safety provided by a background of the empathic clinician’s psychobiologically attuned interactive affect regulation that helps effect . . . change (p. 22).

In order to become attuned to their clients, therapists must be open to their own bodily and emotional states. This is a crucial step in the interpersonal attunement process and is at the core of integration (Schore, 1994; Siegel, 2007). When a therapist allows the client’s emotional state to influence his or her own, he or she is able to see how these inner shifts can offer insight into the internal world of the client (Hariri, Bookheimer, & Mazziotta, 2000). The result is that the client feels felt by the therapist (Siegel, 2007). Countertransference is a term used to describe this important process and objective countertransference describes a therapist’s ability to experience both the client and his or her own from an observer state of mind (Badenoch, 2008; Siegel, 2007). It is when therapists are not authentic and unable to accurately read their own internal states that they increase the risk of miscommunication with their clients (Siegel, 2010). As the therapist becomes more sensitive to the client’s shifts and also to his or her own, he or she naturally becomes more authentic and attuned with the client. As the therapist combines the nonverbal world of sensation with verbal understanding, he or she is able to create a deep sense of “resonance” that can profoundly influence the client’s brain activation in therapy (Badenoch, 2008). Over time, this level of authenticity and attunement can
help rewire the brain toward more adaptive capacities for self-reflection and self-regulation (Schore, 1994; Siegel, 2007). This article will examine pertinent aspects of neurobiology relevant to the ability to be authentic and attuned to a client. The study presented in this article will then explore these findings when applied to child clients in Synergetic Play Therapy.

**LEARNING THROUGH MIRRORING**

It is well understood that children learn how to regulate their own emotions by watching and perceiving caregiver responses. An attuned adult is able to help a child learn how to regulate his or her responses; over time, the child begins to self-regulate (Halfon, Schulman, & Hochstein, 2001). The observation (imitation) strategy for learning that children employ is made possible by the mirror neuron system (Iacoboni, 2007; Rizzolatti, Fogassi, & Gallese, 2002). Through the mirror neuron system and the repeated observation of actions, over time children are able to develop the ability to understand the actions of others and to imitate those actions (Bandura, 1977; Siegel, 2010). The mirror neuron system helps create a mental model of observed movements by simulating and then often imitating what one observes (Heyes, 2009; Rizzolatti et al., 2002). For example, an observer’s brain yawning system becomes activated when observing someone else yawn. Adults generally override this urge, but it is quite evident in children: Infants who have never stuck out their tongues will attempt to stick out their tongues when observing their parents sticking out their tongues. Observing their parents’ behavior and their lack of motor inhibition automatically activates their mirror neurons that prime their motor neurons that activate their tongue projection movements. This phenomenon helps explain why role modeling is such a key component of the learning process. In the therapeutic process, it is speculated that the mirror neuron system makes it possible for the therapist and client to share closely resonant interactions. The result is that through modeling, a child client is able to watch the therapist and learn how to regulate through challenging emotions that arise during the child’s play.

**WINDOWS OF TOLERANCE AND AUTHENTIC EXPRESSION**

In therapy, a client’s painful memories and emotional states become reactivated and are brought into the session. When these states are outside of the client’s window of tolerance, the client will begin to move away from those emotions in an attempt to avoid the intensity. If the therapist can then consciously feel the intensity and move toward the heightened emotional states, the client learns that it is okay to move toward the experience rather than run away from it (Siegel, 2010). What was once an intolerable state of bodily activation and emotional tension in the client can move into the client’s window of tolerance with conscious awareness (Siegel, 2007). The implication is that the same process can occur between a therapist and child client.
Whether or not the therapist should authentically express inner emotional states out loud remains of great debate in the play therapy field and further research is needed; however, studies have demonstrated that when people name their emotions, the region of the brain responsible for calming fear known as the amygdala calms down (Hariri et al., 2000). Naming internal experiences out loud allows a person to move through painful states and helps regulate the nervous system. When there is a balance in nervous system functions, an individual is able to stay within the window of tolerance (Siegel, 1999). “Name it to tame it” (Siegel & Bryson, 2011; Siegel, 2010) allows a person to stay present with what is in conscious awareness and move toward more flexibility in internal states. At the same time, blood flows to the right prefrontal cortex in the brain, a process that is essential to emotion regulation (Schore, 1994). Other methods of moving toward intense internal states include taking deep breaths, rubbing the arms and hands, expanding the chest, stretching, shaking the arms and legs, and shifting positions. These methods also contribute to shifting internal states and allow the therapist to stay at the edge of the window of tolerance (Ogden, Minton, & Pain, 2006; Siegel, 1999).

Fonagy and Target (2002) assert that the ability of the caretaker to engage in self-reflection creates a sense of safety within the child. The child will use the reflective function of the caretaker to become curious about his or her own experience (Levy, 2011). Ginott (1965), Gottman, (1997), and Post (2009) also believe that it is important for adults to honestly express their emotions out loud to a child, so long as the expression was about the child’s actions and not their character. The risk of suppressing emotions is that it can lead to increased dysregulation and arousal for the adult and the child (Gerhardt, 2004).

As the child’s feelings and memories arise in the therapy, the attuned play therapist will begin to feel the corresponding internal states through a process called resonance. The therapist focuses on body sensations and authentically models modulation of internal states through verbalization of emotions, regulation of bodily sensations, and dialogue regarding internal mental states (Ogden et al., 2006). As the child observes the therapist shifting back and forth from the edges to the center of the window of tolerance that the child’s mirror neuron system may become activated. Then if the child perceives the therapist to be in-tune with them, they will allow their traumatic experiences and protection patterns to begin to emerge into conscious awareness. Badenoch (2011) describes the resonance process between client and therapist as follows:

When the relationship is experienced as safe enough, the dissociated experiences will begin to come into conscious awareness. As we resonate together, the activation will amplify and, if our window of tolerance is broad enough to contain this energy and information, our patient will also experience a widening of his or her window. In the research of Carl Marci and colleagues (Marci & Reiss, 2005), these moments of autonomic synchrony were subjectively experienced as empathetically rich interpersonal joining. This research showed that within the session, our nervous systems will flow into, out of, and back into synchrony many times. This rhythm is parallel to the dance of mother and infant as they move from attunement to rupture and back to repair over and over, laying the foundation for security, optimism, and resilience (p. 195).

Research with adults shows that this act of titration allows the client to engage in a personal experience of self observation and mindsight—a term coined by Daniel Siegel (2010) to describe the human capacity to perceive the mind of the self.
and others. As the client senses that it is safe to sit in the feeling state and energy of the memory, the client’s window of tolerance will begin to widen. These experiences of sitting at the edge of the window of tolerance in an attuned and mindful state have the capacity to catalyze changes in the brain’s self-regulatory capacity. Over time, the client will gently be able to approach difficult emotional experiences and associated physical sensations, eventually allowing for integration (Ogden et al., 2006; Siegel, 1999). Schore (2003) explains that therapists use the relationship to allow clients “to reexperience dys-regulating affects in affectively tolerable doses in the context of a safe environment, so that overwhelming traumatic feelings can be regulated and integrated into the patient’s emotional life” (p. 37). Therapists are constantly working with their clients’ windows of tolerance to expand the ability to hold strong emotions of all kinds.

SYNERGETIC PLAY THERAPY

Synergetic Play Therapy (SPT) is a model of play therapy designed to impact the disorganization in the lower brain centers, which according to Rick Gaskill (2010), are “areas that are often unaddressed in many current play therapy models” (p. 20). Synergetic Play Therapy is a research-informed play therapy model that blends together neuroscience, attachment, therapist authenticity, brain development, affect attunement, physics, emotional congruence, nervous system regulation, and the projective process.

A core principle of SPT is the therapist’s ability to be authentic and congruent in his or her expressions, coupled with the ability to model regulation through the crescendos and decrescendos of the therapist’s internal state that are in resonance with similar crescendos and decrescendos in the client’s arousal system (Schore, 2006). This allows the therapist to stay on the edge of the window of tolerance, and serves as a catalyst for the repatterning of the dysorganization in the lower brain centers of the client.

The synergic play therapist aims to replicate the delicate dance of attunement that occurs between a caregiver and an infant. SPT posits that the therapist’s ability to regulate and model regulation of his or her own nervous system and emotional states is the foundation for clients to learn how to manage their own.

Genuine emotional responses will be evoked in the therapist who is emotionally attuned with the client. Much like the mother who is implicitly modeling for the child her own struggles to regulate her own dysregulated state, the therapist must be able to resonate empathically with the clients, psychobiologically feeling their difficult, intense states. Without this ability to self-manage, the therapist cannot help the client to regulate. Such work implies a profound commitment by both participants in the therapeutic scenario and a deep emotional involvement on the therapist’s part. (Dales & Jery, 2008, p. 300)

Synergetic Play Therapy also sets forth that the therapist must work at the edge of the window of tolerance and the regulatory boundary of the dys-regulated states in order to expand those boundaries. This working space needs to be right on the border of uncomfortable. Bromberg (2009) describes these heightened moments in the therapeutic relationship as needing to “feel safe, but not too safe” (p. 90). The
ability for the therapist to engage in mindsight and to authentically express emotions in order to regulate keeps the intensity of the bodily sensations, emotions, and thoughts in tolerable doses within the therapeutic relationship. Tolerable doses need to be aroused so that the client can learn more adaptive ways of regulating (Schore, 2006).

In SPT, the therapist attempts to be as authentic and congruent as possible in both nonverbal and verbal reflections during the play therapy session. Because 60% of communication is nonverbal (Burgoon, 1985), it is important that the therapist’s verbalizations and nonverbal activity are congruent in order to transmit trust and safety to the client (Schore, 2006). In doing so, the therapist maximizes attunement, and can act as an external regulator for the client’s dys-regulated states (Schore, 1994).

As challenging emotional states or enactments (Schore, 2011) enter the play precipitated by the child client, the attuned therapist uses mindfulness to attempt to open to these internal feelings and sensations and not move away or defend against them in some way. The therapist is then able to begin to modulate the intensity using authentic dialogue describing cognitive, emotional, and sensorimotor states, as well as model regulation of bodily sensations through breath and movement. As a client observes the therapist staying at the edge of the therapist’s window of tolerance, the client begins to learn that it is safe to move toward the intensity (Ogden et al., 2006; Siegel, 2010). The client also notices that the therapist remains in contact throughout these regulation activities (Schore, 2006). If, on the other hand, the therapist is not willing to be authentic and experience his or her own bodily, emotional, and cognitive states while working toward modulating these inner experiences in the window of tolerance, the therapist will move away from these states (Schore, 1994), potentially leaving the client feeling unsafe in the therapeutic dyad, lost in relationship with the therapist, and unseen (Siegel, 2010).

With the child’s mirror neuron system activated, the therapist’s mindfulness and authentic expression can initiate new neural firings that can become associated with the feelings in the neural nets of the past memories (Badenoch, 2008; Siegel, 1999). With repeated observation of the therapist’s willingness to stay authentic and present, a disruption of the old neural firing can occur bringing the potential for a new experience, giving the child permission to also move toward challenging internal states. Every enactment is also potentially an act of modification where the client can integrate new information that can help rewire the past encoded experience (Badenoch, 2006; Schore, 1994; Siegel, 1999). Research shows that with dedicated amounts of repetition, neural systems can change, but that most therapeutic interventions do not achieve this goal (Perry, 2006). Research also shows that as clients begin to move toward their challenging internal states, new neural connections can be created until a critical state is reached that results in a new neural organization (Tyson, 2002).

**RATIONALE FOR THE STUDY**

For full neural integration, SPT looks at ways to connect a client’s cognitive, emotional, and sensorimotor experiences. One of the ways that SPT does this is
through authentic expression related to the three main areas that reflect the hierarchal structure of the human brain: sensorimotor (body), emotional (emotion), and cognitive (mental) (Damasio, 1999; Ogden & Minton, 2000; Schore, 1994; Wilber, 1996). “Such an approach ultimately fosters ‘holistic processing where all three levels will operate synergistically” (Ogden & Minton, 2000, p. 3).

When the therapist makes an authentic expression related to the enactment that has arisen in the play, one can observe various reactions in the children as their feelings and bodily sensations become conscious. For many children, these feelings and sensations are clearly within their own windows of tolerance and they show no signs of needing to move away from their internal experience. For other children, the experience is outside or just on the edge of their windows of tolerance and they move away from the intensity. From clinical observation, if the therapist is willing to stay authentic in his or her expressions and model various ways of regulating in the uncomfortable experience, then over time the child will begin to expand his or her window of tolerance and move toward the internal experience that they once resisted. In order to test this hypothesis, an exploratory study was designed to look at the impact of therapist authentic expression on children’s emotional tolerance in Synergetic Play Therapy.

**METHOD**

**Participants**

In the 3-month span between April and June 2013, 34 child clients began play therapy at the Play Therapy Institute of Colorado. Videotapes of the first play therapy sessions of all 34 clients were observed. Ten clients showed evidence of behaviorally moving away from one or more challenging internal states and were selected for the study. Informed consents were received from parents or guardians for the children to participate in the study. There were seven boys (70%) and three girls (30%) in the sample. The age range was between 3 and 10 years with a mean of 5.1 year ($SD = 2.1$). Nine (90%) of the subjects were Caucasian and one (10%) was Asian. Eight play therapists trained in Synergetic Play Therapy participated in the study, seven females (87.5%) and one male (12.5%). They ranged in age from 35 to 50 years with a mean of 37.8 years ($SD = 8.0$). Seven (87.5%) of the therapists were Caucasian and one (12.5%) was Latino.

The therapists’ levels of experience ranged from under supervision to senior practitioners in Synergetic Play Therapy. All the therapists (100%) had MA degrees. Five therapists (62%) were Licensed Professional Counselors and three (37.5%) had at least 1 year of education beyond the MA. One therapist had the RPT-S credential (12.5%), two had the RPT designation (25%) and the remainder of the cohort ($n = 5, 62.5\%$) was in the process of becoming RPT-certified. Four (50%) of the therapists were certified in Synergetic Play Therapy and the other four (50%) were in the process of training for SPT certification. One senior therapist conducted sessions with three clients in the sample, while the other seven therapists each worked with one client.
Instrument

A structured observational checklist was designed for the study. The checklist was developed in a number of stages. First, the authors created a template with variables derived from the theoretical foundations of Synergetic Play Therapy. Next, behavioral response categories were generated based on clinical observations by senior staff play therapists. Videotapes of several play therapy sessions were then viewed to assess whether the behavior categories were representative, and changes were made to the checklist as warranted. After several iterations, the observational checklist for the study was finalized.

The variables that were recorded for each authentic expression/behavioral response interaction were: Form of Therapist Authenticity, Client’s Behavioral Response, and Client’s Dominant Feeling State. Whether the therapist’s authentic expression was an emotional, mental, or physical description of his or her experience, or a combination, was coded under the Form of Therapist Authenticity. The Client’s Behavioral Response was rated as either an Away or Toward behavior, with the specific behavior(s) in that general category also coded. The Away emotional tolerance behaviors on the checklist comprised the following: make joke, distract with new play, change topic, care-take therapist, deny emotion in self, turn back/walk away, and tell therapist feelings/body sensations are wrong. On the other end of the spectrum, the Toward emotional tolerance behaviors included the following subject responses: absence of away behavior (i.e., tolerating therapist’s reflection), acknowledgment of feeling in self, and curious about therapist’s experience. For both the Away and Toward behavior clusters, there was also a more than one and other coding category.

Procedure

All play therapy sessions at the Institute are routinely videotaped. For this study, the first three to five sessions for each subject were coded on the structured observational checklist by trained raters. Coding ended after a minimum of three sessions when emotional integration was achieved, defined as 100% Toward emotional tolerance behaviors and zero Away behaviors evidenced by the subject in that entire play therapy session. Three researchers were trained to observe the play therapy sessions on videotape and code the relevant behaviors on the checklist. The coding team was comprised of the lead author and two therapists affiliated with the Institute. After training and coding multiple play therapy sessions as a group, the researchers each coded a different session independently to establish interrater reliability. Across all coding categories and subcategories, interrater agreement was 86%. There was 100% agreement, however, on the number of therapist authentic expression/behavior response incidents in the play therapy sessions and whether the behaviors were classified as Away or Toward in nature, which were the analyzed levels of the variables of interest in the study.
Data Analysis

Once coding was completed, the observational data were aggregated by sequential sessions for the sample so the effect of therapist authentic expression on emotional tolerance behaviors could be examined over time. Due to the small sample size, the particular form of therapist authenticity (i.e., expression of an emotional, mental, or physical reaction) was not considered as an independent variable nor was any demographic category. Also due to the small sample size as well as the high number of feeling states that surfaced in the coded sessions, specific feeling states were not isolated for analyses. Next, the clients’ specific types of behavioral responses to therapist authentic expression (e.g., distracting therapist with new play, changing topic, acknowledging feeling in self, etc.) were aggregated into either Away or Toward behavior categories for analyses. Finally, within and across clients, the number of emotional tolerance behaviors in response to therapist authentic expression varied widely in the play therapy sessions, with a range between two and 40 total behaviors, and a mean of 15.93 (SD = 10.71) in a single session. Given that the measurement of interest in the study was the proportional change from Away to Toward behaviors over successive play therapy sessions rather than the frequency of behaviors for each category, the numbers of Away relative to Toward behaviors in each session for each subject were converted to percentages for the data analyses.

RESULTS

The first issue of interest in the study was the proportional shift from Away to Toward behaviors from the first to the third play therapy session. Figure 1 displays the comparison of percentage means for the sample population across Sessions 1 to 3. A pretest/posttest analysis was completed with Session 1 percentages of Toward behaviors designated as the pretest scores and Session 3 Toward percentages the posttest scores. A paired t test showed a statistically significant increase in the percentage of Toward emotional tolerance behaviors between the first and third Synergetic Play Therapy sessions (t = 5.79, p < .001, d = 1.83). The effect size was large.

The second issue of interest in the research was the number of sessions on average it took the children in the sample population to expand their emotional windows of tolerance on a particular emotion to the point of full emotional integration. Integration was operationalized as the first session in which each client displayed 100% Toward emotional tolerance behaviors in response to authentic therapist expressions. The results showed that 100% of the population achieved emotional integration in five or fewer play therapy sessions. Fifty-percent of the sample, n = 5, showed integration in two to three sessions and the other 50%, n = 5, evidenced the same in four to five sessions. The mean number of therapy sessions required to achieve full integration was 3.6 (SD = 1.17).
This study must be considered, and qualified as, exploratory in nature due to the small sample size and lack of control of a number of threats to internal validity. Future studies would benefit from using control group designs in order to attribute causality with greater confidence, as well as using coders blind to the hypotheses of the study to control for rater bias. However, the results of this research are promising and suggest compelling directions for future research. With larger sample sizes and more control, future studies will be able to examine, for example, the effects of different modes of therapist authenticity (emotional, mental, and/or physical) on emotional tolerance in general and with respect to specific behavioral strategies, in addition to the effects of sex, age, and race of subjects. With larger populations, particular emotions, such as sadness and fear, could be isolated and observed to see if the paths to emotional integration vary across different feeling states.

Clinical observations of the videotaped sessions also point to potential directions for future research. There were four observations that are relevant for this discussion. The first was that the level of experience of the therapist did not appear as significant as their willingness and ability to be authentic in their expressions. Second, if the therapist was not willing or able to move toward a challenging emotional state, it took longer for the child to integrate that particular emotion. This points to the potential significance of therapist authentic expression in play therapy. Third, the children seemed to demonstrate the following emotional integration pattern: (a) child “moves away” from challenging emotion, (b) child “moves toward” same challenging emotion, and (c) child demonstrates “toward” behaviors independently of the therapist’s expression rather than a reaction to that expres-
sion. Fourth, within a few sessions the child demonstrated similar authentic expressions and regulation patterns (body movements and language) as observed in the therapist.

Kushnir (2009) demonstrated through his studies that children are able to revise existing beliefs with enough good evidence, thus contradicting their earlier assumptions. This is significant in that not all of the 34 children viewed for this study needed to move away from their challenging internal states when the therapist had an authentic expression in response to the child’s play. Another observation relevant to this study was that the 10 children who demonstrated the need to move away from their emotions and body sensations were also the children who seemed to have a correlated belief about those particular emotions: “I am not allowed to feel sad” and “It is not safe for me to feel scared” are examples, suggested by their presenting symptoms, conversations with caregivers and the child’s language used in the play. By observing the therapist moving toward these challenging emotions and modeling regulation to stay in the window of tolerance, it seems that the children were able to gain evidence that contradicted their initial beliefs. The observed outcome was that the children’s beliefs seemed to be rewired in the direction of “It is okay to feel and express my emotions and to feel my body sensations,” as evidenced by their Toward behaviors in the study. In order to verify these findings, future research is needed.

CONCLUSION

The purpose of this research project was to examine whether therapist authentic expression contributes to the expansion of children’s windows of emotional tolerance in Synergetic Play Therapy. The findings of this small, exploratory study suggested that children were able to expand their windows of emotional tolerance in response to authentic expressions from synergetic play therapists, with a statistically significant difference shown between the first and third play therapy sessions. Additionally, all clients in the sample were able to fully integrate the feelings they initially resisted by their fifth therapy session.

The potential significance of these findings relate not only to future research for the play therapy field, but also to potential new ways of training play therapists. This study suggests that play therapists’ ability to move toward the client’s and their own uncomfortable emotional states has a potentially beneficial outcome for the client. This study also suggests that therapist attunement and authentic expression might be a crucial component to impacting a child’s ability to learn how to self-regulate and approach challenging internal states. At the most fundamental level, therapy is about the therapist’s ability to stay authentic and be with the client, not about what the therapist says or does to the client (Schore, 1994).

REFERENCES


Impact Of Therapist Authentic Expression


Received September 16, 2013
Revision received November 7, 2013
Accepted November 8, 2013