The functions of safety in psychotherapy: A comparative analysis across therapeutic schools

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Abstract

There is a certain consensus in the psychotherapeutic literature that safety plays a central role in human development and psychotherapy and that lack of safety undermines mental health. Nevertheless, the role of safety in psychotherapy has not yet been systematically examined. Therefore, we analyzed and compared the concept of safety across some main psychotherapeutic schools (psychodynamic, cognitive-behavioral, humanistic). Our goal was to identify and integrate the different functions of safety in psychotherapy on a transtheoretical basis. Our analysis showed that safety is rightly prioritized across psychotherapy schools mainly because a lack of safety activates psychobiological defense systems. Our findings suggest that the main role of safety is to secure survival, facilitate restoration, promote exploration, sustain risk-taking, and enable integration, with these functions being complementary and dependent on the context. It appears that the effective functioning of human development and psychotherapy does not require the continuous maintenance of the maximum possible safety, but *enough* safety. Although safety provides the necessary basis for an adequate ontogenetic development as well as for treatment progress, safety's misdosage (e.g., lack, excess), misconstruction (e.g., misattunement, misinterpretation), or misuse (exploitation, idealization) may hinder the healthy development of attachment, identity, autonomy, self/co-regulation as well as the ability to tolerate and cope with dangers, risks, insecurities, or frustrations, with negative consequences on the therapeutic process. Future research is suggested to further explore the role of safety in psychotherapy.

Safety And Psychotherapy: A Comparative Analysis Across Therapeutic Schools

The importance of safety in psychotherapy seems to be, at least implicitly, widely recognized in the field of psychotherapy. Safety is considered to permeate most human actions, largely at an automatic and implicit level (Porges, 2021). Moreover, it has been shown that an inadequate experience of safety during early human development has a significant correlation with psychopathology (Cassidy & Shaver, 2016; Gilbert, 2004; Schore, 2003). Finally, the possibility of experiencing adequate safety during the treatment is considered an important element of the psychotherapeutic process and its outcome (Norcross & Lambert, 2019).

However, despite the importance acknowledged to the concept of safety in the field, psychotherapy literature still seems to lack a more systematic account of it. In fact, what is meant by safety, how it is explained, and to what extent and why it can be relevant in psychotherapy still seems to be rather fuzzy and subject to certain variability due to the variety of theoretical perspectives and orientations characterizing the different psychotherapeutic schools (Podolan, 2020). The present paper represents an initial attempt to provide such a systematic account. To this aim, we first review how different psychotherapeutic schools (psychodynamic, cognitive-behavioral, and humanistic) have addressed the concept of safety with regard to its psychological role and clinical value. Second, we draw on this analysis to identify some basic functions that safety may play across different therapeutic orientations. Finally, we conclude by suggesting future lines of research.

Psychodynamic Approaches

From a psychodynamic perspective, safety may be defined as a sense of physical and emotional well-being, free from the pressure of need and anxiety (Greenberg, 1991). Psychodynamic approaches were the first to emphasize the primary role of safety in the ontogenesis and therapy of the psyche (Podolan, 2020). In terms of the ontology of the psyche, Freud was the first one to assert that "the ego is governed by considerations of safety" (Freud, 1966; p. 199). Since then, Alfred Adler's *safeguarding tendencies*, Anna Freud's *defense mechanisms*, Karen Horney's *safety devices*, Joseph Sandler's *background of safety*, or Harry Sullivan's *security operations* have differently referred to basic mechanisms of safety as to overriding aspects of the psyche that secure its survival, protect it against dangerous and unbearable experiences, organize its defensive and coping mechanisms, and manage all of its perceptions, pleasures, and fantasies. Safety has been associated with affective, motivational, and behavioral systems that seek, maintain, or use various forms of safety to maintain homeostasis, secure survival, provide restoration, enable exploration, promote resilience, and enable growth (Cassidy & Shaver, 2016; Lichtenberg et al., 1996; Panksepp & Biven, 2012).

Psychodynamic ontogenesis and clinical practice prioritize safety as well. Imre Herman's research of primate's *clinging instinct* or William Blatz's developmental *security theory* led Mary Ainsworth (1985) and John Bowlby (1988) to introduce the concept of *attachment*, which eventually became a breakthrough in our understanding of our needs for safety and their role for ontogenetic development. Bowlby and Ainsworth convincingly demonstrated that *attachment proximity* to the caregiver is not only a primal need but also a critical source of an infant's safety (Ainsworth, 1985; Bowlby, 1998) because it secures protection (safety) against predators and other dangers through relationships. Sroufe and Waters (2017) clarified that the goal of any type of attachment is for the infant to survive by *feeling secure.* Safety has also been recognized as a precondition for effective psychodynamic psychotherapy. A good therapeutic process requires a client's feeling of safety that arise when the therapist maintains *therapeutic boundaries* that create a *safe environment* (Gabbard, 2016) and when he/she can pass the client's *tests* (Rappoport, 1997; Siegel & Hilsenroth, 2013) and deactivate his/her *defenses* (Frederickson, 2020) that forestall safe disclosure and exploration of dangerous material. Thus, psychodynamic literature emphasizes the role of safety in terms of survival, human development, and effective psychotherapy.

Importantly, psychodynamic literature also underlines that safety is linked not only with survival, homeostatic, and defensive aspects but also with soothing and restoring a distressed organism through a secure relationship. The interpersonal aspect of safety which soothes, calms, and heals has been, for example, addressed by Donald Winnicott (1965). His concept of *holding environment* refers to the union-like symbiotic relationship in which the mother provides safety not only through the protection of the infant but also through her love, support, stability, continuity of being as well as the integration of the infant's inner emotional and cognitive processes. Later, Ainswowrth (1985) used the term *secure attachment* to characterize loving, warm, soothing, sensitive, and reliable care, correct interpretation of the infant's signals, and prompt and appropriate responding to his/her needs (Ainsworth, 1985). Psychodynamic theories developed plentiful relational concepts addressing various forms of relational

safety (e.g., containment, basic trust, extra-uterine matrix) that went far beyond infant's protection and included also his/her recognition and holding in the mind of another, reciprocation of infant's needs, organization, integration, consolidation, naming, and symbolization of his/her experiences, soothing, calming, co-regulation of infant's inner processes, provision of inner and outer boundaries, and facilitation of the infant's exploration and growth. Therefore, from a psychodynamic perspective, safety does not only protect, but also soothes, calms, restores, and heals a distressed organism.

An additional important psychodynamic aspect, that is inseparably interconnected with safety, is the concept of exploration. Attachment theory posits that a feeling of safety initiates the infant's exploration and novelty seeking. Thus, only after the infant experiences sufficient safety, he/she becomes able and motivated to freely seek and explore the outer and inner world without the need to rely on defense mechanisms. Such exploratory activity does not only enable survival (e.g., through seeking food and shelter) but also facilitates the expansion of existing functions and growth (e.g., by gaining new information or learning new skills). Here, the caregiver functions primarily as *a secure base* (Bowlby, 1988), which provides emotional fuel for the infant's exploratory endeavors, as well as a *beacon of orientation* (Mahler et al., 1975), which provides reassurances for new directions and more specific work amid uncertainties and painful emotions.

Psychodynamic theories also posit that psychotherapy may be not effective when a client feels *too unsafe* (hyper or hypo-arousal states with fight/flight/freeze systems being activated), or *too safe* (comfort state with no emotionally distressing experiences and dysregulated arousal states) (Ogden, 2009). For Bromberg (2006), the enhancement of resiliency and expansion of affect tolerance requires that therapy is "safe but not too safe" (Bromberg, 2006, p. 4). In this respect, Allan Schore (2003a) coined the term *regulatory boundaries* (also called *window of affect tolerance*) to describe an optimal arousal zone within which emotions can be effectively experienced, processed, and integrated and within which progress and growth occur. In different moments and phases of therapy, both client and therapist are encouraged to experience *optimal frustrations* and *tolerable disappointments* (Kohut & Orstein, 2011) and remain in a position of *safe uncertainty* (Mason, 2015). They should also engage in certain levels of tension and danger to achieve therapeutic progress and change (Eldridge, 2018). In summary, the psychodynamic perspective underlines the relevance of such a level of safety that fuels both parties with trust and encourages them to take risks, face challenges, cope with uncertainties, tolerate frustrations, and explore vulnerable, threatening, or unknown domains of experience.

Another no less important aspect of safety addressed by psychodynamic literature relates to the integration of the self. On an unconscious level, integration of the self is thought to occur, inter alia, through dreams which serve as a safe environment, *safe place*, *safety valve*, or *secure base* for our overburdened brain. Importantly, the safety of dreaming enables our psyche to (i) creatively and playfully contain and regulate our emotions and integrate our daily experiences into stabile self-image (Hartmann, 1995), (ii) weave in new material into similar experiences that feel the same way to preserve our emotional memory (Payne, 2010), or (iii) adapt to trauma, stress, and the problems of life (Sørensen, 2018). In terms of the development of the self, Kohut similarly showed that the infant's self becomes

integrated and cohesive through interpersonal *mirroring*, *idealizing, twinship*, and *sustenance* (Kohut & Orstein, 2011). These experiences forge security of the infant's self through the development of internal ideals and feelings of cohesiveness, wholeness, consistency, resilience, and cathected image of oneself (inclusive of any fragmented pieces) that are gradually integrated and internalized (Kohut & Orstein, 2011). Another safety-related concept that facilitates the integration of the self is *mentalization* (Fonagy et al., 1991). When being mentalized by the caregiver (e.g., thought about, felt, understood, and recognized) the child feels safer because mentalization fosters the child's ability to think, understand, differentiate, organize, and consolidate experiences about oneself, others, and the world (Fonagy & Allison, 2014). The safety of the interpersonal integration of the self could be also characterized through what has been named *rhythmic attunement* (Kestenberg), *affective resonance* (Stern), *moments of meeting* (Sander), *synchronous interactions* (Levy, Tronick), or *directional fittedness* (Boston Change Process Study Group). Siegel (2010) further argued that the mind's safety and neural integration arise from not only interpersonal but also intrapersonal attunement and integration (ability to perceive the mind of oneself and another) which he called *mindsight*. Thus, in essence, dreaming as well as the therapist's mirroring, mentalization, and mindsight seem to support the development of the client's capacity to safely observe, organize, and integrate one's own self with regard to the self of another person.

From a psychodynamic perspective, safety appears to refer to relationships that regulate, balance, and integrate psychic experiences. In summary, psychodynamic approaches seem to share the view that the role of safety is to ensure psychic survival (e.g., through defenses, coping mechanisms, or security operations), facilitate healing and restoration (e.g., through secure attachments, or attuned/synchronized relationships), promote exploration (e.g., by creating a secure base, secure boundaries, and deactivation of client's defenses), sustain risk-taking (e.g., by sensitive interventions and fluid oscillations between danger and safety), and/or enable integration (e.g., through mirroring, mentalization or mindsight). In essence, the therapist must first create safety through empathic holding, mirroring, attunement, containing, mentalizing, prompt and appropriate responding, the correct interpretation of the client's signals, and observation of therapeutic boundaries. Only if enough safety has been created within the therapeutic relationship may the parties explore the client's vulnerable areas and engage in more risky and painful areas of the client's life to promote transformative and integrative processes.

Cognitive-behavioral Approaches

Approaches from cognitive-behavioral therapy (CBT) rely greatly on evolutionary and neurobiological research indicating that the human brain and mind developed on a continuum between defense and safety (Gilbert, 2004). The contemporary leading theory on safety – the polyvagal theory – postulates that one's sense of safety is determined by the nervous system, whereby the vagal complex inhibits neurobiological defense mechanisms and regulates the bodily state of safety (Porges, 2021). Thus, detection and differentiation between safety or danger cues occur through our sensory (auditory, kinesthetic, organic, visual, gustatory, olfactory, cutaneous, and vestibular) channels (Gilbert, 2004). Recent research on safety in psychotherapy started to provide evidence that the therapist's non-sensory

signals (e.g., language and words) seem to elicit less safety in the client than the therapist's voice intonation and other non-verbal signals such as posture, facial expressions, or eye contact (Mair, 2021).

Experiences of safety within relationships seem to have been necessary for brain development (Allison & Rossouw, 2013; Gilbert, 2004) and for the brain's capacity to detect safety through any relationships that reduce threats and provide a certain form of wellbeing (Porges, 2021). Such relationships may provide safety through attachment (protection and care through bonds), domination (power over subordinates), submission (protection by dominant ones), competition (knowing each other's strengths and weaknesses), hoarding (protection through higher number), and cooperation (sharing of resources and co-regulation of aims) (Ivaldi, 2016). From an evolutionary and relational perspective, the detection and sense of safety in relationships seem to have been the primary goal in the course of human evolution.

It should also be noted that CBT has been increasingly integrating and using various relational aspects of safety (e.g., empathy, unconditional positive regard, cooperation, validation, mentalization, attunement, presence, congruence) from various other psychotherapy schools. It considers these different facets of safety (and their differentiation from danger) to be central for effective therapy and the related work with clients' distorted cognitions and emotions (Bennett-Levy et al., 2015). Concerning danger and safety, CBT differentiates between the perception of *danger signals* (cues indicating that a dangerous event may occur) and/or *safety signals* (cues indicating that there is no threat or that an aversive event will not occur) (Lohr et al., 2007). CBT also developed the concept of *safety behaviors* that – analogously to defense mechanisms – refer to those behaviors intended to detect, avoid, escape, neutralize, or reduce fear or anxiety (Hayes & Hofmann, 2018). In this context, CBT therapies strive to create safety in therapy in order to deactivate defense mechanisms (Bryant, 2006), satisfy the client's attachment or control needs (Epstein, 1998), and promote self-soothing (or elicitation of soothing from others) and regulation (or co-regulation) of inner states (Porges, 2021). Clients' senses of safety are facilitated mainly by psychoeducation, creation of a safe place, sustenance of hope, cognitive structured techniques (exposure techniques), giving advice, providing assistance of some sort or another, offering encouragement, or various forms of enhancement of client's personal, social, or economic resources (Norcross & Lambert, 2019; Rappoport, 1997). Through relational safety, CBT clients are encouraged to engage in vulnerable behaviors, be more authentic, voice disagreements, accept and normalize the expression of negative and positive emotions, or directly discuss and address dysfunctional interactions or escalation of conflicts.

CBT modalities also recognized that safety does not only reduce defenses but also promotes activation of non-defensive exploratory behaviors. Paul Gilbert (2004) clarified that feeling unsafe refers to *safety behaviors* which may include fight-flight-freeze mechanisms and corresponding defensive strategies. However, feeling safe refers to *safeness behavior* which includes exploration with relaxed, open, and non-defensive attention, without the need to rely on safety behaviors. The work of Bennett-Levy et al. (2015) added that the feeling of safety promotes, in addition, self-exploration and self-reflection, which are likewise considered essential for psychotherapy.

According to Gilbert (2004), an inner sense of safety promotes an individual's ability to engage in vulnerable activities, take risks, face dangers, and develop more complex repertoires for thinking and behavior (p. 280). Lohr et al. (2007) similarly suggest that the gradual coping with danger signals – where one feels safe enough to cope with danger (as well as reduction of excessive reliance on safety signals) – contributes to the reduction of pathological fears, dependency, isolation, or energy consumption. Both these authors warned against a continuous or excessive reliance on safety signals (e.g., familiar places or persons, cellular phones), because it may contribute to the maintenance and exacerbation of anxiety, as well as to the development of various maladaptations that employ defensive mechanisms even in non-threatening situations. CBT clients seem to achieve changes and growth if their contact with danger occurs within their *safety zone*, which is represented by the clients' ability to regulate and control their responses to threats (Freeman & Dolan, 2001). In essence, CBT approaches teach clients to cope with threats, insecurities, and uncertainties to reduce over-reliance on safety behaviors and to assume that situations are safe unless there is clear evidence to the contrary.

Cognitive-behavioral literature also posits that our sense of safety arises from a cognitive process called *security priming* (Baldwin, 2007). Security primes may include not only memories, but also pictures, portrayals, text messages or images, or subliminal representations of available and supportive attachment figures (Cassidy & Shaver, 2016). The security primes are activated through guided imagery and visualization of a safe place, mindfulness, or other techniques that all allow clients to draw upon or think about mental states (of oneself and others) as well as fantasies about union with another or memorized experiences of unconditional social connection (Baldwin, 2007). Security priming enhances the integration of the self, including how we see ourselves, others, and our relationship with them (Rowe & Carnelley, 2003). Priming with mental representations of security-enhancing attachment figures also fosters a person's sense of security, activates a sense of attachment security, helps to understand internal working models, improves mood, and has a calming and soothing effect (Gillath & Karantzas, 2019). Within the context of psychotherapy, therapists teach clients to prime security to feel safer, to down-regulate their hyperarousal, up-regulate their hypoarousal, enhance their positive affects, facilitate their self-efficacy through self-regulation of thoughts, emotions, and behaviors, or to co-construct narratives in service of finding new meaning and action and consolidating the self (see Castonguay & Hill, 2012).

In summary, cognitive-behavioral approaches – especially those with a specific trauma-focused orientation – see safety as a need enrooted in the nervous system which ensures survival, enables restoration, and facilitates exploration and development. Safety is experienced through co-regulating relationships (developing through the priming of various security-related relational aspects). Being safe also requires psychoeducation (through understanding and oversight, "I feel to have power"), self-efficacy ("I trust in my qualities and abilities to cope with danger"), and development of the ability to differentiate between safety and danger or between safeness and safety behavior. Cognitive-behavioral approaches seem to integrate various safety-related constructs (e.g., attunement, unconditional positive regard, presence) into their theories. They prioritize the creation and maintenance of safety sources during the process of psychotherapy, in particular when working with traumatized clients. These modalities also

warn against a client's over-reliance on safety signals and encourage clients to foster inner safety by exposition to and coping with danger signals.

Humanistic Approaches

Within humanistic approaches, safety is defined as a need or desire for a secure, familiar, and predictable environment where one is free from illness and danger (Maslow, 1943). Humanistic therapies broadened our understanding of safety. For example, Giddens (1991) developed the term *ontological security* to refer to a sense of self-identity, a sense of order, a sense of continuity in everyday events, a belief in the continuity of the world, the confidence in the social order, a capacity to find meaning in our lives and the belief that self-realization can be achieved. Eric Erikson (1993) used the term ontological security to denote the existential trust in the continuity of relationships with significant others. For Laing (1960), ontological security means the ability to cope with life without the loss of a sense of existence and reality.

Maslow (1943) prioritized safety needs (together with physiological needs) before social and other needs. He proclaimed that "everything looks less important than safety, even sometimes the physiological needs" (p. 376). Importantly, like other authors from different orientations (e.g., Freud, Sandler, Gilbert, or Porges), Maslow was also convinced that our needs and perceptions of safety "serve as the almost exclusive organizers of behavior, recruiting all the capacities of the organism in their service" (Maslow, 1943, p. 376). Humanistic therapies also recognize that the scope and quality of an infant's sense of safety develop through contact at the boundaries of the self in the present meetings or dialogue of *me-you* (becoming "me" through "you") (Buber, 1958). Ludwig Binswanger (1963) underlined that healthy developmental interactions constitute *a dual mode of love*, where the love relationship develops our sense of safety and serves as the basis for our further growth and change. In essence, for humanistic psychotherapy, ontogenetic development proceeds through the interaction between the infant and the world whereby the infant's feelings of safety are formed in the *here and now* and in the *meetings of minds* where the infant is not only able to be present and confirm him/herself but, at the same time, to be open to and confirm another person (Schneider, 2016).

Just like psychodynamic and cognitive-behavioral approaches, humanistic therapies emphasize the role of safety not only in ontogenesis but also in clinical practice. According to existential therapist Victor Yalom (2002), "nothing takes precedence, I emphasize, over the importance of the patient's feeling safe in the therapy office and the therapy hour" (p. 189). Angus and colleagues have for example shown that one of the most important factors in humanistic therapy consists of the therapist's ability to build a client's sense of safety, underlying how slippery and fragile such a sense of safety is (Angus, Watson, Elliott, Schneider, & Timulak, 2015). Therefore, just like psychodynamic and CBT approaches, humanistic approaches also recognize that the sense of safety is primarily provided through relationships. In this respect, it should be noted how humanistic approaches impacted our general conceptualization of psychotherapy by defining certain relational qualities which create or enhance the client's experiences of safety. Rogers (1995) postulated that *psychological safety* in psychotherapy arises from an empathic, genuine, authentic, congruent, and non-judgmental therapeutic stance in which the therapist accepts the

client recognizing his/her *unconditional worth* as a person. Humanistic therapists enhance clients' safety also through an attuned, supportive, kind, and respectful relationship in which the therapists act for the client as a *human sanctuary* and as a safe container (Wheeler & Axelsson, 2015). Concerning the relational qualities of therapists that contribute to the creation of safety in psychotherapy, humanists also developed the concept of *presence*, which refers to the therapists' use of their whole self to be fully engaged and receptively attuned to clients in the present moment (Geller & Porges, 2014). The concept of *presence* may be compared to the concepts of *secure base*, *holding environment*, or *safe place.* In other words, the therapists are present when they are able to listen "without memory or desire" and modulate their "automatic pilots" (i.e., viewing the clients per old automated and processed memory) in order to adequately attune and focus on the present relational moments with their clients.

Just like in psychodynamic or CBT therapies, humanistic approaches also recognize that a sufficient sense of safety that has been gained through relationships triggers human activity toward the exploration of the inner and outer world (Schneider et al., 2014). Gestalt therapists also proclaim that "only with the assurance of absolute safety within treatment can the patient feel secure enough to talk about his most private and upsetting thoughts" (Levin & Gunther, 2004, p. 58).

However, unlike some other approaches, the humanistic approaches rely on a non-directional concept of *invitational mode*, which postulates that the therapist "always invites and never insists that the client explores certain aspects of the experience" (Schneider et al., 2014, p. 526). In other words, the invitational mode invites (does not require) psychological intimacy, because it values and respects the client's need for safety (including his/her resistance to explore vulnerabilities). The client's acceptance (or refusal) to accept the invitation to explore can be seen as an important milestone indicating that the relationship is safe enough (or not yet safe enough) to explore certain vulnerable material. For this reason, humanistic therapists prefer to attend to or respect clients' defenses and resistances until they developed a sufficient sense or source of safety (Leitner & Celentana, 1997). While other types of therapies may use other techniques to make the client feel safe enough (e.g., may confront their clients and try to first de-activate their defenses), humanistic techniques do seem to share the same goal: to first make the clients feel safe enough (in one way or the other) to promote exploration or play and facilitate the development of a true self.

Concerning exploration and safety in psychotherapy, humanistic literature also uses the concept of *safe emergency* (Perls & Andreas, 1969) positing that psychotherapy is effective if it employs and utilizes both exploration and challenges for growth (danger) on one side and guidance and support (safety) on the other (Cozolino, 2002). The concept of *safe emergency* is similar to the psychodynamic concept of *necessary danger* (Carr & Sandmeyer, 2018; see also the systemic idea of *safe uncertainty*; Mason, 2015). It posits that during the co-construction of the relationship, therapists must not only build a client's sense of safety but also use the client's safety in a dialectic relationship with danger, so that the client may eventually achieve changes and progress (Cozolino, 2002). In other words, while too much arousal and stress may activate defenses and inhibit optimal cortical processing involved in exploration, too little stress and arousal may lead to insufficient stimulation or focus required to take in new information

(Cozolino, 2002). Gestalt approaches place a positive value on empathy and support (safety) as well as frustrations and confrontation (danger). Both are needed for optimal development and growth. Perls warned that a steady and continuous focus on safety might prevent clients from taking risks and from learning how to effectively cope with life's dangers (Perls & Andreas, 1969). Therefore, when being fueled by sufficient safety, the client's free and creative will emerges and begins choosing how to cope with life's surprises, insecurities, or dangers. In this respect, Rogers (1995) underlined that psychological safety allows the client to move towards self-actualization, creativity, and self-development. Moreover, the promotion of clients' external and internal sources of safety helps them to integrate their selves through a sense of identity, aliveness, autonomy, and boundaries (Birtchnell, 2002).

In summary, humanistic therapies identify safety as a need that organizes all human behavior and as a belief in the continuity and predictability of the world that arises from relationships, routines, and experiences. A person feels safe to the extent he or she can existentially trust significant others and the continuity of the inner and outer world. The most important aspects of personal safety – identity, autonomy, and firm boundaries – are created through present meetings of minds (such as the *me-you* dialogue at the boundaries of the self) within a relationship that is characterized by unconditional acceptance, empathy, presence, congruence, and the invitational mode. Similarly, like psychodynamic and cognitive-behavioral approaches, humanistic therapies also posit that safety is enhanced and maintained through assimilation of new experiences arising from bearable safety-danger encounters (i.e., coping with tolerable risks and frustrations through a warm, accepting, and supportive relationship).

Safety And Psychotherapy: Basic Developmental Functions Across Psychotherapeutic Schools

Our analysis reveals that safety is an articulated and complex concept, which has as many facets and functions as we consider different schools of psychotherapy. In ontogenesis and psychotherapy, safety is being described differently through various concepts and related functions that are both non-defensive (e.g., relational co-regulation, window of affect tolerance, safeness behavior, internalized secure base) and defensive (safe zone, psychic retreat, safety behavior, safeguarding tendency, defense mechanisms). In the previous sections, we have seen that different psychotherapeutic approaches tend to define and use safety differently. At the same time, we believe it is possible to identify some common functions that safety plays both in ontogenesis and in clinical practice and that cut across different therapeutic orientations. These are described in Table 1.

Overall, we suggest that the discourse on client change (i.e., successful psychotherapy) may be compared to the discourse on successful child development (i.e., adaptive ontogenesis) (see Beebe & Lachmann, 2005). More specifically, we postulate that safety plays a fundamental role in the development and adaptation of both children and clients. At the outset of life/therapy, each child/client requires a responsive *enough* caregiver/therapist providing a *sufficient* amount of non-defensive (functional) experiences of safety. This enables the child/client to form basic trust and a secure attachment that facilitates the development of a secure self and identity, self-esteem, and safeness

together with adequate levels of mentalizing abilities, related flexible strategies of emotional regulation, and consequently higher degrees of biopsychosocial adaptation (Bowlby, 1988; Cortina & Liotti, 2010; Schore, 2003).

Table 1

School-independent Developmental Roles of Safety in Ontogenesis and Clinical Practice

Securing survival	Facilitating restoration	Promoting exploration	Sustaining risk-taking	Enabling integration
Ontogenesis. Humans seek survival and safety through evolutionary selected behaviors and relationships with primary caregivers (however functional or dysfunctional). Clinical practice. The therapist prioritizes the creation of a *safe environment* and starts functioning as *safe heaven* by providing therapeutic boundaries, attunement, acceptance, holding, and containment (mainly through *supportive* interventions) and by enduring him/herself the client's experiences of danger. This fosters the client's ability to better tolerate the experience of danger as well as to experience safety within the therapeutic relationship. This in turn reduces the client's defenses and favors his/her mentalization with a consequent better (self- and co-) regulation of the therapeutic relationship. As a consequence of this, a *good enough* relationship begins to form (*alliance building*).	Ontogenesis. Human ability to gain or restore inner safety evolves through the quality of the relationship with primary caregivers (however adequate or inadequate). Clinical practice. The therapist further provides a safe environment and functions increasingly as a *safe haven* by soothing and calming through a safe enough relationship marked by empathy and mentalization (mainly through *supportive* interventions). This allows the client to restore a sense of safety while facing danger (*alliance ruptures-repairs*) and reinforce his/her experiences of safety (*alliance stabilization*) and internalize therapy as a *secure base*. As a consequence of this, the clients can further develop mentalizing abilities and their ability to face danger without excessive reliance on defenses.	Ontogenesis. Human capacity to explore is promoted by safety gained or restored through proximal and responsive (internalized) relationships with caregivers who concurrently, actively promoted authenticity and exploration (however great or small). Clinical practice. The therapist takes advantage of having become a *secure base* to increasingly serve as *a beacon of orientation* and *actively invite* and *promote the* client's *exploration* (at a behavioral, emotional, and/or cognitive level) mainly through change-oriented interventions but still against the background	Ontogenesis. Human ability to take risks and face danger is sustained by having constructively experienced safety in a dialectic with danger which succeeds to renew inner organismic balance in times of disequilibrium (e.g., conflicting experiences). Clinical practice. The therapist takes advantage of having become a *safe haven* and *secure base* to create and manage the conditions for *transformative safety*. This is done through an adequate and dialectic balance between *supportive* and *change-oriented interventions* against the background of a safe-enough relationship, enabling the client (i) to dialectically experience and cope with danger within an overall safe relationship and (ii) to co-regulate and assimilate new and conflicting experiences (*corrective emotional experiences*). This enhances the client's mentalization, self-efficacy, self-, and co-regulation,	Ontogenesis. Human ability to assimilate new experiences and reorganize old ones, reform boundaries and update identity in an integrated and coherent way requires safety provided by dreaming, mirroring, narrating, identifying and recognizing, and differentiating self from non-self. Clinical practice. The therapist creates conditions of *integrative safety* amidst internal and external stressors through supportive interventions (dreamwork, meditation, self-narration), *recognition* of the client's individuality (boundaries, personal continuity, and needs, set of core values), adequate *mirroring* of the client's self, *mentalization*, and *mindsight*. This enhances the client's self-integration and self-determination, ability to make decisions based

Securing survival	Facilitating restoration	Promoting exploration	Sustaining risk-taking	Enabling integration
		of a *safe-enough and supportive relationship*. This further promotes the client's curiosity, creativity, mentalization, and self- and interpersonal regulation.	affect tolerance, resilience, sense of reality, and the ability to tolerate danger and value risk-taking.	on free will, as well as the ability to recognize and determine what resonates with the client's self and what does not (the true self dominates, defenses are deactivated).

It is here important to stress the "enough" character of the caregiver's/therapist's responsivity and of the related safety he or she provides. In fact, only in this case the child/client may have the opportunity to experience frustrations, disappointments, and insecurities that become increasingly tolerable as long as the caregiver/therapist is able to adequately co-regulate them through the repair of relational ruptures (Beebe & Lachmann, 2005; Safran & Kraus, 2014). This co-regulated dialectic between safety and danger (Segalla, 2018) allows the child/client to increasingly internalize the experience of sufficient safety through repeated renewals of the balance of biopsychosocial arousal. Consequently, the child/client learns new and more functional modalities of self- and interactive regulation and increases the possibility of biopsychosocial exploration, thus starting to move within what has been defined (therapeutic) zone of proximal development (Leiman & Stiles, 2001).

The more this is the case, the more the child/client will be able to increasingly assimilate new experiences leading to change over time (to this aim, see the concept of corrective emotional experiences; see Castonguay & Hill, 2012 for a comprehensive review). With specific reference to psychotherapy, what plays a primary role in this whole process is both *relational* and *technical*: on one side, the therapist's ability to intersubjectively mentalize the client and therefore to attune to him/her (Siegel, 2010); on the other side, the ability to strategically use this attunement to deliver appropriate and well-timed interventions which either support him/her or promote change at an emotional, cognitive, and/or behavioral level.

These school-independent developmental functions of safety appear to be coherent with quantitative empirical findings in the field of psychotherapy research (both within and outside the framework of attachment theory). Firstly, from the perspective of attachment theory, it has been found that secure clients, compared to insecure ones, show a stronger therapeutic alliance (Diener & Monroe, 2011), a better commitment and compliance to treatment (e.g., Dozier, 1990), and a better treatment outcome (e.g., Levy, Kivity, Johnson, & Gooch, 2018). Analogously, secure therapists, compared to insecure ones, facilitate more often corrective emotional experiences (Dozier et al., 1994), are more able to facilitate a good alliance as well as treatment outcome (Degnan et al., 2016), and are more able to repair alliance ruptures through empathy (Rubino et al., 2000). Second, therapist's secure attachment is associated with his/her

in-session attunement and engagement (Talia et al., 2020). On the other side, client's pre-treatment reflective functioning (RF) predicts his/her in-session RF as well as in-session autonomy and security (affect sharing, self-assertion, and autonomous reflection) (Talia et al., 2019). Third, client's in-session security is associated with both his/her working alliance and with alliance rupture-repairs (Mallinckrodt & Jeong, 2015; Miller-Bottome et al., 2019); with other clinically productive in-session processes such as the client's level of exploration (Parish & Eagle, 2003), self-disclosure (Saypol & Farber, 2010), and session depth (Romano et al., 2008); and with better outcome (e.g., Sauer et al., 2010).

Some other quantitative research, conducted outside the specific framework of attachment theory, seems also to be consistent with the basic developmental functions of safety we propose. First, a client's sense of safety is predictive of treatment outcome (Beck et al., 2006). More specifically, clients' early feeling of safety predicts subsequent treatment improvement, with early alliance mediating this relationship (Friedlander et al., 2008). Moreover, clients' concerns about safety are associated with low alliance values (Beck et al., 2006). Second, alliance ruptures are associated with a reduction in client safety while, on the contrary, an increase in client safety is associated with alliance repairs. Interestingly, therapist repairs are characterized by his/her ability to enhance a shared sense of purpose with the client following an emotional connection with him/her and requiring the client to feel safe (Escudero et al., 2012). Finally, client-rated session safety is associated with session positivity, smoothness, and depth as well as with the therapeutic bond, confident collaboration, and overall alliance (Siegel & Hilsenroth, 2013).

Finally, also qualitative research has produced preliminary evidence which seems to be coherent with the above-described functions of safety. Regarding the clients' perspective, one of their core experiences of what is helpful in therapy deals with safety, reassurance, and support (Timulak, 2007, 2010). Moreover, therapist authentic caring as well as boundary-setting allows clients to feel safe and connected with the therapist and, consequently, to engage in the "vulnerable work of self-exploration and discovery" (Levitt et al., 2016; p. 823). Finally, therapists experienced as protective and caring provide a safe environment that represents a platform for self-discovery (Kirsha, 2019). Analogously, studies on therapists' perspective showed that the development of relational security allows the client to constructively deal with the in-session risks associated with change (Williams & Levitt, 2007) and to tolerate the vulnerability and uncertainty experienced during the client's exploration required for change (Levitt & Piazza-Bonin, 2016). For this reason, therapists should particularly preserve clients' safety by engaging their subjective world especially when client-therapist disagreements occur (Williams & Levitt, 2007).

Conclusions And Future Directions

The concept of safety seems to permeate much of the discourse around psychotherapy, as revealed by our review of psychodynamic, cognitive-behavioral, and humanistic approaches. These different schools emphasize different aspects of safety and draw from it different implications for clinical work. Psychodynamic approaches prioritize unconscious, developmental, and relational aspects of safety (e.g., holding, containing, mirroring, mentalizing, and reflective functioning). Cognitive-behavioral approaches emphasize neurobiological, psychoeducational, relational, and exercisable aspects of safety (e.g.,

attunement, safety/safeness behavior/signals, narrating, priming, sourcing). Finally, humanistic approaches see the importance of safety mainly in its dialectical and relational nature (e.g., trust, unconditional acceptance, presence, congruence). At the same time, however, our analysis has shown how different therapeutic schools may converge around a set of basic issues regarding safety. At a very general level, we would say that safety is *the sine qua non* of both healthy human development and effective psychotherapy. In other words, safety plays a fundamental role in the (functional vs dysfunctional) ontogenetic development of an individual, and, exactly for this reason, it plays a fundamental role also in (effective vs. non-effective) psychotherapy. Yet, to be healthy and effective, human development and therapy do not need to be perfectly safe, but *sufficiently* safe, because humans thrive if they experience *enough* safety leaving some space for tolerable frustrations, disappointments, and insecurities that promote resilience, growth, and change.

With this regard, we have proposed five basic school-independent and therefore integrative functions of safety (securing survival and defense, facilitatinig restoration, promoting exploration and play, sustaining risk-taking and coping with danger, and enabling balance and integration). These functions deal with the developmental processes involved in both ontogenesis and clinical practice. They seem to be coherent, although to different extents and in different ways, with different school-specific theorizations about the nature and function of safety in clinical contexts. More research is needed to further understand the role of safety in psychotherapy. First, it should be better explored how other therapeutic schools conceive safety and its functions within the clinical process and to what extent they are coherent with the school-independent functions of safety we have proposed. Second, an effort should be made to more explicitly connect both the identified school-specific and school-independent functions of safety to interpersonal neurobiology and developmental affective neuroscience (Fosha et al., 2009; Schore, 2003). Such approaches have already provided very useful insights and therefore represent good candidates for the development of a more general theory of safety able to account for its various functions within psychotherapy. Third, empirical research should attempt to explicitly test hypotheses regarding the developmental functions of safety proposed. To this aim, the assessment of safety should be first further articulated through the systematic employment of both self-reports and observational instruments. Process studies should then explicitly explore the relationship between client and/or therapist safety and other clinically relevant aspects of in-session processes, such as the therapeutic alliance (including ruptures and resolutions episodes), client and therapist mentalization as well as their relationship over time, interpersonal cycles, and therapeutic interventions (supportive vs. change-oriented). Thereafter, process-outcome studies should be conducted to assess the extent to which safety-related process dynamics are predictive of within-session, post-session, and treatment outcome. Finally, moderator analyses should be conducted to assess the extent to which different variables (e.g., treatment orientation and setting, client diagnosis attachment style) influence the relationship between in-session safety-related dynamics and outcome.

Declarations

Author contributions.

The present paper is based on the doctoral dissertation of the first author. All authors contributed to the study conception and design and literature search. The first draft of the manuscript was jointly written by both authors who also commented on later versions of the manuscript. All authors read and approved the final manuscript.

References

1. Ainsworth, M. D. (1985). Patterns of infant-mother attachments: antecedents and effects on development. In *Bulletin of the New York Academy of medicine* (1985/11/01, Vol. 61).
2. Allison, K., & Rossouw, P. (2013). The Therapeutic Alliance: Exploring the Concept of “Safety” from a Neuropsychotherapeutic Perspective. International Journal of Neuropsychotherapy, *1*(1), 21–29. https://doi.org/10.12744/ijnpt.2013.0021-0029
3. Angus, L., Watson, J. C., Elliott, R., Schneider, K., & Timulak, L. (2015). Humanistic psychotherapy research 1990–2015: From methodological innovation to evidence-supported treatment outcomes and beyond. Psychotherapy Research, *25*(3), 330–347. https://doi.org/10.1080/10503307.2014.989290
4. Baldwin, M. W. (2007). On Priming Security and Insecurity. Psychological Inquiry, *18*(3), 157–162. https://doi.org/10.1080/10478400701512703
5. Beck, M., Friedlander, M. L., & Escudero, V. (2006). Three perspectives on clients’ experiences of the therapeutic alliance: A discovery-oriented investigation. Journal of Marital and Family Therapy, *32*(3), 355–368. https://doi.org/10.1111/j.1752-0606.2006.tb01612.x
6. Beebe, B., & Lachmann, F. M. (2005). *Infant research and adult treatment: Co-constructing interactions*. The Analytic Press.
7. Bennett-Levy, J., Thwaites, R., Haarhoff, B., & Perry, H. (2015). *Experiencing CBT from the inside out: A self-practice/self-reflection workbook for therapists*. Guilford Press.
8. Binswanger, L. (1963). *Being-in-the-world: Selected papers of Ludwig Binswanger*. Basic Books.
9. Birtchnell, J. (2002). *Relating in psychotherapy: The application of a new theory*. Routledge.
10. Bowlby, J. (1988). *A secure base. Parent-Child Attachment and Healthy Human Development*. Routledge.
11. Bowlby, J. (1998). *Attachment and loss: Volume III: Loss, sadness and depression*. Pimlico.
12. Bromberg, P. M. (2006). *Awakening the dreamer: Clinical journeys*. Routledge.
13. Bryant, R. A. (2006). Cognitive behavior therapy: Implications form advances in neuroscience. In N. Kato, M. Kawata, & R.. Pitman (Eds.), *PTSD: Brain mechanisms and clinical implications* (pp. 225–270). Springer.
14. Buber, M. (1958). *I and Thou* (2nd ed.). Scribner’s.

15. Carr, E. M., & Sandmeyer, J. (2018). Exploring the Vicissitudes of Safety and Danger in Psychoanalysis: Developing Trust Through Mutual Engagement. Psychoanalytic Inquiry, *38*(8), 557–568. https://doi.org/10.1080/07351690.2018.1521219
16. Cassidy, J., & Shaver, P. R. (Eds.). (2016). *Handbook of attachment: Theory, research, and clinical applications*. The Guilford Press.
17. Castonguay, L. G., & Hill, C. E. (Eds.). (2012). *Transformation in psychotherapy: Corrective experiences across cognitive-behavioral, humanistic, and psychodynamic approaches*. American Psychological Association. https://doi.org/10.1037/13747-000
18. Cortina, M., & Liotti, G. (2010). Attachment is about safety and protection, intersubjectivity is about sharing and social understanding: The relationships between attachment and intersubjectivity. Psychoanalytic Psychology, *27*(4), 410–441. https://doi.org/10.1037/a0019510
19. Cozolino, L. J. (2002). The neuroscience of psychotherapy: Building and rebuilding the human brain. In *The neuroscience of psychotherapy: Building and rebuilding the human brain*. W W Norton & Co.
20. Degnan, A., Seymour-Hyde, A., Harris, A., & Berry, K. (2016). The role of therapist attachment in alliance and outcome: A systematic literature review. Clinical Psychology & Psychotherapy, *23*(1), 47–65. https://doi.org/10.1002/cpp.1937
21. Diener, M. J., & Monroe, J. M. (2011). The Relationship Between Adult Attachment Style and Therapeutic Alliance in Individual Psychotherapy: A Meta-Analytic Review. Psychotherapy, *48*(3), 237–248. https://doi.org/10.1037/a0022425.supp
22. Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. Development and Psychopathology, *2*(1), 47–60. https://doi.org/10.1017/S0954579400000584
23. Dozier, M., Cue, K. L., & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organization in treatment. Journal of Consulting and Clinical Psychology, *62*(4), 793–800. https://doi.org/10.1037/0022-006X.62.4.793
24. Eldridge, A. (2018). When Danger Is Safe: Down the Rabbit Hole with Liz. Psychoanalytic Inquiry, *38*(8), 596–604. https://doi.org/10.1080/07351690.2018.1521226
25. Epstein, S. (1998). Cognitive-experiential self-theory. In D. F. Barone, M. Hersen, & V. B. Van Hassel (Eds.), *Advanced Personality* (pp. 212–238). Plenum Press.
26. Erikson, E. H. (1993). *Childhood and society* (2nd ed.). Norton & Company.
27. Escudero, V., Boogmans, E., Loots, G., & Friedlander, M. L. (2012). Alliance rupture and repair in conjoint family therapy: An exploratory study. Psychotherapy, *49*(1), 26–37. https://doi.org/10.1037/a0026747
28. Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. Psychotherapy, *51*(3), 372–380. https://doi.org/10.1037/a0036505
29. Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment.

Infant Mental Health Journal, *12*(3), 201–218. https://doi.org/10.1002/1097-0355(199123)12:3<201::AID-IMHJ2280120307>3.0.CO;2-7

30. Fosha, D., Siegel, D. J., & Solomon, M. (2009). *The healing power of emotion: Affective neuroscience, development & clinical practice*. WW Norton & Company.
31. Frederickson, J. (2020). *Co-creating safety*. Seven Leaves Press.
32. Freeman, A., & Dolan, M. (2001). Revisiting Prochaska and DiClemente's stages of change theory: An expansion and specification to aid in treatment planning and outcome evaluation. Cognitive and Behavioral Practice, *8*(3), 224–234. https://doi.org/10.1016/S1077-7229(01)80057-2
33. Freud, S. (1966). An Outline of Psycho-Analysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 144–207). The Hogarth Press and the Institute of Psychoanalysis. (Original work published in 1940).
34. Friedlander, M. L., Lambert, J. E., & de la Peña, C. M. (2008). A step toward disentangling the alliance/improvement cycle in family therapy. Journal of Counseling Psychology, *55*(1), 118–124. https://doi.org/10.1037/0022-0167.55.1.118
35. Gabbard, G. O. (2016). Boundaries and boundary violations in psychoanalysis. In *Boundaries and boundary violations in psychoanalysis.* (2nd ed.). American Psychiatric Publishing, Inc.
36. Geller, S. M., & Porges, S. W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. Journal of Psychotherapy Integration, *24*(3), 178–192. https://doi.org/10.1037/a0037511
37. Giddens, A. (1991). *Modernity and self-identity: Self and Society in the Late Modern Age*. Wiley.
38. Gilbert, P. (2004). *Evolutionary Approaches to Psychopathology and Cognitive Therapy*. Springer Publishing Company.
39. Gillath, O., & Karantzas, G. (2019). Attachment security priming: a systematic review. Current Opinion in Psychology, *25*, 86–95. https://doi.org/10.1016/j.copsyc.2018.03.001
40. Greenberg, J. (1991). *Oedipus and beyond: A clinical theory*. Harvard University Press.
41. Hartmann, E. (1995). Making connections in a safe place: Is dreaming psychotherapy? Dreaming, *5*(4), 213–228. https://doi.org/10.1037/h0094437
42. Hayes, S. C., & Hofmann, S. G. (Eds.). (2018). *Process-based CBT: The science and core clinical competencies of cognitive-behavioral therapy*. New Harbinger Publications.
43. Ivaldi, A. (Ed.). (2016). *Treating Dissociative and Personality Disorders: A Motivational Systems Approach to Theory and Treatment*. Routledge/Taylor & Francis Group.
44. Kirsha, A. (2019). *Becoming a better version of oneself in the safe environment of the platform for self-discovery*. [Unpublished doctoral dissertation]. Sigmund Freud University.
45. Kohut, H., & Orstein, P. (2011). *The Search for the Self: Selected Writings of Heinz Kohut 1978–1981*. Routledge.
46. Laing, R. (1960). *The divided self: An existential study in sanity and madness*. Penguin.
47. LeDoux, J. (2015). *Anxious*. Oneworld Publications.

48. Leiman, M., & Stiles, W. B. (2001). Dialogical sequence analysis and the zone of proximal development as conceptual enhancements to the Assimilation Model: The case of Jan revisited. Psychotherapy Research, *11*(3), 311–330. https://doi.org/10.1093/ptr/11.3.311
49. Leitner, L. M., & Celentana, M. A. (1997). Constructivist therapy with serious disturbances. The Humanistic Psychologist, *25*(3), 271–285. https://doi.org/10.1080/08873267.1997.9986886
50. Levin, F. M., & Gunther, M. S. (2004). *Psychotherapy Pearls: Critical Insights for Doing Psychotherapy*. Xlibris Corporation.
51. Levitt, H. M., & Piazza-Bonin, E. (2016). Wisdom and psychotherapy: Studying expert therapists' clinical wisdom to explicate common processes. Psychotherapy Research, *26*(1), 31–47. https://doi.org/10.1080/10503307.2014.937470
52. Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. Psychological Bulletin, *142*(8), 801–830. https://doi.org/10.1037/bul0000057
53. Levy, K. N., Kivity, Y., Johnson, B. N., & Gooch, C. V. (2018). Adult attachment as a predictor and moderator of psychotherapy outcome: A meta-analysis. Journal of Clinical Psychology, *74*(11), 1996–2013. https://doi.org/10.1002/jclp.22685
54. Lichtenberg, J. D., Lachmann, F. M., & Fosshage, J. L. (1996). The clinical exchange: Techniques derived from self and motivational systems. In *The clinical exchange: Techniques derived from self and motivational systems*. Analytic Press, Inc.
55. Lohr, J. M., Olatunji, B. O., & Sawchuk, C. N. (2007). A functional analysis of danger and safety signals in anxiety disorders. Clinical Psychology Review, *27*(1), 114–126. https://doi.org/10.1016/j.cpr.2006.07.005
56. Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant. Symbiosis and individuation*. Karnac.
57. Mair, H. (2021). Attachment safety in psychotherapy. Counselling and Psychotherapy Research, *21*(3), 710–718. https://doi.org/10.1002/capr.12370
58. Mallinckrodt, B., & Jeong, J. (2015). Meta-analysis of client attachment to therapist: Associations with working alliance and client pretherapy attachment. Psychotherapy, *52*(1), 134–139. https://doi.org/10.1037/a0036890
59. Maslow, A. H. (1943). A theory of human motivation. Psychological Review, *50*(4), 370–396. https://doi.org/https://doi.org/10.1037/h0054346
60. Mason, B. (2015). Towards positions of safe uncertainty. InterAction-The Journal of Solution Focus in Organisations, *7*(1), 28–43.
61. Miller-Bottome, M., Talia, A., Eubanks, C. F., Safran, J. D., & Muran, J. C. (2019). Secure in-session attachment predicts rupture resolution: Negotiating a secure base. Psychoanalytic Psychology, *36*(2), 132–138. https://doi.org/10.1037/pap0000232
62. Norcross, J. C., & Lambert, M. J. (Eds.). (2019). *Psychotherapy relationships that work. Volume 1: Evidence-based therapist contributions*. Oxford University Press.

63. Ogden, P. (2009). Emotion, mindfulness, and movement. In D. S. S. Fosha & M. F. Solomon (Ed.), *The healing power of emotion: Affective neuroscience, development & clinical practice* (p. 204). W. W. Norton.
64. Panksepp, J., & Biven, L. (2012). *The archaeology of mind: Neuroevolutionary origins of human emotions*. Norton.
65. Parish, M., & Eagle, M. N. (2003). Attachment to the therapist. Psychoanalytic Psychology, *20*(2), 271–286. https://doi.org/10.1037/0736-9735.20.2.271
66. Payne, J. D. (2010). Memory consolidation, the diurnal rhythm of cortisol, and the nature of dreams: a new hypothesis. In *International review of neurobiology* (Vol. 92, pp. 101–134). Elsevier. https://doi.org/10.1016/s0074-7742(10)92006-0
67. Perls, F. S., & Andreas, S. (1969). *Gestalt therapy verbatim*. Real People Press.
68. Podolan, M. (2020). Exploring the meaning of safety in psychotherapy. SFU Forschungsbulletin, *8*(2), 106–123. https://doi.org/10.15135/2020.8.2.106-123
69. Porges, S. W. (2021). *Polyvagal safety: attachment, communication, self-regulation*. Norton.
70. Rappoport, A. (1997). The patient's search for safety: The organizing principle in psychotherapy. Psychotherapy: Theory, Research, Practice, Training, *34*(3), 250. https://doi.org/10.1037/h0087767
71. Rogers, C. R. (1995). *On becoming a person: A therapist's view of psychotherapy* (2nd ed.). Mariner Books.
72. Romano, V., Fitzpatrick, M., & Janzen, J. (2008). The secure-base hypothesis: Global attachment, attachment to counselor, and session exploration in psychotherapy. Journal of Counseling Psychology, *55*(4), 495–504. https://doi.org/10.1037/a0013721
73. Rowe, A., & Carnelley, K. B. (2003). Attachment style differences in the processing of attachment–relevant information: Primed–style effects on recall, interpersonal expectations, and affect. Personal Relationships, *10*(1), 59–75.
74. Rubino, G., Barker, C., Roth, T., & Fearon, P. (2000). Therapist empathy and depth of interpretation in response to potential alliance ruptures: The role of therapist and patient attachment styles. Psychotherapy Research, *10*(4), 408–420. https://doi.org/10.1093/ptr/10.4.408
75. Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. Psychotherapy, *51*(3). https://doi.org/10.1037/a0036815
76. Sauer, E. M., Anderson, M. Z., Gormley, B., Richmond, C. J., & Preacco, L. (2010). Client attachment orientations, working alliances, and responses to therapy: A psychology training clinic study. Psychotherapy Research, *20*(6), 702–711. https://doi.org/10.1080/10503307.2010.518635
77. Saypol, E., & Farber, B. A. (2010). Attachment style and patient disclosure in psychotherapy. Psychotherapy Research, *20*(4), 462–471. https://doi.org/10.1080/10503301003796821
78. Schneider, K. J. (2016). Existential–humanistic psychotherapy. In I. M. & M. A. Stebnicki (Ed.), *The Professional Counselor's Desk Reference* (2nd ed., pp. 201–206). Springer Publishing Company. https://doi.org/10.1891/9780826171825.0033

79. Schneider, K. J., Pierson, J. F., & Bugental, J. F. T. (2014). *The handbook of humanistic psychology: Theory, research, and practice* (2nd ed.). Sage Publications.
80. Schore, A. N. (2003). *Affect Dysregulation and Disorders of the Self*. W. W. Norton & Company.
81. Segalla, R. J. J. (2018). The Intersubjective Safety/Danger Dialectic. Psychoanalytic Inquiry, *38*(8), 575–586. https://doi.org/10.1080/07351690.2018.1521636
82. Siegel, D. F., & Hilsenroth, M. J. (2013). Process and technique factors associated with patient ratings of session safety during psychodynamic psychotherapy. American Journal of Psychotherapy, *67*(3), 257–276. https://doi.org/10.1176/appi.psychotherapy.2013.67.3.257
83. Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. Norton.
84. Sørensen, P. F. (2018). *Why do we dream?: The nature and function of dreams* (K. edition (Ed.); 1st ed.). BoD–Books on Demand.
85. Sroufe, A., & Waters, E. (2017). Attachment as an Organizational Construct. In B. Laursen & R. Žukauskienė (Eds.), *Interpersonal Development*. Routledge.
86. Talia, A., Miller-Bottome, M., Katznelson, H., Pedersen, S. H., Steele, H., Schröder, P., Origlieri, A., Scharff, F. B., Giovanardi, G., Andersson, M., Lingiardi, V., Safran, J. D., Lunn, S., Poulsen, S., & Taubner, S. (2019). Mentalizing in the presence of another: Measuring reflective functioning and attachment in the therapy process. Psychotherapy Research, *29*(5), 652–665. https://doi.org/10.1080/10503307.2017.1417651
87. Talia, A., Muzi, L., Lingiardi, V., & Taubner, S. (2020). How to be a secure base: Therapists' attachment representations and their link to attunement in psychotherapy. Attachment & Human Development, *22*(2), 189–206. https://doi.org/10.1080/14616734.2018.1534247
88. Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. Psychotherapy Research, *17*(3), 305–314. https://doi.org/10.1080/10503300600608116
89. Timulak, L. (2010). Significant events in psychotherapy: An update of research findings. Psychology and Psychotherapy: Theory, Research and Practice, *83*(4), 421–447. https://doi.org/10.1348/147608310X499404
90. Wheeler, G., & Axelsson, L. (2015). *Gestalt therapy*. American Psychological Association.
91. Williams, D. C., & Levitt, H. M. (2007). A qualitative investigation of eminent therapists' values within psychotherapy: Developing integrative principles for moment-to-moment psychotherapy practice. Journal of Psychotherapy Integration, *17*(2), 159–184. https://doi.org/10.1037/1053-0479.17.2.159
92. Winnicott, D. (1965). *Maturational processes and the facilitating environment: Studies in the theory of emotional development*. Hogarth Press.
93. Yalom, I. D. (2002). *Gift of Therapy: An Open Letter to a New Generations of Therapists and Their Patients*. Perennial.