A model for working with client's emotions: Integrating insights from neuroscience into attachment-based psychotherapy

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Introduction

With recent developments in the field of neuroscience, attachment theory and trauma research, psychotherapy has experienced a shift in the locus of effective therapeutic intervention from models favouring cognition to models emphasising emotion (Fosha, Siegel, & Solomon, 2009). Insight, according to the 'bottom-up' therapies, is considered to be the result, rather than the catalyst of therapeutic change. The deeper the intervention impacts the brain (at the neuronal circuitry, brainstem and limbic system) the more effective and efficient the treatment (Fosha et al., 2009; Schore, 2011). The implications for counsellors are that even though 'emotionally traumatic events can tear apart the fabric of individual psyches, emotions can also act as powerful catalysts' (Fosha et al., 2009, p. viii) for intra-psychic and interpersonal healing. In this paper, I will to outline a five-step model for working with emotions, developed by Gordon Neufeld, a Canadian Developmental psychologist, which I have adapted in my work with child and adult clients.

The data generated by the current research in the fields of attachment, mentalization and emotion regulation not only offers a more detailed model of human development and healthy emotional functioning, it is also being incorporated into the clinical models, radically altering our understanding of the dynamics of psychotherapy (Badenock, 2008; Fosha et al., 2009; Siegel, 2010, 2012; Siegel & Goleman, 2011). Many researchers have considered attachment (or the alliance) to be a critical ingredient in the therapeutic process (Bowlby, 1988; Hall & Maltby, 2014; Wallin, 2007). Additionally, with the recent advances in the field of neuroscience, much of what counsellors know intuitively about the healing power of emotional connection with our clients has now been validated and further elucidated by neuro-scientific research (Roussouw, 2014).

However, as many of us are aware, dealing with client's extreme emotions can be a delicate and sometimes confusing 'dance'. The courage to attempt new

behaviour or experience a more coherent sense of self are among the outcomes we long for in our client's lives. However, many of our clients may present as emotionally 'stuck'. This paper offers an adaptation of Gordon Neufeld's five-step model of working with emotions, from a developmental, attachment-informed perspective, incorporating neuroscience research to gain insight into emotional healing and regulation in our clients.

1 This article is a condensed form of my original conference presentation: McConnell, R. A (2016). The neuroscience of relational healing: the role of corrective emotional experiences in the counsellor-client attachment. A paper presented at the PACFA, CCAA, SCAPE and APECA Conference, *Transformation through Relationship: The Heart and Soul of Therapy*. Sept. 9-11, 2016; Melbourne, Australia. Psychotherapy & Counselling Federation of Australia

My training as a Counselling Psychologist has been influenced by Gordon Neufeld, a developmental clinical psychologist, whom I trained with in Vancouver, Canada2. I have integrated his developmental, attachment-informed approach in my work with parents whose children are experiencing emotional and behavioural difficulties. It informs my work with adult clients who struggle with anxiety or depression due to early attachment injuries or neglect in childhood. I have integrated insights from neuroscience and attachment theory into this model to develop a framework for working with emotions experienced by adult clients. This approach is intended to be used with mild to moderate clinical symptomatology, and has not been used, and is not recommended for use, with clients suffering from complex trauma, bipolar or schizophrenic symptomatology.

Neufeld's five-step model for working with emotions

Neufeld (2015) has formulated a five-step model for working with emotions in children as he believes emotion is the engine of maturation: 'that which was discarded [emotion] has become the key to the unfolding of human potential; that which moves us, grows us up' (Neufeld, 2015). The word 'emotion' comes from the Latin word *immovere*: to move. The function of emotion is to move us toward a response. Greenberg (2006) postulates that emotion is primarily a signalling system, which, if ignored, remains unregulated or underdeveloped. A basic assumption of both neuroscience and psychotherapy is that 'optimal functioning and mental health are related to increasingly advanced

levels of growth, integration, and complexity' in emotion regulation (Cozolino, 2016, p. 25). What follows is a step-by-step explanation of how to work with clients who are emotionally dysregulated, helping them regulate, ultimately leading to integration between the limbic system and prefrontal regions of the brain, opening up potential for healthier emotional functioning and psychological maturity.

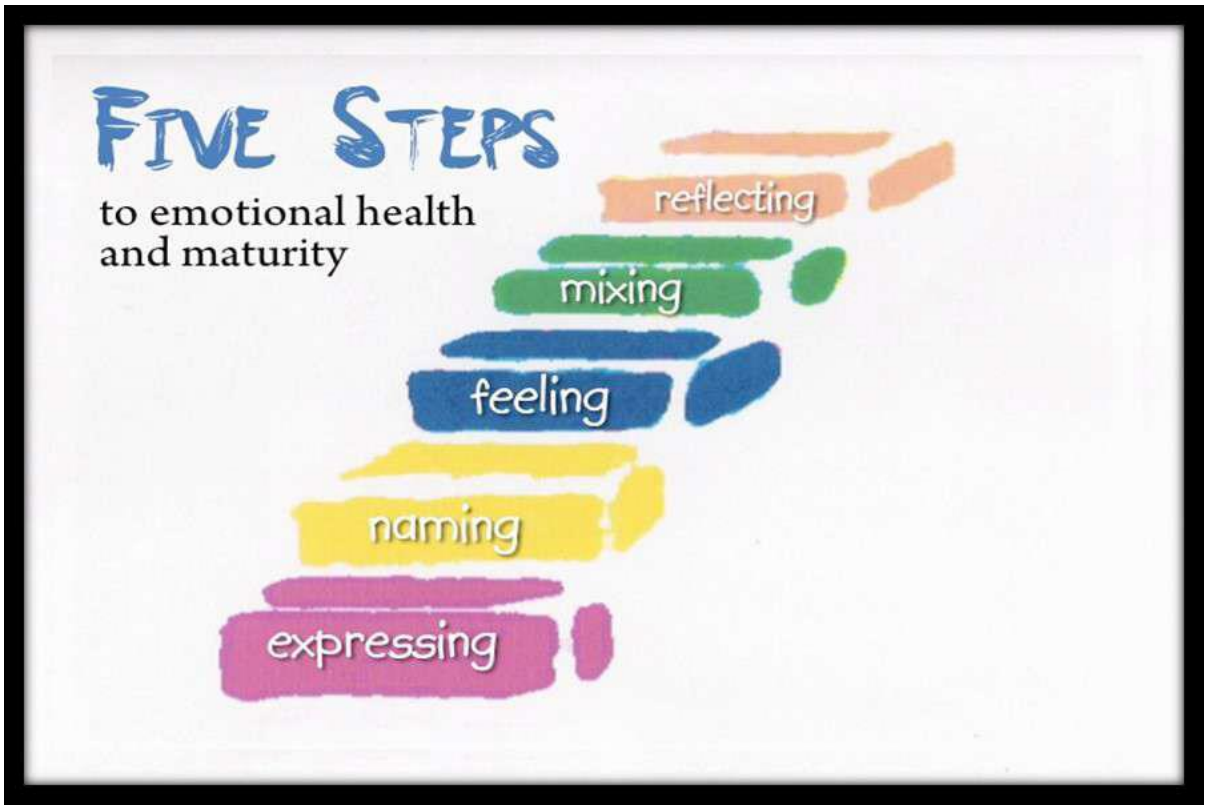


Figure 1. Neufeld, G. (2015). Heart Matters: the science of emotion, a fresh look at the pivotal role of children's feelings on behaviour and development. DVD video course, Vancouver, Canada. Used with permission.

2 To find out more about the resources and training that Dr. Neufeld offers go to www.neufeldinstitute.org

Step One: Express the emotion

The first step in working with emotions is to help our clients express the emotion they are feeling. Neufeld (2015) states that a key principle when working with emotions is that emotions seek expression; suppressed emotion cannot do its work. If emotional expression is thwarted it can lead to devastating effects, such as depression (flattened affect); distorted or displaced emotional expression (impulsivity or aggression); failure to adapt to life circumstances and feelings of

'stuckness' (Neufeld, 2015). A lack of emotional expression may suggest a lack of internal emotional movement; the client presents as 'unmoved', cold, expressionless and shut down (Neufeld, 2015).

An emotion can only be felt when it moves, or is 'stirred up' inside us. The primary defence of the limbic system is to retreat from feeling or to 'numb out' (Neufeld, 2015). The Social Engagement System (SES) of the brain, according to Porges' Polyvagal theory, regulates the expression, detection and subjective experience of emotion; if this system is shut down it can result in client's 'poor affect regulation, poor affect recognition and poor physiological state regulation' (Porges, 2009, p. 44).

The expression of emotion is viewed as crucial to a positive therapeutic experience and to the change process (Wampold, 2001 as cited in Lewis, 2008, p.64). The role of the therapist is to help their clients express the emotion they may be experiencing but may not be aware of: making the implicit explicit. Therefore the first thing a counsellor needs to do is come alongside the client to help them express the emotion in order to be able to accept it, invite it or assist it in coming to consciousness, so that it can be managed or processed healthily (Neufeld, 2015).

A great deal of learning about emotional regulation and interpersonal relationship skills takes place, according to Cozolino (2016):

… before we have the necessary cortical systems for explicit memory, problem solving or perspective. Consequently many of our most important socio-emotional learning experiences are organized and controlled by reflexes, behaviours, and emotions outside of our awareness and distorted by our immature brain. (p.9)

One of the goals of attachment-based therapy is to increase the client's ability to access their emotional states (Hall & Maltby, 2014). When working with some very 'stuck' or emotionally shut-down clients, it can be difficult for them to express the emotion they are feeling. I often start by focusing on the client's felt sensations in their body. Gendlin, (1981) calls this focusing on a 'felt sense.' This may be a preverbal internal bodily sensed feeling, experienced but often difficult to capture in words; an implicit higher level meaning via symbolic expression which can be accessed by internal attending and experiential process. Mindfulness practices can be helpful to access this felt sense. According to Baum (2013, p.38) awareness of physical sensations forms the very foundation of

human consciousness; body-centred therapeutic approaches help clients come into the present moment and shift out of fear, numbing and hyper-arousal.

Porges (2009) argues that 'all emotional states require specific physiological shifts to facilitate their expression and to reach their implicit goals' (p.30) (e.g., fight, flight, freeze, proximity-seeking/ attachment instincts). The importance of engaging the body in therapeutic work is further emphasised by Van der Kolk (2014) who suggests that clients take up yoga, drama, theatre and music (playing or singing) to help process emotions that may have been shut down due to trauma:

'in order to find our voice, we have to be in our bodies… the opposite of dissociation …acting is an experience of using your body to take your place in life' (p.331). Psychodrama techniques can be helpful for clients who find it difficult to express a bodily sensed emotion. Art therapy, Interactive Drawing Therapy (Withers, 2006), Music Therapy or any other expressive therapy is a good place to start with clients who may struggle to identify or name their emotions.

Step Two: Name the emotion

One reason a client may be unable to express their emotion may be due to a lack of appropriate words for the feelings. Once a feeling can be expressed, it then needs to be named (Neufeld, 2015).

The role of the therapist is to coach, explore and teach the words or names of emotions that match the client's inner experience. This is the psycho-educational component of working with emotion. Many of our clients did not have early attachment figures who coached them in pairing words with emotions.

Words open the door to consciousness; we cannot take up a relationship with something of which we are not conscious. According to Johnson (2011) words are 'handles' that open the door to the client's emotional experiences. Neurologically, this equates to the 'integration and communication of neural networks dedicated to emotion, cognition, sensation and behaviour' (Cozolino, 2016, p.10). From an attachment perspective, growth and integration of these neural networks are 'optimized by a positive early environment, including stage-appropriate challenges, support and parents who are capable and willing to put feelings into words' (Cozolino, 2016, p.25).

The role of the therapist is to coach and match words to feelings; this is similar to the role of a safe attachment figure for young children who are emotionally dysregulated. According to Porges (2009) 'psycho-therapeutic treatments may change the neural regulation of physiological states' (p.29), especially those involved in anxiety, fear, panic and pain. In my early career as a CBT trained Children's Counsellor, I found that emotion was not given much focus in the CBT model, yet intuitively I felt that it was the vital missing ingredient for many of the children with whom I worked. Southam- Gerow (2013) states that 'children with mental health problems had emotion-related gaps in their understanding that might not be adequately treated by a focus on behaviours and thoughts' (p. 5).

Research stemming from clinical observations suggests that children with anxiety problems struggle to understand and name emotions (Southam-Gerow, 2013, p. 5).

On a practical note, it can be very helpful for clients who have not been given a wide ranging emotional vocabulary from young, to be able to see a chart with facial expressions and emotions attached to them (e.g. there are many helpful resources available online: such as feeling charts

http://www.freeprintablebehaviorcharts.com/feeling_charts.htm).

Step Three: Feel the emotion

The third step in processing emotions is to help the client feel their feelings. According to an adage: 'if you can't feel it, you can't heal it'. Many of our clients seem to not be able to access their feelings; when asked what they are feeling, they often respond by telling us more of what they are thinking.

One reason a client may not feel an emotion may be due to their sense of a lack of safety from wounding (Neufeld, 2015). For many of our clients, to express and experience their full emotional reactions in childhood may not have felt safe. We have a complex brain, vulnerable to a variety of factors that can 'disrupt the growth and integration of important neural networks' (Cozolino, 2016, p.10). The field of psychotherapy has emerged because of the brain's vulnerability to these developmental and environmental risks (Cozolino, 2016, p. 10).

The role of the therapist is to provide safety for the client to feel their feelings, without shame, censorship or fear of punishment. For this to happen the counsellor has to be a safe attachment figure. For a young child, Neufeld (2008)

suggests the key ingredients which contribute to feeling emotionally safe in the presence of their caregiver is that they experience (at least some of the time) delight, enjoyment and emotional warmth which translates as 'an invitation to exist in our presence'.

Research on children who have experienced abuse, or extreme neglect point to the need for children to have both stable emotional attachment with and safe emotionally soothing touch from primary adult caregivers (Perry, 2002, p. 79). If these ingredients were missing in our client's childhoods, they may experience difficulty accessing and regulating their emotional responses.

The client needs to be emotionally 'held' by a safe attachment while processing early attachment wounds (active/abuse or passive/neglect). There needs to be a deep empathic connection with the therapist, limbic resonance (e.g. mirroring the emotion in facial expressions and body language) (Lewis, Amini, & Lannon, 2000) and building capacity for the emotion to be fully felt. According to Lyons-Ruth (1998) 'clients remember "special moments" of authentic person-to-person connection with their therapists, moments that altered their relationship with him or her and thereby their sense of themselves… these moments of inter-subjective meeting constitute a pivotal part of the change process" (p. 283). This is the crucial role of a corrective emotional experience leading to change in psychotherapy (Bridges, 2006; Knight, 2005).

Step Four: Mix the emotions – Emotional Integration

The fourth step of working with our client's emotions involves helping them mix the emotions they have already expressed, named and felt. The role of the therapist is to draw out the range of emotions present in the client, finding the 'answer' or the antithesis to the troublesome impulses, helping the client develop their capacity to feel the opposite and complementary emotion in order not to 'lose their temper' (Neufeld, 2015). The term 'temper' originated in the early 1800s from the Latin word *temperare* which means 'to mix correctly'; to lose one's temper means to lose self-control or to dysregulate emotionally. Getting the right 'temper' or mix of emotions is crucial for healthy emotional regulation and integration.

The integrative process, according to Neufeld (2015), involves dealing with inner conflict or mixed emotions, which is a sign of emotional maturity. It involves the capacity to attend to conflicting emotional signals and being able to integrate or mix them to the right balance.

All virtues consist of mixed emotions; for example, self-control is made up of impulses to react tempered by caring about the impact of one's reactions. Patience is a mix of feeling frustrated but loving the other or the outcome too much to sabotage it by venting one's frustration in verbal or physical attack. Courage is not the absence of fear, but 'fear of the dragon mixed with love for the treasure' (Neufeld, 2015).

Many of our clients come to therapy because of this lack of integration, which may manifest as a lack of emotional regulation, or losing the 'mix'; for example, erupting in aggression towards self (e.g. internalizing problems, self-harm, negative self-talk or depression) or aggression towards others (externalizing problems, verbal or physical attack/bullying). One factor which may affect our client's ability to integrate or mix competing emotions is that vulnerable emotions are more likely to be defended against and therefore not felt (Neufeld, 2015). The word vulnerability comes from the Latin *vulnera* which means "to wound." Examples of vulnerable feelings include: feelings of being wounded (hurt, anguish, pain rejection and abandonment); feelings of dependence (neediness, missing, loneliness, insecurity, emptiness); feelings of shyness or timidity; feelings of embarrassment, including blushing; feelings of shame (something is wrong with me, I am not enough (Brown, 2010)); feelings of futility (sadness, disappointment, grief, sorrow); feelings of alarm (anxiety, apprehension, unsafety and fear); feelings of caring (compassion, empathy, devotion, concern, being invested in); feelings of responsibility (regret, feeling badly or remorseful).

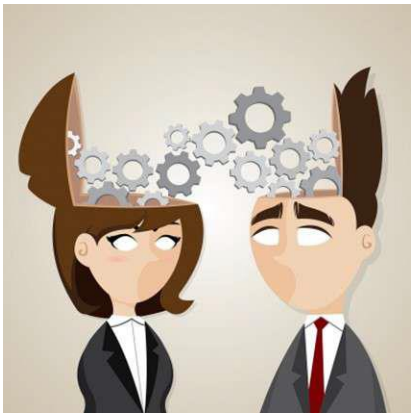
If our clients were shamed or had their feelings disavowed during infancy, they may find it too vulnerable to experience their full range of emotions. Emotions can only mix when they are felt (*step three*) and can only be felt if expressed (*step one*) and named (*step two*).

A second factor impeding feelings from mixing is that the person's prefrontal cortex may not be fully developed. Neufeld (2015) has nicknamed the prefrontal cortex the 'mixing bowl' of the brain.

Impulsivity is a classic sign of non-integrative functioning in the prefrontal cortex; the limbic brain is unable to process more than one emotion at a time or has limited capacity for mixed emotions (Schore, 2003). The development of the prefrontal cortex's capacity to process two or more competing emotions begins between the ages of 5 to 7 years old, under optimal conditions (Neufeld,2015). Siegel (2012) outlines nine functions of the prefrontal cortex: body regulation,

attuned communication (emotional understanding), emotional balance (flexibility in one's emotional responses), empathy, insight (reflecting on past, present and future), fear modulation, intuition and morality (the ability to think of the larger social good and enact those behaviours even when alone).

Optimal sculpting of the prefrontal cortex through secure attachment allows us to: trust others, think well of ourselves, regulate our emotions, maintain positive expectations, utilize our intellectual and emotional intelligence in moment-to-moment problem solving (Cozolino, 2006, p.9).



In order for the client to be able to mix their emotions, they must have capacity in their prefrontal cortex to integrate competing emotions (Neufeld, 2015).

According to Ogden (2009), the counsellor's role is to help the client expand their windows of tolerance of emotionally triggering states. This involves developing the client's capacity in the prefrontal cortex to manage two competing or conflicting emotions to come to the right 'mix' in **order to demonstrate self-control or self-regulation** (Neufeld, 2015). To use an example from the CBT model, the cognitive distortion of 'all or nothing thinking' is a sign of an unintegrated prefrontal cortex, where only one feeling or perspective can be held at a time, rather than the more 'mature' or nuanced perspective of holding two emotions or perspectives in balance.

The third factor which keeps emotions from mixing is that inner conflict is not embraced (Neufeld, 2015), or there is no room for mixed feelings in the client's narrative. This is where the therapist has to 'tread carefully' using deep empathy and active listening skills when painful experiences are being explored in a session (Lewis, 2008). Without a supportive response from the therapist, the flow of narrative may abruptly stop followed by intense emotional responses which may disrupt the client's sense of self. This is when the counsellor may see the client 'dis-integrate' and swing back to all-or nothing/ black-and-white intense emotional responses, possibly followed by 'shutting down' or 'numbing out'. Therefore, it is important that the counselling is able to self-regulate in these circumstances and stay present to the client's emotional reactions. Van der Kolk (2009) is of the opinion that 'you're only as good of a therapist as you are an affect regulator' (as cited by Ogden, 2009, p.204). According to Coombs,

Coleman, and Jones (2002), clinicians, 'whatever their theoretical background, must forge a path in therapy through a welter of client affect . . . as well as their own emotional reactions to the client' (p.233). This emphasises the vital necessity for therapists to have regular supervision, and ideally our own on-going therapy.

Step 5 – reflecting on emotions

The fifth and final step in processing emotions is to help the client reflect on the emotion or range of emotions they are experiencing (Neufeld, 2015). After years of collecting observational data on mothers and infant interactions, Tronick (2003) notes that:

" Mother and infant, as well as client and therapist, co-create dyadic states of consciousness, making implicit and explicit sense of the world out of their normally messy exchanges of age possible meanings. These co-creative processes lead to change in the child's, and client's state of knowing the world, and also change the way the client makes sense of the world and ways of being with others." (p.473)

The process of reflecting on emotions is what Neufeld (2015) calls 'taking up a relationship with the emotions.' This implies moving from implicit or unconscious emotional regulation to the client becoming conscious of their emotions, what may be happening in their body, possibly displayed in their behaviour and choices, as well as within the narrative of their lives. With reflection, the client is able to move from impulsive reacting, to empowered responding.

From a Jungian Psychoanalytic perspective, Hollis (1993) posits that:

Life is unsparing in asking us to grow up and take responsibility for our lives... [this] means finally confronting one's dependencies, complexes and fears …. It requires us to relinquish blaming others for our lot and to take full responsibility for our physical, emotional and spiritual wellbeing. (p. 42)

Reflecting on our emotions can lead to 'positive affect regulation, biological homeostasis and the quiet internal milieu allowing for the consolidation of … a positive sense of self' (Cozolino, 2016, p.25). What Cozolino means by 'quiet internal milieu' may be similar to Neufeld's term 'psychological rest'.

Neufeld (2015) posits that the end goal in working with emotions is to bring the child (or the adult client) to 'psychological rest'; all growth, physical and psychological, comes from rest (Neufeld, 2008).

So, according to Neufeld's five-step model of processing emotions in therapy, the ability to reflect on emotions is the crown jewel mounted on the foundation of the other processes of being able to express, name, feel and mix emotions. If these earlier steps have not been processed, then it may be futile to reflect on that which cannot be expressed, named, felt or even felt simultaneously and mixed with other feelings. That is why an emotionally safe, attuned therapeutic relationship is key to doing this deep emotional work. As Hall and Maltby (2014) explain:

"From an attachment-based psychoanalytic perspective, pathology is the inability to fully experience emotions and/or to use significant relationships to regulate affective experiences. Therefore, the goal of therapy from this perspective is to help [clients] use the therapeutic relationship to regulate strong affect, thereby eliminating the need to avoid or disown certain affective experiences. "(p.19)

Conclusion

In conclusion, this paper presented Neufeld's (2015) five step model for processing emotions with clients: helping clients express, name, feel, mix and reflect on their emotional experiences. His model of working with emotions in children has been adapted and expanded to include attachment research and neuroscience findings to more fully understand emotional regulation in adult clients. It has been argued that safe emotional connection (attachment) in the therapeutic relationship is vital for the processing of emotion. Relationships have come to take centre stage in all clinical fields with attachment now considered the key element in emotional well-being across the lifespan (Schore, 2012). We have also seen that the communication of emotions in the first years of life ultimately leads to the child's ability to self-regulate in later years based on their early emotional experiences of care (Schore & Schore, 2008).

References

Badenock, B. (2008). *Being a Brain-Wise Therapist: A Practical Guide to Interpersonal Neurobiology*. New York: Norton.

Baum, R. (2013). Transgenerational trauma and repetition in the body: The groove of the wound. *Body, Movement and Dance in Psychotherapy*, *8*(1), 34–42. https://doi.org/10.1080/17432979.2013.748976

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory*. London: Routledge.

Bridges, M. (2006). Activating the Corrective Emotional Experience. *Journal of Clinical Psychology*, *62* (5), 551–568.

Brown, B. (2010). *The Gifts of Imperfection: Let Go of Who You Think You're Supposed to Be and embrace who you are*. Centre City, MIN: Hazelden.

Coombs, M. M., Coleman, D. E., & Jones, E. E. (2002). Coombs, M.M., Coleman, D.E., & Jones, E.E. (2002). Working with feelings: The importance of emotion in both cognitive-behavioural and interpersonal therapy in the NIMH Treatment of Depression collaborative research study. Psychotherapy: Theory/ Research/Practice/Training, 39, 233244. *Psychotherapy: Theory/ Research/Practice/Training*, *39*, 233–244.

Cozolino, L. (2006). *The Neuroscience of Human Relationships*. New York: W.W. Norton & Co.

Cozolino, L. (2016). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). New York, NY.: W.W. Norton & Co.

Fosha, D., Siegel, D. J., & Solomon, M. F. (2009). *The healing power of emotion: Affective neuroscience, development, and clinical practice*. New York: W.W. Norton & Co.

Gendlin, E. (1981). *Focusing.* New York, NY.: Bantam Books Trade Paperbacks.

Greenberg, L. (2006). Emotion-Focused Therapy: A Synopsis. *Journal of Contemporary Psychotherapy*, *36*(2), 87–93. https://doi.org/10.1007/s10879-006-9011-3

Hall, T. W., & Maltby, L. E. (2014). Attachment based psychoanalytic therapy and Christianity. In *Christianity and Psychoanalysis: A new conversation.* Downers Grove, IL: InterVarsity Press.

Hollis, J. (1993). *The middle passage: From misery to meaning in midlife.* Toronto, Canada: Inner City

Books.

Knight, Z. (2005). Knight, Z. G. (2005). The use of the'corrective emotional experience'and the search for the bad object in psychotherapy. American journal of psychotherapy, 59(1), 30. *American Journal of Psychotherapy*, *59*(1), 30.

Lewis, I. (2008). With feeling: Writing emotion into counselling and psychotherapy research. *Counselling and Psychotherapy Research*, *8*(1), 63–70.

Lewis, T., Amini, F., & Lannon, R. (2000). *A general theory of love.* Toronto, Canada: Random House.

Neufeld, G. (2008). *The Power to Parent Part 1: Attachment the vital connection.* [DVD videocourse](Vol. 1). Vancouver. Canada.

Neufeld, G. (2015). *Heart Matters: the science of emotion, a fresh look at the pivotal role of children's feelings on behaviour and development.* [DVD videocourse]. Vancouver. Canada: Mediamax interactive productions.

Ogden, P. (2009). Emotion, mindfulness and movement: Expanding the regulatory boundaries of the window of affect tolerance. In *The healing power of emotions: Affective neuroscience, development and clinical practice.* (pp. 204–231). New York, NY.: W.W. Norton & Co.

Perry, B. D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. *Brain and Mind*, *3*, 79–100.

Porges, S. W. (2009). Reciprocal influences between body and brain in the perception and

expression of affect: A polyval perspective. In *The healing power of emotion.* New York, NY, US: W.W. Norton & Co.

Roussouw, P. (2014). *Neuropsychotherapy: Theoretical underpinnings and clinical applications.* St.Lucia, QLD, Australia: Mediros.

Schore, A. N. (2012). *The Science of The Art of Psychotherapy*. Conference at UCLA.

Schore, A. N. (2003). *Affect regulation and the repair of the self*. New York: W.W. Norton & Co.

Schore, A. N. (2011). The Right Brain Implicit Self Lies at the Core of Psychoanalysis. *Psychoanalytic Dialogues*, *21*(1), 75–100.

Schore, J. R., & Schore, A. N. (2008). Modern Attachment Theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal*, *16*, 9–20.

Siegel, D. J. (2010). *The mindful therapist: A Clinician's Guide to Mindsight and Neural Integration*. New York: Norton & Co.

Siegel, D. J. (2012). *The Developing Mind: How relationships and the brain interact to shape who we are.* (2nd Edition). New York: The Guilford Press.

Siegel, D. J., & Goleman, D. (2011). *Mindsight: the new science of personal transformation*. New York: Bantam Books Trade Paperbacks.

Southam-Gerow, M. (2013). *Emotion Regulation in Children and Adolescents: A Practitioner's Guide.* New York, NY.: Guilford Press.

Tronick, E. Z. (2003). "Of Course All Relationships Are Unique": How Co-creative Processes Generate Unique Mother–Infant and Patient–Therapist Relationships and Change Other Relationships. *Psychoanalytic Inquiry*, *23*(3), 473–491. https://doi.org/10.1080/07351692309349044

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma.* London; New York: Allen Lane/Penguin Books.

Wallin, D. J. (2007). *Attachment in psychotherapy*. New York: Guilford Press.

Withers, R. (2006). Interactive Drawing Therapy: Working with Therapeutic Imagery. *New Zealand Journal of Counselling/Te Ropu Kaiwhiriwhiri O Aotearoa*, *26*(4), 1–14.