Chartering a Smoother Passage:
How Emotion-Focused Work Can Transform Mental Health Care

Sarah Joy

Sarah Joy (B.A. (Hons)/B.S.W (Hons), Sydney University, Grad.Dip.EFT (IEFT), Annandale. She has worked as a social worker for the past 10 years. Sarah has been working within the mental health system, in Western Sydney and Eastern Suburbs of Sydney in the areas of early intervention, adult (inpatient) mental health and family and carer mental health programs. Sarah can be contacted on sarahjoycounselling@gmail.com

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"A major premise of Emotionally Focused Therapy (EFT) is that emotion is fundamental to the construction of the self and is a key determinant of self organisation" (Greenberg, 2010, p. 32). However, the current mental health system in Australia, driven by its attendant medical model, does not honour or conceptualise mental ill health in this way. In this article, I seek to critique the medical model with emotion-focused principles and ways of working with clients. Clinical examples will be used to demonstrate how emotion-focused work has the potential to significantly alter treatment outcomes for mental health consumers on adult inpatient units.

As I began the process of reading literature for this article and reflecting on my practice in the past ten years, I spent time questioning what is currently missing from the care of clients who are currently inpatients on adult mental health units. I wondered why is it that when people are at their most vulnerable that their treatment can be so alienating and judgemental. I reflected on my position as a social worker in the multi-disciplinary hierarchy and as a therapist who desired to practice from a minority approach (EFT), awash in the powerful sea of the medical model and cognitive behavioural therapy (CBT). As I continued to swim deeper into these ideas, I went through a process of critiquing the medical model and juxtaposed it with principles from Emotion-Focused therapy. An image of a lone sailor adrift in unfriendly seas came to my mind. How, as the lone sailor, to convince others of the centrality of emotions in how we assess and conceptualise clients? A further image of wanting to build a stronger vessel, so that we could all be on the same boat, came to mind; one that did not tip clients overboard if they wanted to do their journey in a different way. A boat that acknowledged and honoured the lifelong journey that clients had already been on and which understood that the client needs to be the captain of their journey and the therapist their first mate.

We will start this journey with a critique of the medical model, juxtaposed with Emotion-Focused principles and interventions. On this journey we will navigate how clients are assessed and conceptualised in order to underscore that the most solid foundation for any treatment is how the case is formulated and whether there is inter-disciplinary agreement in where the treatment is headed and what may be on the horizon for the client. Significantly, this involves consideration of language, power (transference and counter-transference) and the therapeutic relationship. Finally, this article will consider how this journey has played out for two very different, complex cases.[1]

[1] This article cannot explore all aspects of Emotionally Focused theory in the space available. The article will

How cases and clients are formulated within the current mental health system is heavily constrained by the medical model with its focus on symptoms, dominance of pharmacological treatments as the front-line response, issues of power and control (inherent in therapeutic and professional relationships) and language that labels and stigmatises. It is through this paradigm that professionals and society pathologise and compartmentalise individuals as being solely responsible for their problems, thereby separating the individual from their psycho-social and relational contexts (Barr, 2009, p. 3; Beresford, Nettle, & Perring, 2010, p. 7). An Emotion-Focused approach, on the other hand, "takes into account the sociological, the psychological, the interactional and the intra-personal dynamics" (Webster, 2006a, p. 20) and perceives "emotion [as] fundamental to the construction of the self and [as] a key determinant to self-organisation" (Greenberg, 2010, p. 32). From this point of view, we are able to see that an Emotion-Focused approach is premised on building a client's awareness of their emotions and assessing their ability to have and express their emotional experiences. A client's capacity to do so is critically important as emotions are what give our neurophysiological pathways the information they need in order to determine whether it is safe to proceed and be our true self or whether aspects of ourselves need to be hidden away or protected (Greenberg, 2010, pp. 32-33; Rothschild, 2000, pp. 15-36). It is these emotional memories that are laid down into schemas throughout our childhood and adolescence and which determine our patterns of relating and responding to ourselves and others. As Miller (1990, p. 126) argues, "experience has taught us that we only have one enduring weapon in our struggle against mental illness: the emotional discovery and emotional acceptance of the truth in the individual and unique history of our childhood."

However, in the adult mental health system, exploring clients' emotional signatures and schemas is not prioritised. Questions are asked to elicit answers that fit within the dominant medical model, in order to assess and ultimately diagnose. This manner of engaging with clients is reinforced by the clinicians' professional training, organisational pressures and social and professional hierarchies, whereby the focus may be more on appearing knowledgeable and competent rather than on spending time with clients and truly understanding the clients' perception of the origin of their symptoms (Light, 1982, pp. 34-

give examples from a counselling perspective, rather than a therapy perspective which would be contra-indicated on an inpatient unit.

39). Thus, professionals within the mental health system often assess and conceptualise a client's illness as fitting within the confines of certain psychiatric diagnoses, according to the prescribed bible of psychiatry, the Diagnostic and Statistical Manual of Mental Disorders (DSM), and utilise language that serves to reify their subjective, clinical judgements as fact.

Diagnoses may change over time depending on multiple factors, such as how the person has presented to hospital, who they are being assessed by and the client's perceived willingness to engage in, and be compliant with treatment. This may or may not reflect how the client themselves conceptualise their illness, symptoms and psycho-social problems. I have often been mystified by how quickly diagnoses and pharmacological treatments are prescribed after such short times spent with clients and how little is known about their psycho-social situation from the initial assessment. Given that the medical model has such a narrow focus, one of the main criticisms toward it is that it does not honour the complexity of clients' lives or the conditions they present with (Beresford et al., 2010, p. 4). Interestingly, these (and other) problems of the medical model have been noted and mental health has seen an "explosion of neurobiology research [that] has [actually] led to a decline in psycho-social formulation skills among psychiatry residents" (Kendjelic & Eells, 2007, p. 67). This is extremely problematic as a client's psycho-social situation are usually where emotional, relationship and communication issues would be noted. Hence, what could be a positive area of research has somewhat operated to relegate the centrality of emotions to the sidelines and keep conceptualisation of client's functioning firmly within the realm of 'objective', 'neutral' science. I would argue that this serves to privilege the perspectives of 'expert' psychiatrists and then avoids the "messiness of what [is] need[ed] to be described" i.e. emotions and intra and inter-personal difficulties (Wylie, 2010, pp. 23-24). Given the predilection of many psychiatrists to assess, 'diagnose' and prescribe, this avoidance of assessment of emotions and other psycho-social problems can serve to obfuscate the true nature of the illness that a client may be experiencing and sentence them a long and fraught relationship with the mental health system.

Though I acknowledge the severe time pressures and bed management focus within the adult mental health system, I have often reflected on issues such as, 'if clinicians did thoroughly assess clients' psycho-social and trauma histories, whether this obliges that clinician to actually do something with that information' and 'is there a way to do such assessments

(including from an Emotion-Focused perspective) more quickly?' I have further wondered, in thinking in this way, whether I am colluding with what Barr (2009) argues as,

> *short term [therapies] that primarily focus on symptom management fit easily with a market and consumer culture that is taught to increasingly expect quick-fix techniques and drugs, yet have the potential for marginalising a process-oriented approach to treatment (p. 8).*

Given that our emotion schemas take our childhood and adolescence to form, why is it that clinicians and society expect that, when they have progressed into maladaptive patterns of relating and responding, that these intra and inter-personal problems can be resolved with short term therapy? I know that in my own practice, in responding to the perceived time and bed pressures of the system and maladaptive schemas of clients, I have lost sight of the need to maintain a process-oriented approach to treatment and have interwoven emotion-focused assessments and interventions with psycho-education regarding emotion regulation, distress tolerance, mindfulness and interpersonal communication skills. Why did I do this and for whose benefit? Was it for the client so that they could have more effective tools with which to be aware of their emotions and thereby process their emotional experience? What difference would this intellectual knowledge of brain function and neurophysiology actually do for the client as they struggled with their trauma history and inability to have primary experience? Was it so that they could be soothed enough to be able to safely do the work required to become more integrated? Was it so that they could see the validity of what I was trying to achieve using Emotion-Focused techniques? Was there, as Olds (2009) describes in her article 'Shaping the Transference', an aspect of counter-transference going on in my pursuit of convincing my colleagues that Emotion-Focused work, a minority therapy within my practice context, could have clinical merit?[2] These were some of the questions that I struggled with and it is to this aspect of my journey of seeking to understand how Emotion-Focused principles and interventions can be applicable within adult mental health units that I'd now like to turn to.

Before I do this however, I want to spend a short time reflecting on the importance of adequate case formulation in order to reinforce my comments regarding the inadequacy of the medical model and the importance of thoroughly assessing the emotional and psycho-social

2 Olds (2009, p. 40) describes counter-transference as "the therapist's internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities."

aspects of clients' lives who present to hospital. Kendjelic and Eells (2007) provide an excellent article regarding the importance of case formulation. Whilst they describe an example of 'preliminary research', I would argue that what they present has significant merit and application to the adult mental health system. They note that there are four components in generic case formulation:

1. symptoms and problems (information necessary for diagnosis, inclusive of psycho-social aspects)
2. precipitating stressors
3. predisposing events (events from clients' past which increase vulnerability to precipitating stressors e.g. developmental issues, attachment style and interpersonal schemas) and
4. an inferred explanatory mechanism accounting for the previous three components

In reviewing case formulations by those clinicians who attended the two-hour training provided, they found that "formulations of the training group were more likely to be complex and precise in the use of language... went beyond a summary of descriptive information… and made moderate-level inferences that included a mechanism linked to symptoms and problems" (Kendjelic & Eels, 2007, p. 73). Because this happened earlier in treatment, it also had the effect of enhancing communication and case formulation within treatment teams and aided therapists in their understanding of clients, thereby increasing client/therapist confidence and more adequately predicted length of treatment (Kendjelic & Eels, 2007, p. 75).

Such components of case formulation would go a long way toward improving treatment outcomes for clients as it would minimise the amount of time spent in hospital as treatment more accurately reflects the lived reality of the client and the circumstances that brought them to the point in their life where they required an admission. Furthermore, such components may overcome some of Light's (1982, p. 40) criticisms of the medical model and psychiatry in that such as approach avoids unnecessary pathology, sees the individual as more than their diagnosis, acknowledges clients' strengths and the recognises the importance of recording information accurately (thereby avoiding personal biases and counter-transferences from clouding clinical judgement).

This would seem to be a position that is supported by Emotion-Focused therapy, as rather than telling the client the source of their problems, clients are instead invited to discover *and*

experience previously unfelt emotion in the presence of the therapist in order to create new understanding and adaptive responses (Greenberg & Goldman, 2010; Greenberg & Watson, 2006; Smith & Greenberg, 2007; Webster, 2006a). Through continually drawing the client's attention to their emotion and bodily felt sense, diagnosis becomes less of a focus of treatment as the therapist seeks to be in relationship with the client and develop a sense of the client's patterns of relating and responding to themselves and others. However in describing an 8-step model for short-term[3] Emotion-Focused therapy case formulation they argue that it is not appropriate for "high suicide risk; long-term alcohol or drug addiction; three or more depressive episodes; psychotic; and schizoid, schizotypal, borderline, and antisocial personality disorders" (Greenberg & Goldman, 2010, p. 386).

Whilst I am not disagreeing that it would be contra-indicated to do therapy with clients with many of these diagnoses, especially on an inpatient unit, I wonder who exactly they are wanting to work with and whether they are selling Emotion-Focused assessment and case formulation short? I would put to them that clients with these diagnoses often have them for a reason. I would remind them of Herman's (1992, p.123) comments that "survivors of childhood abuse, like other traumatised people, are frequently misdiagnosed and mistreated within the mental health system" and "because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete". I would highlight that both Herman (1992) and Wylie (2010) (and many others) have written on the fact that clients who have certain diagnoses are more likely to attract more than one diagnoses. It has been my practice experience that many clients with these diagnoses receive little or no counselling as part of their mental health treatment and that many therapies avoid them altogether due to their complexity and so the treatment these patients receive is largely pharmacological in nature with a bit of recovery focus thrown in if they are lucky. Finally, I would query what aspects of Emotion-Focused assessment and case formulation are relevant to those receiving inpatient mental health treatment. I will do so for the remainder of this paper and do so with the awareness that inpatient clinicians do not get to pick and chose who they work with and that they must reflect on how to use different modalities, like Emotion-Focused therapy, in a safe and appropriate manner. In doing so, I will specifically reflect on how I think Emotion-Focused *principles and interventions* may be applied in adult inpatient mental health settings.

3 Short term meaning 16-20 weeks (Greenberg & Goldman, 2010, p. 386)

Greenberg (2010, p. 34) argues that “EFT intervention is based on two major treatment principles: the provision of a therapeutic relationship and the facilitation of therapeutic work”. Whilst facilitation of therapeutic work must occur within a context of safety, it is critical to note that often “individuals only consider change when they have got to feeling their lowest in their lives and something snaps for them” (Webster, 2006b p. 14). For some, this may result when they have an admission to hospital and for those entering the public mental health system, this may be an unexpected and unwanted event. Regardless of the circumstance of admission and diagnosis, the individual will be allocated to a multi-disciplinary team. By the time the team meets the client, the client may have had one or multiple initial assessments and therefore a great deal of assessment information may already be known about the client. However, it is usually discipline dependant as to whether the clinician has read these initial assessments or chosen to meet the client with a 'clean slate' (albeit with an awareness of risk issues such as aggression, sexual safety and suicidality). This may be the first juncture from which mental health assessment differs from an Emotion-Focused assessment.

Greenberg and Goldman (2010, p. 380) argue that, “in EFT, formulations are never performed a priori (i.e. based on early assessment) as we do not attempt to establish what is dysfunctional or presume to know what will be most salient or important for the client”. Naturally, on an inpatient unit, the clinician would use their clinical judgement as to when and how this is appropriate, based on the markers that the client has given them in-session. My own practice style has vacillated between both approaches and I think there is merit in both. Whilst I believe useful, 'fresh' assessment information can be recorded from meeting clients prior to a thorough file review, it can be unwise and unsafe to do so on an inpatient unit without speaking with nursing staff regarding basic risk issues. Further to this, I hold the position that it is possible to read the assessment of others and still meet clients with an open, non-judgemental mind and conduct EFT assessments appropriately. In social work assessment, it has often been my experience that the first meeting may need to be purely regarding the client's psychosocial situation, as many initial (medical) assessments often neglect this area. There may be obvious tasks that arise, such as housing or financial difficulties, but after these goals have been identified and actioned, it is possible to pursue EFT assessments. Even if the goal has not initially been counselling, I have found it

incredibly helpful (and less 'clinical' for the client) to explore problems utilising "the hand" (Webster, 2006a, p. 112). In doing so, the client has the opportunity in their own words to describe in their own words what they see as their core functional, intra-personal and inter-personal problems, their frequency/intensity and what they have tried themselves. During these discussions, I have also been able to look out for markers for potential avenues for Emotion-Focused work and found that clients most commonly present with markers of "unclear felt sense", "unfinished business" and "vulnerability" (Greenberg, 2010, pp. 34-35)[45]. What I have found determines the extent of the work that is possible on an inpatient unit is length of stay, agreement by the team regarding approach, a real and genuine relationship between the therapist and the client, and client motivation toward counselling and changing their maladaptive patterns of relating and responding (to themselves and others).

Given that many of the clients that I work with may have never done any counselling before, a big part of increasing their motivation toward changing maladaptive patterns has been to increase their awareness of their emotions. Whilst expression of these emotions, in order to move past secondary 'venting' of emotions would be ideal (long term), it is highly dependent on client mental state, the circumstances of their admission and the type of expression being proposed. As Greenberg (2010, p. 36) argues "emotional arousal and expression are not always helpful in therapy or in life and that, for some clients, training in the capacity for emotional down-regulation must precede or accompany utilisation of emotion". Through the provision of a real and genuine therapeutic relationship and a safe, nurturing environment, the client is able to take the first steps toward emotion regulation and "internalisation of the soothing functions of the protective other" (Greenberg, 2010, p. 36). As Webster (2002, p. 4) notes, "clients need to sense and feel us in this way, in addition to us being empathetic to their experience, in order to reveal themselves." It has been my practice experience that providing this realness in both my demeanour and language has put clients at ease and

4 Greenberg describes (1) unclear felt sense as "the person is on the surface of or feeling confused and unable to get a clear sense of his or her experience (2) unfinished business "a lingering unresolved feeling toward a significant other" (3) vulnerability "a state in which the self feels fragile, deeply ashamed, or insecure." (Greenberg, 2010, pp. 34-35).

5 It may be that clients have presented with other markers as discussed by Greenberg (e.g. problematic reactions, conflict splits, self interruptive splits) but it may not be appropriate to intervene or these may have come out during outpatient work. Given that this paper focuses on what is possible on inpatient units, those markers will not be discussed.

conveyed a sense that I "get it" and that they can trust me to receive their vulnerability and treat it with respect. I believe this is why I have been able to attend multi-disciplinary meetings and contribute a different level and kind of information regarding the clients' feelings and explanations for their behaviour. I believe that when others have practised from a medical model paradigm that clients have experienced this as "empty" and have had to spend more energy reacting against what "was currently being evoked by...[the clinician]" rather than being able to sit in their vulnerability and make sense of it (Webster, 2002, p. 7).

What has been additionally problematic is the lack of reflectiveness on the part of the clinicians involved that their practice may evoke a reaction in the client and the acceptability with which subjective judgements and labels become applied to the client (such as being non-compliant, splitting or treatment resistant). At times, when I have attempted to advocate for a particular client and suggest an alternative (more Emotion-Focused way) of conceptualising their problems and symptoms, my clinical opinions have been relegated in favour of more medically oriented formulations, such as those from medical, psychology or nursing clinicians and ones that do not expressly promote the centrality of client emotions in their presentations. Disagreement between clinicians on the team has had the impact of creating dissension regarding diagnosis and suitable interventions, lack of focus (thereby wasting valuable bed days) and lack of faith in the treatment by the client. I would like to share with you now a couple of my experiences whereby these struggles and successes have had an impact on the formulation, treatment and illness journey of clients that I have worked with.

Amie, is a young woman who was allocated to one of the teams that I work on and had an admission for a duration of 4 months.[6] She had been admitted in context of a serious suicide attempt on the background of drug and alcohol issues, significant childhood neglect and abuse trauma, and depression. Over the course of a 6 year period she had had multiple, brief admissions, sometimes only for a 2 day period. She had multiple diagnoses attributed to her, none of which adequately reflected the significant trauma that she had experienced or offered a way forward toward change. Growing up, she had significant annihilation and abandonment from her mother (who either blamed her for the trauma she experienced or denied that it had occurred). She utilised drugs to numb her primary emotional experience and to silence her raging inner critic. In seeking the start where she was prepared to work from, I initially

6 Pseudonyms have been used to protect the identity of clients.

utilised "the hand" in order to get a sense of how she conceptualised her "presenting problems" and what she had attempted in the past in order to survive. Without seeking to work more deeply, Amie began to allow for her vulnerability to show through and offered a number of important disclosures.

In our third session, she reported that she felt angry at herself for disclosing things about her trauma, unquestioned and completely unexpectedly. Rather than being able to allow for her primary experience of grief and devastation, she experienced her secondary (Inner Critic) response of anger. We spent our next session exploring where she felt it in her body, what she thought the function of her anger was and to normalise the anger as an adaptive, protective response to the extreme pain she had experienced in her life. So what had been different on this admission? These were questions that I asked myself and that she had asked during our sessions (and that we had had to spend some sessions processing her emotional reactions to).

Firstly, I believe there was a shift in the focus and formulation of her problems and an illumination of their emotional and developmental origin. In using gentle, curious questions regarding her emotions and continually drawing her back to her bodily felt sense, she was able to engage with her emotions in a different way and allow for the possibility that maybe the trauma was not her fault and that her reactions were normal (albeit maladaptive after years of repression of her emotions). Secondly, she was able to have the experience of a supportive other, who was not seeking her short-term discharge, but who was communicating a genuine and real interest in her welfare. She reported on one occasion, "I have never allowed someone to care about me before." Thus, whilst the work was very slow and tentative given the circumstances for admission, she was able to receive for the first time a nurturing, respectful, caring other and as Kahn argues, "the relationship is the therapy" (cited in Webster, 2012, p. 4). Thirdly, in being able to be in relationship with me, she was able to see that I could hold her emotions, that they were not too big or scary for me and that I would not punish her for having them. In allowing for some emotions (her fear, anger and grief) to be present, we were able to work creatively to bring them into awareness but to highlight other areas for work (e.g. the need to develop emotion regulation and distress tolerance skills). Finally, there was agreement amongst the team regarding the formulation of diagnosis and safe interventions that could be worked towards whilst the client was an inpatient. Hence,

in utilising Emotion-Focused assessment and integrating the source of her pain into her case formulation, the team was able to make a positive difference to her life and treatment.

The second client I will introduce is Talia, whom I had worked with over multiple admissions over a 3-year period. Initially, I had worked with her from a social work (strengths-based) perspective and completed traditional psycho-social assessments with her. Talia's admissions followed a very similar pattern of alcohol abuse in context of depression, financial stressors and decreased functional abilities. During these periods, Talia would cease leaving her house and would not attend to tasks of daily living (washing her hair, paying bills etc). This was the complete antithesis of how she conceptualised herself (being a hard working, fun, social woman, who had travelled the world and enjoyed the company of her friends and family).

Over a period of time, as I began to work in a more Emotion-Focused manner, we identified that a major source of pain for her was that she had experienced the loss of approximately 15 friends and family over a 5-10 year period. Through completing sequences around some of these losses, we were able to explore her pattern of denial of her grief and how this suppressed grief increased her sense of vulnerability and low self-esteem. In further sessions, we were able to sit with and identify unfinished business in significant interpersonal relationships, such as with her father and ex-partner (who had been her most significant intimate relationship). In consistently providing a safe, empathetic mirror to her emotional experience, she was increasingly able to identify her emotions accurately and build connections as to how her problems had evolved to the point where she had required mental health admissions (which made her feel shame and embarrassment).

Given that our sessions occurred in context of a medical intervention (and model), I had to almost hold dual roles – that of social worker seeking to resolve her financial issues and that of Emotion-Focused counsellor, seeking to help her to progress toward understanding of the origins of her emotional distress and current life circumstances. As in many cases before (and after her case), when I raised my alternate formulation of her case, the medical team referred her for psychological intervention (namely cognitive behaviour therapy - CBT), despite her positive feedback to medical staff of our relationship and counselling work being completed. This was a reflection of the popularity of CBT as a short-term therapy (that is readily adaptable to inpatient units) and the status of psychology over social work in the provision of counselling interventions. It was also a reflection that others were not familiar with Emotion-

Focused therapy. Frustratingly, it was not that others did not agree with my formulation, rather that the medical model operated to privilege certain voices over my own. As a result, I believe that this client had many more admissions than she perhaps should have had, given that her follow up access to Emotion-Focused counselling in the community was so poor.

In conclusion, what I have attempted to convey through this article and in sharing these clinical examples is the importance of utilising Emotion-Focused approach in assessing and conceptualising treatment for mental health clients on adult mental health units. In critiquing the medical model and proposing an alternative way of conceptualising diagnoses and treatment, I believe that a stronger, more inclusive treatment is constructed in which clients are able to have shared language with the clinicians that are their 'first mates' as they navigate what are often uncharted waters in their lives.

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