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CASE STUDY

Lifespan Integration Therapy with Trauma-Exposed Children: a Hermeneutic Single Case Efficacy Study

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Abstract

Childhood trauma is a devastating reality with immense psychological impact to a child. Outcome research of therapy with trauma-exposed children is scarce and mostly focuses on cognitive and behavioural changes. Anecdotal evidence suggests that Lifespan Integration (LI) therapy purports to integrate traumatic experiences into a cohesive autobiographical narrative. In this research study, we investigate the efficacy of LI with children through the careful examination of one participant. We applied Robert Elliott's Hermeneutic Single Case Efficacy Research Design (HSCED; 2002, 2014), which uses quantitative and qualitative data to argue for and against therapy efficacy. The 12-year-old research participant received nine sessions of LI over 3 months, and data was collected before, throughout, and after therapy. The extent of the client's change over the course of therapy was investigated, as well as LI's contribution to the change, and what parts of LI were most helpful in bringing about change. Findings indicate that the client changed significantly over the course of therapy with lasting effects at follow-up, and that LI was substantially responsible for this change. Conclusions: The results provide evidence for LI as an important tool that mental health professionals can use to help trauma-exposed children.

Keywords Lifespan integration · HSCED · Psychotherapy outcome research · Evidence-based treatment · Trauma-exposed children · Case study

Introduction

Children worldwide are plagued by both human-made and natural disasters and traumas from the devastating effects of hurricanes, shootings in schools, incest, relational trauma from caregivers, and bullying (Diehle et al., 2015; Pereda, Guilera, Forns, & Gómez-Benito, 2009; Rosner, König, Neuner, Schmidt, & Steil, 2014). Experts and studies estimate that, in western countries, between 14% and 67% of children experience at least one kind of trauma, and nearly 20% of women and 8% of men experience sexual abuse as children (Diehle et al., 2015; Pereda et al., 2009; Rosner et al., 2014). Yet neither the DSM-IV nor the DSM-5 offer a category for multiple or complex trauma, which describes the experience of most trauma-exposed children. Briere and Scott (2012, p. 14) define an event as traumatic "if it is extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms." The psychological consequences of these traumas are devastating to children who are at greater risk for later detrimental outcomes such as future substance abuse, mental health problems, emotional dysregulation, re-victimization, and parenting difficulties (Rosner et al., 2014; Gilbert et al., 2009; Hendricks, 2013; Schore, 2003).

Psychological interventions for children exposed to trauma have received increased empirical attention within the last few decades (Mash, 2006). Therapies such as Trauma-Focused Cognitive Behaviour Therapy (TF-CBT), Prolonged

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Exposure Therapy (PE), and Developmentally Adapted Cognitive Processing Therapy (D-CPT) have been increasingly researched, and have consequently gained greater credibility. Unfortunately, these therapies focus mainly on cognitive aspects of trauma and some might also re-traumatize the child by revisiting traumatic experiences without sufficient safeguarding (U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2012). Interventions that are less cognitively focused have not yet received the same kind of research-attention.

Lifespan Integration (LI)

Lifespan Integration (LI) is a relatively new approach to psychotherapy, which uses a gentle, body-based approach to trauma recovery. Developed in 2002 by Peggy Pace, this therapeutic technique aims to heal trauma and build self-structure by facilitating neural integration using a variety of treatment protocols (Thorpe, 2012). When Pace first developed Lifespan Integration therapy, she was influenced by contemporary research findings from attachment theory, interpersonal neurobiology (including neural integration and neuroplasticity), as well as ego-state therapy, body-mind integration, and imagery guidance (Thorpe, 2012). The primary therapeutic mechanism of LI is a timeline with memories of the client's life. By repeatedly and sequentially going through these memories, the client experiences a coherent whole story of her or his life by integrating different states of mind across time (Thorpe, 2012). The movement through the timeline is quick in order to avoid intense emotions arising from these memories. LI is also not a talk therapy, per se; rather than talking about a traumatic topic to work through with the timeline, it uses a body-mind affect bridge, which uses somatic markers to find traumatic events that are not integrated. In this way, LI therapy facilitates the integration of traumatic material sequestered in subcortical or right brain areas by working bottom-up (emotion first, then cognitively) and deepening mindfulness (which may increase cortical activity), with the practice of new actions (Lanius, Lanius, Fisher, & Ogden, 2006, p. 161). Another important technique in LI is the internal dialogue between the various ego states. The therapist coaches the client to have a conversation between the current ego state and the younger self (Thorpe, 2012). Depending on the protocol used, the therapist asks the adult client to imagine their current self to help their younger self with the traumatic experience. The therapist will coach the client to do and say helpful things to their younger self. This internal dialogue is used to strengthen internal attachment between various selves, increase integration of the selves, and to prove to the younger self, by means of the timeline, that the traumatic event is over. LI uses a variety of different protocols which give clinicians the opportunity to address various presenting issues. Most protocols were developed for adult clients, though Thorpe (2012) developed child specific protocols and adapted others, which will be implemented in the present research.

Lifespan Integration with Children

Lifespan Integration therapy seems to be especially suitable for children as they engage easily in the process of utilizing a timeline to remember life events. Pace (2012) mentions three advantages children and youth have over adults in regard to responsiveness to LI: First, their brains are malleable; second, they have not built up as many defenses; third, they enjoy the imagination required by the timeline and they can help their younger selves. In terms of practicalities of LI with children, there are a few differences compared to the adult protocols. According to Thorpe (2012), children under the age of 12 are not asked to enter with their current self into the trauma scene to help the younger self. Rather, a safe adult is imagined to come into the scene to rescue the child and take them to a peaceful place. Another modification is that the timeline needs to contain more cues per year, since it will be substantially shorter than those of adults. Depending on the age of the child, two to four cues per year are recommended for children's timelines in LI therapy (Thorpe, 2012; Pace, 2012).

LI has been used with several kinds of presenting issues, including children who have anxiety, Attention Deficit Hyperactivity Disorder, have experienced birth trauma, early surgeries, sexual abuse, car accidents, adoption issues, and other concerns. When attempting to treat trauma-exposed children with LI, it is important to keep a two-step process in mind (Thorpe, 2012). First, the actual trauma memory needs to be addressed and resolved with repetitions of the timeline, mainly to prove to younger states that the trauma is over. Once the child has less somatic expressions about the trauma memory, the second step is to address coping mechanisms that the child developed as a result of the trauma. In order for a child to deal with the conflicting and intense emotions resulting from a trauma, the child often comes up with ways to avoid the memory of the trauma in order to build resources to function in spite of it (Thorpe, 2012).

Objectives

Anecdotal evidence from clients and their parents speak for LI's efficacy without the need for protection against re-traumatization (Thorpe, 2012). These clients also report that they experienced change in other behaviours that were not specifically targeted by LI. Unfortunately, there is a lack of empirical research to support LI's efficacy with children which, as a result, precludes it from being utilized in many treatment contexts. Within the wider field of psychotherapy efficacy research, LI has received only limited attention.

Many sources indicate anecdotal evidence of LI efficacy, such as discussions on LI's electronic mailing list, books written by clients who received LI (Sprout, 2015; Whitacre, 2014), books written by the developers (Pace, 2012, 2013; Thorpe, 2012, 2015), and conversations with local established therapists who use LI in their work with trauma-exposed adults and children. At this point, publicly available formal research has been conducted by Balkus (2012), Binet and Tarquinio (2015), and Rajan et al. (2020). Balkus (2012) concluded that LI was effective in reducing intrusive symptoms in women who have experienced abuse. Rajan et al. (2020) concluded that a form of Modified Lifespan Integration therapy was effective in significantly reducing post-traumatic stress disorder (PTSD) for victims of sexual abuse. Given anecdotal evidence from over 10 years of clinical practice, with over 1000 therapists (Thorpe, 2012), systematic research into the efficacy and mechanisms of LI is overdue and warranted.

Therefore, this research project aims to add to the evidence base regarding LI efficacy, with a mixed method case study research design, to shed light on the potential for LI to help trauma-exposed children's healing journey. For this study, Robert Elliott's (2009, 2014) Hermeneutic Single Case Efficacy Design (HSCED) will be utilized. This method uses a series of qualitative and quantitative data to argue for and against the efficacy of a therapy and, as the name implies, is an in-depth study of one client's experience of change and therapy. This research approach has some distinct advantages over other single case designs because the design demands a thorough investigation of evidence from two different perspectives and input from multiple experts – strengthening arguments for ruling out alternative explanations. HSCED is also complementary to randomized clinical trials (RCT), the standard in therapy outcome research, as the HSCED design can capture the idiographic complexity inherent in the therapy process (Wall, Rensch, Hu, McDonald, & Kwee, 2015, p. 2).

With this systematic case study, the research aims to demonstrate that Lifespan Integration therapy can be efficacious with a trauma-exposed child. More globally, this research aims to contribute toward a foundation of evidence for LI therapy. The specific research questions addressed with the HSCED method in this study are: (1) Did the client change substantially over the course of therapy? (2) Is this change substantially due to the effect of therapy?; and (3) What factors may be responsible for the change?

Method

We chose to investigate the above stated research questions through the Hermeneutic Single Case Efficacy Design (HSCED; Elliott, 2002, 2012, 2014). The HSCED is a mixed-method adjudicated case study method integrating qualitative and quantitative data from the client, the parents, the therapist, and an outside jury of research and therapy specialists. As indicated by its title, HSCED uses a hermeneutic approach to discovery; By interpretive and in-depth readings of the outcomes, researchers glean an approximation of knowledge about the client's change.

The method of HSCED addresses shortcomings of randomized clinical trials (RCTs), in particular its limitations in identifying change processes, as well as the shortcomings of traditional $N = 1$ case studies, such as reliance on anecdotal evidence, confirmatory bias, and narrative smoothing (Stephen & Elliott, 2011; Stephen, Elliott, & Macleod, 2011). The HSCED was developed to be used in a naturalistic setting (i.e. psychotherapy practice) while providing solid and replicable evidence for therapy outcomes (Partyka, 2010). Researchers have proposed case studies as viable alternatives to RCTs in order to gain insights into the clinical details of the therapy process. Advocating a methodologically pluralistic approach to accumulating knowledge about processes and outcomes of therapy as a platform for therapy policy and practice, McLeod & Elliott (2011) advocate for making use of "practice-based evidence, qualitative research, critical conceptual analysis, consumer satisfaction studies, and systematic case studies (p. 1)."

The HSCED is the most appropriate method for the aims of the present research because, (a) it is a novel exploration of LI with children; (b) it seeks to offer an in-depth exploration of LI therapy processes; and (c) it is contextualized in the naturalistic setting of a psychotherapy practice. As a pioneering study about LI for trauma exposed children, HSCED is positioned to shed more light on the primary research questions (i.e., does LI work? and what works?) than would an RCT or traditional case study.

Participants

The research participant, "Kelly" (all names have been changed) was 12 years old at the time of the research, attended Grade six at the time of therapy and attended Grade seven at the time of follow-up. Noteworthy observations of Kelly's developmental history include feeding and respiratory issues at birth, and some ongoing respiratory challenges. Developmental milestones were met within a normal timeframe. Specific traumatic events that Kelly and her parents described largely pertained witnessing and coping with the health and serious medical concerns of immediate family members. At age 18 months, Kelly saw her mother attached to hospital equipment after a traumatic birth with Kelly's younger brother. Following this, there were frequent emergency hospitalizations for her brother (requiring emergency childcare for Kelly, sometimes in the middle of the night) who was also eventually diagnosed with Autism Spectrum Disorder (ASD) and tics. Kelly was reportedly also significantly impacted by her dad's accident in which he broke his

back. As a result of family needs related to health concerns, Kelly also experienced a sudden and unexpected move at age nine.

At the time of the research, Kelly lived with her mother and brother. Her father was present every other weekend and otherwise lived separately for work. Presenting problems reported for Kelly included that she, (a) carried others' guilt and responsibilities, (b) had difficulty expressing emotions, (c) had a short attention span, (d) lacked self-control, (e) demonstrated a predominantly unhappy mood, and (f) was overreactive to problems.

Research Team

A local therapist with advanced training in Lifespan Integration therapy agreed to make her therapy practice available for conducting this research. The therapist provided notes from all of her sessions. The Research team engaged in analysis of the therapy data included a variety of experts. For this research project, these expert judges were selected using on the following criteria: Experts had either or a combination of (1) a doctorate in counselling psychology or a similar field, (2) extensive experience (at least 5–10 years) in trauma therapy with children, (3) extensive knowledge of Lifespan Integration, and/or (4) had teaching experience in counselling psychology. Candidates were recruited based on existing professional relationships with the researchers; however, none of them had any pre-existing relationship with the LI research programme. The three judges who agreed to be part of this project had the following relevant characteristics: Judge A held a Doctorate degree in Educational Leadership with more than 20 years of experience in counselling trauma-exposed children. Judge B held a Master's degree in Counselling Psychology, had training in LI and 7+ years experience using this modality, and had extensive knowledge in trauma therapy with adults. Judge C held a Master's degree in Counselling Psychology, worked with children for more than 14 years, and had extensive LI training.

Measures

Instruments and assessment processes gathered quantitative and qualitative data relevant to the participant's well-being and change, as well as to what occurred in the therapy process. Multiple assessment instruments were utilized including: (a) the Behavioural Assessment System for Children (BASC-2; Reynolds & Kamphaus, 2004); (b) the Parenting Relationship Questionnaire (PRQ; Kamphaus & Reyonlds, 2006); (c) the Family Adaptability and Cohesion Scales (FACES-IV; Olson, 2010); (d) the Simplified Personal Questionnaire (PQ; Elliott, Mack, & Shapiro, 1999); (d) the Helpful Aspects of Therapy form (HAT; Elliott, 1993); (f) the Change Interview (Elliott, Slatick, & Urman, 2001); and (g) the Therapist Session Notes Questionnaire (TSNQ) and video observation. All of these measures, including additional information about the client, comprised the Rich Case Record (RCR), which is at the heart of the HSCED process. The RCR was utilized in skeptic and affirmative case development and was submitted to the adjudicators for making determinations about therapy efficacy. Other informal data included an email from the mother to the therapist mid-therapy and a letter at the end of therapy.

Procedure

Recruitment took place in the naturalistic context of a psychotherapy process where new clients and wait-listed clients were given the opportunity to be part of the research project. Selection criteria included: (a) that the child's caregiver was not identified as the perpetrator of trauma; (b) that the child was exposed to trauma and currently experiencing symptoms; (c) the child had not previously received LI therapy; (d) the child was not receiving any other counselling or psychotherapy at the time; (e) the child and caregiver were willing to participate in the study; (f) the child did not attend sessions under the influence of alcohol, recreational drugs, or benzodiazepines; (g) the child was at least 3 years old; and (h) that the child was able to communicate verbally about his or her experiences. Children were excluded from the study if they demonstrated severe dysregulation that would impede their ability to participate in the research, were currently suicidal, were 13 years or older, or were not able to complete the requirements of the sessions over the course of the study.

The Research Ethics Board (REB) of the university with which the authors are affiliated approved the procedures for this study. The child participant's caregiver provided informed consent for her participation in the study and the child provided verbal assent to participate. Data was collected through an initial intake interview, implementation and evaluation of eight therapy sessions integrated with common therapeutic factors over a three-month period, a closing interview, and a one-month follow-up interview. During the first session, Kelly and her therapist created a list of 12 items that Kelly wished would change in her life and that may be impacted by counselling. These items became the basis for Kelly's PQ. Kelly received nine sessions of LI therapy, which took place almost weekly over two and half months, and she was asked to rate her PQ items before each session and to complete a HAT at the end of each session. After the last session, adapted versions of the semi-structured Change interview were conducted with Kelly and her caregiver. At pre-therapy, post-therapy, and follow-up, the following assessments were administered: (a) the BASC-2 (Reynolds & Kamphaus, 2004); (b) the PRQ (Kamphaus & Reynolds, 2006); and (c) the FACES-IV (Olson, 2010). At pre-therapy, the Structured Developmental History of the BASC-2 was gathered. The therapist kept thorough counselling notes and completed a

Therapy Session Notes Questionnaire (TSNQ). One of the researchers viewed video recordings of each therapy session and completed a TSNQ from watching the sessions. Volunteer research team members were either assigned to a skeptic or affirmative team (described later). Each team had a balanced representation of skills and experience related to the method, LI, and child trauma therapy. Following the HSCED protocol, judges are asked to provide a determination and rationale for two questions: (1) To what degree did the client change? and (2) To what degree was therapy responsible? (Elliott, 2012).

Lifespan Integration

Lifespan Integration (LI) therapy offers an embodied therapeutic approach to facilitate integration of the body-mind system in trauma treatment and recovery. Although talk therapies can offer clients insight and tools for changing dysfunctional patterns, primitive feeling states are still activated by situations that are triggering. LI therapy integrates current understandings about body memory and treatment methods (Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, 2015) into an innovative therapeutic approach that directly targets neurophysiological processes through an implicit, body-based process (see Pace, 2012). The basic process in LI therapy is that the client's sense of self is able to become increasingly coherent and integrated in a cohesive autobiographical narrative through repetitions of the client's memory cues in the presence of an emotionally attuned therapist.

Each LI session typically focuses on one particular protocol that is determined using an initial assessment and treatment plan, adapted accordingly as therapy progresses. The session length for adult clients can be up to 90 min, while for children up to 60 min is adequate. There is no time requirement between the last or most recent trauma and LI therapy. Normally the PTSD protocol can be applied as soon as the client presents for therapy, however protocols may be adjusted depending on an individual client's needs and presentation. During a session of Lifespan Integration, the therapist attunes to the client and leads him or her year by year through his or her life. This is accomplished by reading one cue (or memory) per year from the client's list of memory cues created together at the outset of therapy. According to Thorpe (2012), the timeline for children needs to contain more cues per year since it will be substantially shorter to adults. Thorpe (2012), who focused on refining LI for children suggests two cues per year in approximately 6 months' interval; Pace (2012) suggests three to four cues per year. The LI timeline differs from the trauma narrative in trauma-focused cognitive behavioural therapy (TF-CBT) in that the life memory cues in LI around the trauma are repeated for each year consecutively to stimulate an implicit body-based integration. In TF-CBT, children develop a trauma narrative by gradually telling the story of what occurred during their traumatic experience(s), most often through the writing of a book, poem, song or other written narrative (Cohen & Mannarino, 2008), which is less focused on body-based integration and more focused on cognitive processing. Although the repetitions of the LI timeline are verbal from the therapist to the client, the timeline may be initially constructed with the child through art or play. For the child in this study, the therapist implemented a variety of LI protocols, with consultation from an approved LI consultant, as the treatment planning evolved. The therapist, client, and parent determined that it better fit the needs of this child client for the parent to not be involved in sessions. Particularly with younger children, parents are often present in LI therapy with children.

Lifespan Integration Training and Certification Lifespan Integration involves practitioners complete three levels of certified training. To qualify, a therapist must have a graduate degree in the field of mental health such as an MA, MSW, PsyD, PhD degree in Psychology, or MD in Psychiatry. Level 1 training introduces participants to the basics of LI therapy where they are taught to assess clients and to create a treatment plan for LI therapy based on the client's goals and the clinician's assessment. During the two-day training clinicians learn several basic LI protocols and how to stay attuned to clients while leading them through repetitions of their Timelines. The training involves supervised sessions where participants practice and experience LI protocols from each of three roles: therapist, client, and observer. One supervision session from an approved LI consultant is required before attending the Level 2 training. Therapists are also strongly encouraged to receive at least one session of the LI therapy from a certified therapist and practice foundational LI concepts with clients before taking the Level 2 training. Level 2 training builds upon the foundational level training by introducing additional protocols and advanced assessment techniques with clients utilizing LI treatment plans with three supervised practice sessions included. In the Level 3 training therapists learn new variations of LI protocols to heal early trauma and to repair attachment wounds and practice under supervision. The training is conducted by certified LI Instructors and Consultants to ensure rigour and fidelity to the LI protocols and methods. Certified LI therapists and consultants also undergo ongoing continuing education workshops and participate in consultation groups in order to keep up to date with changes. At the time of this research, the current standards for certification were not yet in place. However, the therapist in the research had completed the most advanced training in LI therapy available at the time and is now a certified LI therapist and approved LI consultant under the current standards. More information about this trauma-based therapeutic approach can be found at: https://lifespanintegration.com/.

Rich Case Record

All of the data was compiled into the Rich Case Record (RCR), which was submitted to skeptic and affirmative case development teams, and later to the adjudicators. The HSCED decision-making process resembles court decisions. The following sections describe the systematic procedure to carry out the HSCED.

Affirmative Case

Following the model of case law, the affirmative team carries the burden of proof and its purpose is to convince the judges that the client changed substantially because of the therapy (Stephen, Elliott, & McLeod, 2011). The affirmative team rests its case predominately on direct evidence from the RCR that change occurred through therapy. Elliott (2014) proposes four direct kinds of evidence for therapy efficacy and requires at least two of them to prove change. The direct evidence methods include: (a) change in long-standing problems; (b) attribution of post-therapy change to therapy; (c) links between therapy-specific processes and change; and (d) covariation between week-to-week changes in the client's life and specific therapeutic interventions.

Skeptic Case

The task of the skeptic team is to find evidence in the RCR that change either, (a) did not occur; or that, (b) change could be attributed to factors other than therapy. To do this, the skeptic team draws from eight kinds of indirect evidence as proposed by Elliott (2002). These include: (a) non-improvement; (b) statistical artifacts; (c) relational artifacts; (d) expectancy artifacts; (e) self-correction; (f) extra-therapy events; (g) psychobiological causes; and (h) reactive effects of research.

Case Presentations and Rebuttals

The affirmative team first presented its side since they carry the burden of proof. Next, the skeptic team gave its brief. Each team then separately prepared rebuttals taking into account the case from the other team. The affirmative team presented its rebuttal first, followed by the skeptic team.

Adjudication

Three independent, external judges adjudicated the written cases and supporting evidence. The judges were asked to rate on a 0–100%, their perception of client change, therapy's role in change, and the judge's level of certainty about their ratings. Judges were asked to provide additional qualifying comments to support their rating. Elliott's recommended cut-off of 80% probability was chosen to represent 'beyond reasonable doubt.' (For an in depth explanation about standard of proof, see Stephen & Elliott, 2011.) After the adjudication was competed, the results were integrated and an overall conclusion was drawn about the likelihood of a causal relationship between therapy and client change. For an overview of the HSCED process, see Fig. 1.

Results

The overall results are based on information from the rich case record, the research team briefs and rebuttals, as well as the judges' conclusions.

Rich Case Record

Quantitative Outcome Data

The BASC-2 self-reports (SRP) indicated a reduction in Social Stress and Interpersonal Relations from the 'At Risk' level at pre-therapy to 'Similar to others' at post-therapy and follow up. Self-esteem changed from 'Similar to others' at pre-therapy and post-therapy to 'At-risk' at follow up. The parent reports (PRS) indicated an overall reduction from 'At risk' to 'Similar to others' in multiple domains including: (a) depression; (b) anxiety; (c) atypicality; (d) attention problems; (e) activities of daily living; and (f) functional communication. Results for withdrawal indicate that Kelly changed from 'Similar to others' at pre-therapy and post-therapy to 'At risk' at follow up. The BASC-2 teacher reports (TRS) indicated an improvement in study skills and a decline in hyperactivity, attention problems, and adaptability.

Results from the PRQ indicate low parenting confidence in Kelly's mother at pre-therapy and follow-up, but not at post-therapy. The PRQ also indicated above average discipline practices in the father at pre-therapy and follow-up but not at post-therapy.

Results from the FACES-IV seem to indicate a balanced family system, with only a few areas out of the ordinary. These include: (a) Kelly's father's rating for Rigidity was 'High' at pre-therapy, 'Low' at post-therapy, and 'High' at follow-up; (b) Kelly's mother's rating for Family Satisfaction was 'Low' at pre-therapy and 'High' at post-therapy and follow-up; (c) Kelly's own rating for Family Communication was 'Low' at pre-therapy and 'Very Low' at post-therapy and follow-up; and finally (d) Kelly's rating for Family Satisfaction was 'Very Low' at pre-therapy, 'Moderate' at post-therapy, and 'Very Low' at follow-up.

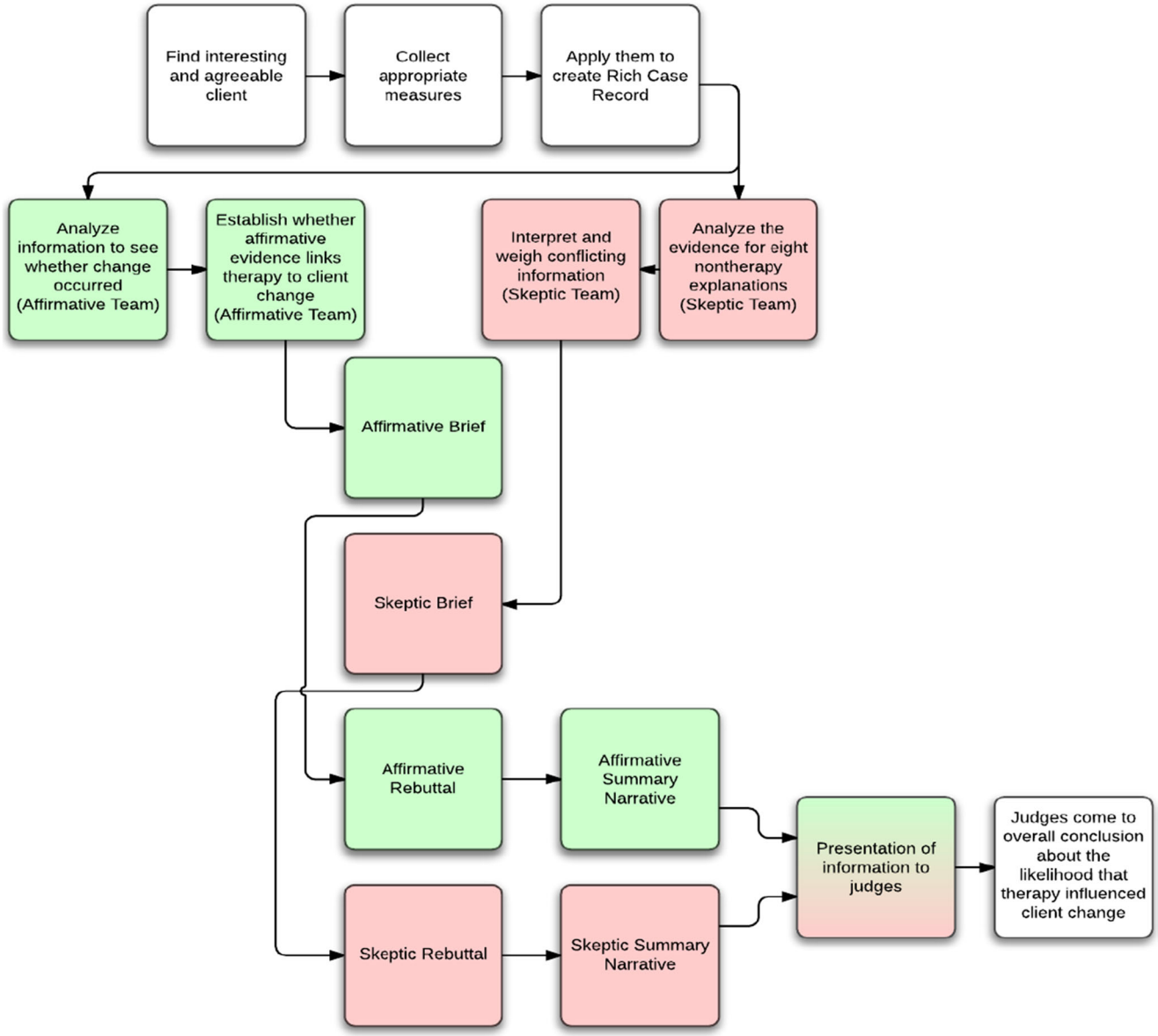

Fig. 1 HSCED analysis procedure

In regard to Kelly's weekly PQ, results indicate an overall drop in the mean score of two points from pre-therapy to post-therapy (unfortunately, there is no data from follow-up). A decrease of two points decrease is considered a significant shift (Elliott, Wagner, Sales, Rodgers, Alves, & Café, 2015). See Fig. 2 for progression of PQ mean.

Qualitative Outcome Data

Kelly's engagement with the HAT was minimal; besides conveying Kelly's impression that she found it helpful to talk to the therapist, it was generally uninformative about therapy. In the adapted Change Interview with Kelly, she indicated positive changes in her life such as being bugged less about being bullied, feeling less scared for her father's health, and worrying less about the possibility of moving schools. She attributed these changes mainly to 'it just happened', rather than to therapy. Kelly said that it helped to talk about her feelings and that sometimes the timeline was difficult for her.

Kelly's mother reported in her Change Interview that she saw seven areas in which her daughter's life changed since the beginning of therapy. All of these changes were reported to be a surprise, most of them unlikely to have happened without therapy, and most of them were extremely important to the client's mother. See Table 1 for an overview of the seven changes. Other informal data include an email from the mother to the therapist mid-therapy indicating that she saw change in Kelly already and a letter at the end of therapy, in which she delineated several facets in which Kelly has changed.

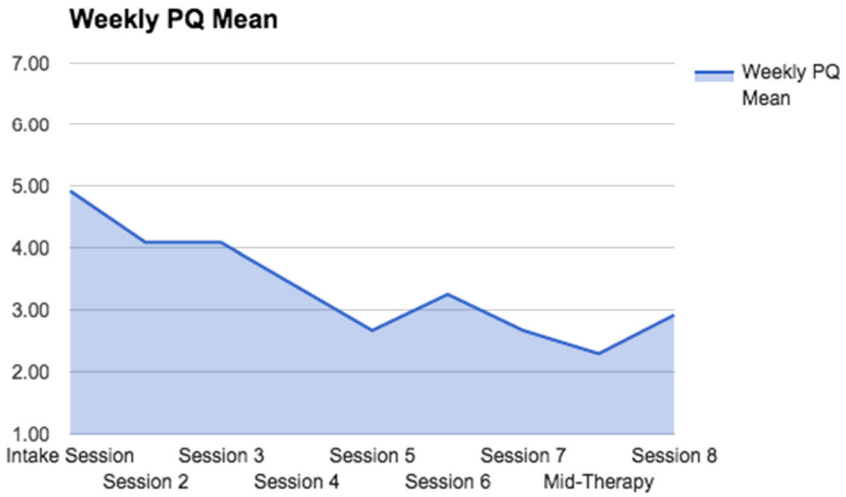

Fig. 2 Progression of PQ mean

Adjudication Process

Affirmative Brief

The affirmative team identified three out of four types of evidence for change and change due to therapy. For change in long-standing problems, the team pointed towards Change Interview with the mother, the improvements seen on the teacher, parents, and self-reports of the BASC-2, and descriptive evidence in the mother's letters. The team noted that the mother indicated in the Change Interview that several important changes would not have happened without therapy. They also pointed to the mid-therapy email and post-therapy letters, which commented on the fact that Kelly sleeps more and has more tolerance for her brother that was not there when she was not in therapy. In regard to helpful aspects of therapy, the team pointed to comments made in the client's HAT forms, the therapist notes, and the video observation notes that identified helpful aspects, such as talking about feelings, Kelly talking about her bullying experiences, and Kelly's involvement in some of the timeline repetitions. An overall improvement could be seen in 7 out of 12 PQ items.

Skeptic Brief

The skeptic team argued that there were types of evidence pointing towards non-improvement, including that Kelly's score on anxiety and self-esteem in the BASC-2 got worse. The team also pointed out that many of the apparent improvements on the BASC-2 may not be significant if the standard error of measurement were accounted for. As evidence of relationship artifacts and expectancy, the team pointed out that the mother's previous relationship with the therapist through her son's therapy could have influenced her perception on Kelly's changes. They further identified that there could have been a self-generated return to the baseline since there had not been many crises for one and a half years (the last of which was her father's back injury). Also, positive extra-therapy events (bullies moving away, increased stability in her father's health) were cited as factors that may have positively

Table 1 Changes observed in Kelly by her mother with attributions

Change	Change was: 1 – expected 3 – either 5 – surprised by	Without therapy: 1 – unlikely 3 – neither 5 – likely	Importance: 1 – not at all 2 – slightly 3 – moderately 4 – very 5 – extremely
1. Discovered her backbone	5	1	5
2. Gained maturity	5	1	5
3. Communicates better	5	2	5
4. Taking downtime	5	1	5
5. Improved sleeping pattern	5	3	3
6. Increased self-confidence	4	1	5
7. Emotional awareness/expression	4	1	5

influenced change. In terms of psychobiological changes, it was pointed out that Kelly was most likely undergoing hormonal changes associated with puberty, which could have affected and improved her sleeping patterns. Similar to the relational artefacts, the team pointed out that Kelly might have wanted to please the researchers.

Affirmative Rebuttal

The affirmative team pointed out that there was a substantial amount of evidence through the BASC-2, FACES-IV, and the qualitative measure to indicate that change occurred. They also argued that Kelly's mother was unlikely to have wanted to please the researchers or therapist. This was based on the therapist's description of the mother as a strong advocate for her children. Also, contrary to what the skeptic team pointed out, there had been a few crises in the last years, which could have prevented a self-generated return to baseline. Additionally, the team pointed out that since the bullying had been going on for years and at two different schools, it could be expected that Kelly's fear of being bullied would have remained even after those particular bullies left. In terms of reactive effects of research, the team pointed to a few results, which indicate the opposite, such as Kelly's willingness to inform the researcher about parts of therapy that she did not like.

Skeptic Rebuttal

In the skeptics' rebuttal, the team mainly offered alternative explanations for some of the affirmative team's arguments, such as that Kelly's calmness and patience towards her could also be due to Kelly's increased need to sleep.

Adjudication

Following the case development session, the three judges received written copies of the RCR and the briefs and rebuttals for independent review. An overview of their responses is given in Table 2, in addition the mean and the median score of their results. Stephen, Elliott, and MacLeod (2011) propose to use the median to represent majority with three judges.

Judge A mentioned that most of the qualitative reports of change were substantiated by assessment outcomes. Judge B mentioned that while they agreed that change occurred, they also agreed with the skeptical side that change was minimal. Judge B relied mainly on the skeptic arguments about statistical insignificance of change and lack of a self-reported change from Kelly. Judge C mentioned that they saw change from multiple perspectives, such as a shift in PQ scores, Kelly's mother's Change Interview, email and letter, as well as therapist notes.

Judge A agreed with the skeptical team that change largely occurred due to common factors of therapy, and that LI appeared to have influence on the change compensating for a less-than-ideal therapeutic alliance. Judge B suggested that, because Kelly's mother attributed most changes to therapy and because all of the changes occurred within a short period of time, the change that did happen was fairly likely due to therapy. Judge C asserted that there were numerous reports that change happened and that they would have been unlikely to have happened without therapy. Additionally, the LI-specific Timeline can be seen in three different places to have been crucial in bringing about change.

In summary, the judges agreed that Kelly's experience in therapy resulted in a change to her presenting issues. Results from the assessments brought varying degrees of evidence for and against client change, as well as for and against LI's involvement in the change. After analyzing the data in affirmative arguing and skeptic arguing research teams, three experts concluded that Kelly changed significantly and that change was due to LI.

Discussion

As can be seen by the results from the various assessments, as well as the research teams' arguments, and the judges' rulings, Lifespan Integration appears to have been helpful in causing change in the participant's presenting problems. Overall, the judges concluded that the client changed substantially (80%) over the course of therapy with 80% certainty. They also concluded that therapy played a substantial part (80%) in the change and were unanimously 80% certain. It was evident that all judges based their decisions on their readings of the rich

Table 2 Judges' rulings

	Judge A	Judge B	Judge C	Mean	Median
1a. To what extent did the client change over the course of therapy?	80%	20%	80%	60%	80%
1b. How certain are you?	95%	60%	80%	78%	80%
2a. To what extent is this due to therapy?	60%	80%	80%	73%	80%
2b. How certain are you?	80%	80%	80%	80%	80%

Note. Anchors for questions 1a and 2a: 0%: no change, 20%: slightly, 40%: moderately, 60%: considerably, 80%: substantially, 100%: completely

case record and the case development document, with briefs and rebuttals, and made use of both skeptical and affirmative arguments. All judges showed proof of an in-depth analysis of the available assessments and seemingly answered the questions in alignment with their area of expertise.

According to Stephen and Elliott (2011), a probability of 80% indicates 'clear and convincing evidence'. In this research study, the judges' summary conclusions passed this standard of proof in terms of the extent the client changed, as well as the extent that this change was due to LI. Using the HSCED, helpful insights emerge about Kelly's process of change as well as the working mechanisms of LI.

Overall, the judges concluded that most of the change in Kelly is attributable to Lifespan Integration. The judges pointed out several therapy processes that were helpful to the client. Some of these can be attributed to specific LI modalities, such as the use of the timeline and being 'pulled in' to the therapist's narrative about Kelly's birth. Other helpful processes belonged to the benefits that can be seen to be common factor in many therapies, such as being the central figure, talking about feelings, experiencing a supportive person, doing a project together with mom, and problem solving.

Limitations and Future Directions

While using and implementing HSCED, a few situations presented themselves that would warrant further investigation for a possibility of improvement. First, the adjudicators seemed to have worked with different definitions of the scope of client change; a formal definition was not provided and thus every judge used their own definition. This difference became evident in the sections of the adjudication form that asked the judges to provide comments about their decisions. On a similar note, Hu (2014) mentioned that the term 'completely' for 100% change would warrant revisiting and clarification. Saying that somebody 'changed completely' depends on a subjective view of the areas in which the client changed. For future studies, a literature review of client change could be conducted in order to come to a clear definition. This definition then could be better operationalized in the adjudication forms to avoid varying definitions.

Second, there seemed to have been a slight misunderstanding in regard to the second question on the adjudication form. Judges were asked to answer to what degree therapy was responsible for the change, and at least two of the three judges seemed to have made their decision on an assumption that they were to look for LI specific traits as solely responsible for the change. These judges pointed out it was less LI and more common factors that were responsible for the change. As mentioned above, LI as a therapy is expected to use common factors just as other therapies. Thus a division between LI specific traits and common factors is misleading to consider when answering this question. To avoid similar confusions in the future, more specific instructions for this question might be of benefit. These instructions would need to include common factors of therapy as part of the therapy in question.

Third, as mentioned above, the PQ, HAT, and Change Interview seemed to have left gaps in the full assessment of Kelly's experience in therapy. For future studies, different kinds of expressive measures could be applied to inform the rich case record better about the child's experience. This could be done with adaptations to the assessments as discussed above, or it could include different kinds of expressive material, such as pictures for younger children, song lyrics for older children, etc. This would need to be incorporated on an individual basis to fit the client's way of expression.

Another limitation to this study was the data from the BASC-2 measures. As discussed in more details above, the automated results on the assessment reports did not take into account any Standard Error of Measure. Especially when comparing results longitudinally, what seemed like improvements were in fact not statistically significant improvements. Fortunately, these errors came to the attention of the researchers in the process of the case development and the judges could be presented with the proper results.

Although not a formal limitation, it is important to acknowledge that not every area of suffering for this client improved. For example, self-esteem scores appeared to decrease which may be due to developmental factors or self-awareness through therapy, and withdrawal scores increased which may be a self-protective factor in relation to the client's family system. The case of Kelly provides a multilayered, complex, and systemically embedded case for therapy, with multiple traumas present. The client experienced hyper arousal and chronic threats to stability within a family system of chaos and hyper-vigilance, including Kelly's brother's health, multiple medical emergencies, and Kelly's mother's complex trauma presentation. Therefore, parental and family systemic factors are clearly displayed in this case. The HSCED design is most appropriate for this rich case study because it offers an in-depth exploration of LI therapy processes and is contextualized in the naturalistic setting of a psychotherapy practice.

Implications for Counselling Practice

This research has important implications for counselling practice, particularly for counselling trauma-exposed children. The judges concluded with 80% certainty that the therapeutic experience as a whole had a substantial influence on the changes in the client. This result is encouraging in that counsellors can be more certain that LI has the potential to help a child client. While this research focused on only one case, Kelly's presentation to counselling has similarities with other

trauma-exposed children who participate in counselling. For example, Kelly's presentation of anxiety and hypervigilance is typical of symptoms presented by children exposed to trauma. Therefore, LI could be utilized effectively with trauma-exposed children.

In Kelly's case, she experienced considerable change in her trauma symptoms over the course of therapy. People close to Kelly attribute this change to therapy, while Kelly did not make this attribution. This seems to indicate that Kelly's symptoms got better without Kelly realizing that she underwent trauma-therapy. In other words, she experienced relief of her symptoms from trauma without an emotionally intense exposure or discussion of this trauma. By inference, one can conclude that Lifespan Integration is an effective and gentle technique for trauma-therapists to use, especially with children who may not have the words to verbalize their traumatic experiences. As LI works at a deep level of neural integration and 're-sets' the neural system, often clients may not be aware they are reacting differently to previously triggering stimuli. This 're-setting' happens very rapidly for most people, as indicated in this study after nine sessions.

Although the authors of this study utilized LI as a stand-alone therapy, it is important to note here that LI can be used as a valuable tool in conjunction with other trauma-informed approaches. As with most trauma treatments, LI would be expected to be more effective for a single identified trauma, especially if it were recent.

Implications for Policy

The findings from this study have important implications for policy as related to children. While prevention of avoidable trauma for children is a collective ethical imperative, effective treatments are still needed. The present results demonstrate that LI is a treatment approach that works well within clinical settings for children exposed to trauma. LI has the added benefit of being useful for children across the age range from toddlers through adolescents. Therefore, this study shows that LI can reduce children's distress following trauma—making recovery both possible and probable. The findings from this study also have broader health-related implications. Childhood trauma is a public health issue and adverse childhood experiences are associated with health consequences continuing into adulthood, including physical and psychological conditions, risk behaviours, developmental disruption, and increased healthcare utilization (Kalmakis & Chandler, 2015). However, most of the research and outcomes are cross-sectional and descriptive in nature. This study provides evidence of a clinical intervention that, if implemented widely during childhood, could offset childhood adversity outcomes and reduce the total public health burden.

Conclusion

Siegel (2001) stated, "If we can find a way to facilitate neural integration within the minds of individuals across the lifespan, we may be able to promote a more compassionate world of human connections" (p. 90). Based on initial evidence, Lifespan Integration offers a resource to target precisely this and may be a step towards a more connected and compassionate world. Trauma in children can have devastating effects and may influence their life well into adulthood if left untreated. Trauma therapy for children that omits the need for the client to re-experience the trauma has received little empirical research attention. Lifespan Integration claims to be an effective trauma therapy without the need for a child to re-experience the trauma. The results from this research study seem to support this statement; the client's presenting issues seemed to have changed considerably because of the client's experience in Lifespan Integration and she was not re-traumatized. With this information, LI might be one step closer to being accepted as an evidence based practice, in which the timeline plays a crucial part of its therapy. Results of this project may also have impact on counselling psychology as a profession; with more tools available to help trauma-exposed children, counsellors will have more tools to use in their endeavour to help overcome trauma challenges. While we have not tested the bounds of Lifespan Integration with all its intricacies and working mechanisms, this research provides indications that Lifespan Integration is helpful in providing gentle relief from trauma.

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Declarations

Conflict of Interest The authors of this manuscript have no conflicts of interest to disclose.

References

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders *(*4th ed.*, text rev.).* American Psychiatric Press, Inc.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Press, Inc.

Balkus, B. (2012). *Lifespan Integration effectiveness in traumatized women* (unpublished doctoral dissertation). Northwestern University.

Binet, E., & Tarquinio, C. (2015). Intérêt et limites de l'Intégration du Cycle de la Vie (Lifespan Integration) auprès d'adultes victimes du Syndrome de Münchhausen Par Procuration pendant leur enfance. *L'évolution Psychiatrique*, 81(3), 2016, pp. 625–640. https://doi.org/10.1016/j.evopsy.2015.09.003.

Briere, J., & Scott, C. (2013). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed). Sage.

Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioural therapy for children and parents. *Child and Adolescent Mental Health, 13*(4), 158–162. https://doi.org/10.1111/j.1475-3588.2008.00502.x.

Diehle, J., Opmeer, B. C., Boer, F., Mannarino, A. P., & Lindauer, R. J. (2015). Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: What works in children with posttraumatic stress symptoms? A randomized controlled trial. *European Child & Adolescent Psychiatry, 24*(2), 227–236. https://doi.org/10.1007/s00787-014-0572-5.

Elliott, R. (1993). Helpful Aspects of Therapy Form. Retrieved from http://www.experiential-researchers.org/instruments/elliott/hat.html.

Elliott, R. (2002). Hermeneutic single-case efficacy design. *Psychotherapy Research, 12*(1), 1–21. https://doi.org/10.1080/713869614.

Elliott, R. (2012). Qualitative methods for studying psychotherapy change processes. In D. Harper & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*. Wiley.

Elliott, R. (2014). Hermeneutic single-case efficacy design: An overview. In K. Schneider, F. Fraser, & J. Bugental (Eds.). *The Handbook of Humanistic Psychology*. SAGE.

Elliott, R., Mack, C., & Shapiro, D. (1999). *Simplified personal questionnaire procedure*. Unpublished manuscript. Retrieved May 28, 2014 from http://www.experiential-researchers.org/instruments/elliott/pqprocedure.html.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: *Alternative strategies. Psychologische Beiträge, 43*(3), 69. https://ezproxy.student.twu.ca/login?url=https://www.proquest.com/scholarly-journals/qualitative-change-process-research-on/docview/212158667/se-2?accountid=14411.

Elliott, R., Partyka, R., Alperin, R., Dobrenski, R., Wagner, J., Messer, S. B., Watson, J. C., & Castonguay, L. G. (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research, 19*(4–5), 543–557. https://doi.org/10.1080/10503300902905947.

Elliott, R., Wagner, J., Sales, C., Rodgers, B., Alves, P., & Café, M. J. (2016). Psychometrics of the personal questionnaire: A client-generated outcome measure. *Psychological Assessment, 28*(3), 263–278. https://doi.org/10.1037/pas0000174.

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet, 373*(9657), 68–81. https://doi.org/10.1016/S0140-6736(08)61706-7.

Hendricks, A. (2013). *The revised child welfare trauma training toolkit: What's new in version two?* [PowerPoint slides]. Retrieved May 28, 2014, from NCTSN learning center: http://learn.nctsn.org/course/view.php?id=12.

Hu, M. (2014). *Lifespan Integration efficacy: A mixed method multiple case study* (Unpublished Master's thesis). Trinity Western University.

Kalmakis, K. A., & Chandler, G. E. (2015). Health consequences of adverse childhood experiences: A systematic review. *Journal of the American Association of Nurse Practitioners, 27*(8), 457–465. https://doi.org/10.1002/2327-6924.12215.

Kamphaus, R., & Reynolds, C. (2006). *Parenting relationship questionnaire (PRQ)*. Pearson.

Lanius, R., Lanius, U., Fisher, J., & Ogden, P. (2006). Psychological trauma and the brain: Toward a neurobiological treatment model. In P. Ogden, K. Minton, & C. Pain (Eds.), *Trauma and the body* (pp. 139–161). W. W. Norton & Company, LLC.

Mash, E. J. (2006). Introduction. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed.). The Guilford Press.

McLeod, J., & Elliott, R. (2011). Systematic case study research: A practice-oriented introduction to building an evidence base for counselling and psychotherapy. *Counselling & Psychotherapy Research, 11*(1), 1–10. https://doi.org/10.1080/14733145.2011.548954.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. W. W. Norton & Co.

Olson, D. (2010). *FACES IV manual*. Life Innovations.

Pace, P. (2012). *Lifespan integration: Connecting ego states through time* (5th ed.). Lifespan Integration, LLC.

Pace, P. (2013). *Lifespan integration: Beginning lifespan integration workshop training materials*. Lifespan Integration, LLC.

Partyka, R. (2010). Robert Elliott: Commitment to experience. In L. G. Castonguay, J. C. Muran, L. Angus, J. A. Hayes, N. Ladany, & T. Anderson (Eds.), *Bringing psychotherapy research to life: Understanding change through the work of leading clinical researchers* (pp. 283–293). American Psychological Association.

Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review, 29*(4), 328–338. https://doi.org/10.1016/j.cpr.2009.02.007.

Rajan, G., Wachtler, C., Lee, S., Wändell, P., Björn, P., Wahlström, C. G. S., & Carlsson, A. (2020). A one-session treatment of PTSD after single sexual assault trauma. A pilot study of the WONSA MLI project: A randomized controlled trial. *Journal of Interpersonal Violence,* 1–22. https://doi.org/10.1177/0886260520965973.

Reynolds, C., & Kamphaus, R. (2004). *Behavior assessment system for children* (2nd edition (BASC-2) ed.). Pearson.

Rosner, R., König, H.-H., Neuner, F., Schmidt, U., & Steil, R. (2014). Developmentally adapted cognitive processing therapy for adolescents and young adults with PTSD symptoms after physical and sexual abuse: Study protocol for a randomized controlled trial. *Trials, 15*(1), 195–195. https://doi.org/10.1186/1745-6215-15-195.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. W. W. Norton & Company.

Schore, A. N. (2003). *Affect dysregulation & disorders of the self*. W. W. Norton & Company, Inc..

Siegel, D. J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, "mindsight," and neural integration. *Infant Mental Health Journal, 22*, 67–94. https://doi.org/10.1002/1097-0355(200101/04)22:1<67::AID-IMHJ3>3.0.CO;2-G.

Sprout, S. (2015). *Naked in public: A memoir of recovery from sex addiction and other temporary insanities* [Kindle version]. Retrieved May 28, 2014 from http://www.amazon.com.

Stephen, S., & Elliott, R. (2011). Developing the adjudicated case study method. *Pragmatic Case Studies in Psychotherapy, 7*, 230–241. https://doi.org/10.14713/pcsp.v7i1.1079.

Stephen, S., Elliott, R., & Macleod, R. (2011). Person-centred therapy with a client experiencing social anxiety difficulties: A hermeneutic single case efficacy design. *Counselling & Psychotherapy Research, 11*(1), 55–66. https://doi.org/10.1080/14733145.2011.546203.

Thorpe, C. (2012). *The success and strategies of lifespan integration: An overview and client stories*. TimeLine Press, LLC.

Thorpe, C. (2015). *Notes from lifespan integration with children and adolescents*. Workshop.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2012). *Interventions addressing children exposed to trauma: Part 2 – Trauma other than maltreatment and*

family violence. Retrieved May 28, 2014 from www.effectivehealthcare.ahrq.gov.

van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Wall, J., Rensch, C., Hu, M., McDonald, M., & Kwee, J. (2015, August). *Lifespan integration therapy with trauma-exposed children: A hermeneutic single case efficacy study*. Poster session presented at the meeting of APA, Toronto.

Whitacre, S. (2014). *My father's prostitute: Story of a stolen childhood* [Kindle Edition]. Retrieved May 28, 2014 from http://www.amazon.com.

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