Transformance, Recognition of Self by Self, and Effective Action

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In K. J. Schneider (Ed.) *Existential-Integrative Psychotherapy: Guideposts to the Core of Practice*, pp. 290-320. New York: Routledge, 2008.

INTRODUCTION

People have a fundamental need for transformation. We are wired for growth and healing. And we are wired for self-righting and resuming impeded growth (Emde, 1988). We have a need for the expansion and liberation of the self, the letting down of defensive barriers, and the dismantling of the false self (Ghent, 1990; Schneider, in press). We are shaped by a deep desire to be known, seen, and recognized (Sander, 1995, 2002), as we strive to come into contact with parts of ourselves that are frozen (Eigen, 1996). Along with needing to be known authentically, we have a need to know the other (Buber, 1965; Ghent 1990), a profound and undeveloped aspect of attachment.[1] In the process of radical change, we become more ourselves than ever before, and recognize ourselves to be so (Fosha, 2005).

Even prior to the need for authentic self-expression and contact, there is the need for effective action on behalf of the self (van der Kolk, in press), which is why emotions are wired into our brains and bodies: the categorical emotions[2] ---fear, anger, joy, sadness, disgust-- play a powerful role in survival. Their full expression bestows access to broadened thought-action repertoires (Damasio, 2001; Darwin, 1872; Fosha, 2000; Frederickson & Losada, 2005). Transformational vehicles themselves, each categorical emotion is associated with a set of *adaptive action tendencies* evolutionarily dedicated to bringing about conditions within which the individual's optimal development can unfold.

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[1] This idea is being developed in an upcoming paper: Fosha (*in preparation*). On being known by and knowing the other: An attachment perspective on transformation and emergence.

[2] The term *categorical emotion* refers to dispositional tendencies we share with our animal predecessors wired in by evolution that serve our survival. The categorical emotions are universal (Darwin, 1872): each has a specific identifying brain landscape, bodily signature, and characteristic arrangement of facial musculature.

The existential need for recognition and the functional need for effective action on behalf of the self are powerful motives; they are both manifestations of *transformance*. *Transformance*[3] is my term for the overarching motivational force, operating both in development and therapy, that strives toward maximal vitality, authenticity, and genuine contact. Residing deeply in our brains are wired-in dispositions for transformance. Naturally occurring adaptive affective change processes, such as emotion, dyadic affect regulation, empathic recognition of the self, etc., (Fosha, 2002), are manifestations of transformance-driven processes. AEDP (Accelerated Experiential Dynamic Psychotherapy: Fosha, 2000), the model of therapy that informs my work, seeks to facilitate therapeutic change first through creating the conditions of safety transformance forces require in order to be entrained; it then seeks to actively engage these affective change processes from the first moments of the first therapeutic encounter, and then experientially process them through to completion. Moment-to-moment accompanied by positive somatic markers, affective change processes effect state transformations and culminate in the positive affects that characterize resilience, expansive growth and flourishing (Frederickson & Losada, 2005; Loizzo, in press; Tugade & Frederickson, 2004). The positive affects are desired states: as such, they themselves become motivational forces (Ghent, 2002; Sander, 2002).

[3] Ghent, in his beautiful, deep, and brilliant (1990) paper, uses the term "surrender" to mean something very akin to what I mean by the term "transformance," also choosing a term to denote the opposite of resistance. I opted not to join him in the use of the term "surrender" which seems to me more appropriate to adult psychotherapy, where one has to let go of some organization (i.e., surrender it), so as to reach something more primal, more basic, more organic. I am looking for a term to apply both to therapy and development. Moreover, the ordinary-language connotations of "surrender" are, I think, hard to overcome. Hence, "transformance."

Transformance is the motivational counterpart of resistance: it is driven by hope and the search for the vitalizing positive affects that accompany all adaptive affective change processes (Fosha, 2002). Resistance, on the other hand, is fueled by dread and the desire to avoid bad feelings -- be they deadening or terrifying. Resistance drives processes that eventuate in disorganization, deterioration, and immobility (Frederickson & Losada, 2005; Loizzo, in press; Russell & Fosha, in press; Tugade & Frederickson, 2004).

This chapter comprises three sections. In Section 1, I will introduce some defining aspects of AEDP theory and practice, and show how transformance is foundational to both. In Section 2, I will provide a microanalysis of an initial session with a male patient with a history of trauma suffering from a current relapse of sexual addiction behavior. Work with him will illustrate the transformational spiral which, in less than 45 minutes, takes us from a frenzy of self-loathing and uncontrollability to a moving recognition of the self by the self, and to confidence in his capacity for effective action. It will also allow us to look at the phenomenology of healing. Finally, using transformance as a bridging construct that might help promote the kind of integration to which this volume is devoted, Section 3 will examine some of the resonances between AEDP and the existential-integrative (EI) model.

SECTION 1-- ON AEDP

> "*...love and hate are not opposites. The real polarity is between love and fear. Only when there is no fear, love flourishes*." (Ghent, 1990, p. 229).

The notion of transformance is part of a larger project of developing a theory of and for a therapy which is change-based, rather than psychopathology-based (Fosha,

2002, 2005). Understanding how healing transformational processes --their dynamics, their phenomenology-- work and how they can be effectively and systematically harnessed is central to such an endeavor**.**

Credo: Basic Concepts and Values

In AEDP, the difference between whether the forces of transformance or the forces of resistance are entrained is determined by the attachment relationship. "Attachment decisively tilts whether we respond to life's challenges as opportunities for learning and expansion of the self or as threats leading to our constriction of activities and withdrawal from the world" (Fosha, 2006, p. 570). To entrain transformance forces, and from the first moments of the first session, AEDP seeks to facilitate the co-creation of a dyadic relationship characterized by secure attachment. Evolved to counter fear and protect against danger (Bowlby, 1988; Main, 1999), the attachment relationship is essential for the moment-to-moment regulation of intense emotion, which would otherwise be overwhelming and stressful (Schore, 2001). Through the regulatory powers of the attachment relationship and its subsequent internalization into the individual's self-regulatory repertoire, the individual is able to harness the adaptational advantages conferred upon the organism by the full experience of the categorical emotions. The self can thus benefit from the expanded range of thoughts and behaviors they enable (Frederickson & Losada, 1995).

The therapeutic task is to create a safe environment in which the motivation for transformation can come to the fore. This environment is then buttressed by therapeutic efforts that help the aforementioned motivation grow stronger than the motivation for

maintenance of the status quo (which upholds the principle that "the evil you know is better than the evil you don't," a motto for traumatized people everywhere).

Two different pathways are used by treatments that aim for therapeutic healing. The well-established pathway of seeking to overcome resistance, or fix what is broken, characterizes most systems of psychotherapy. Its assumption, articulated cogently by Alexander and French (1946), is that while resistance-driven functioning is inevitable, a corrective emotional experience is achieved when the repetition scenario unfolds but has a different ending.

The road less traveled promotes the activation of healing tendencies--the forces of transformance-- from the beginning and not just as a result of having worked through the damage of the past. In AEDP, we don't just seek a new ending, but also a new beginning (Fosha, 2006; Fosha & Yeung, 2006; Lamagna & Gleiser, 2006; Russell & Fosha, in press; Tunnell, 2006). We are on the lookout for glimmers of transformance and resilience, and we focus on these and amplify them. Aiming *to lead with a corrective emotional experience*, AEDP's pathway entails a stance and a set of techniques, as well as the creation of conditions for the entrainment of the transformance forces always present as dispositional tendencies (Winnicott, 1960). In the right environment,[4] dispositional tendencies toward healing and self-righting that are dormant, frozen, or moribund can begin to emerge. Thus resourced, the patient becomes a partner for the journey ahead. We

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[4] By *environment* here, I mean the human environment that any dyad co-constructs. In a therapeutic setting informed by an attachment perspective, however, the therapist has a greater role in setting its tone and parameters. As Lachmann (2001) has said, in caregiving dyads, be they mother-infant, or therapist-patient, the bi-directional process of influence characterizing such dyads is indeed mutual, but asymmetric. A similar point is made by Hughes (2006).

call this "working with the self-at-worst from under the aegis of the self-at-best" (Fosha, 2000, 2002, 2005).

In addition to its transformance-based, healing orientation, I will focus here on seven other fundamental and holographic aspects of AEDP[5]:

1. Attachment-Based Stance Sprinkled Liberally with Intersubjective Delight in the Patient: The therapeutic relationship in AEDP aims to be the secure base from which experiential explorations of deep, painful emotional experiences can be undertaken. Key to AEDP's attachment stance is that the patient not be alone with overwhelming emotions. The AEDP therapist, aiming to promote security of attachment and intersubjective contact and to facilitate affective experience, is explicitly empathic, affirming, affect-regulating, and emotionally engaged, broadcasting the willingness to help. Such an attachment relationship obviates the fear associated with intense, stressful-when-not-regulated, emotional experience (see dyadic affect regulation below). Similarly, the therapist's delighting in the patient, while in active intersubjective engagement, is a powerful antidote to the patient's shame (Trevarthen, 2001). With fear and shame reduced, the defenses erected to protect the self can come down, yielding access to more somatically-based primary emotional experience (Fosha, 2003, 2006; Greenan & Tunnell, 2003, Chapter 2; Hughes, 2006; Lamagna & Gleiser, in press; Tunnell, 2006).

Two features distinguish AEDP's use of attachment: Attachment is not the *aim of* therapy, but rather the *sine qua non for* therapy. Secure attachment in the therapeutic

[5] Because of space limitations, I can only provide a thumbnail sketch here, and since each of these aspects of AEDP has been extensively written about, in parentheses at the end of each paragraph will be the references where the interested reader can explore these ideas in a more fully developed fashion.

relationship is what we seek to entrain from the start, so as to optimize experiential work with intense emotions. Second, it is not sufficient that attachment operate implicitly, working as the background hum against which experience takes place. The patient's *experience* of the attachment relationship needs to be a major focus of therapeutic work (Fosha, 2006).

2. Dyadic Affect Regulation: The goal that the patient not be alone with overwhelming emotions is achieved through the process of dyadic affect regulation. Through the moment-to-moment affective communication between dyadic partners that occurs through non-verbal, right-brain-mediated processes involving gaze, tone of voice, rhythm, touch, and other vitality affects, members of the dyad establish coordinated states. The process of dyadic affect regulation proceeds through countless iterations of cycles of attunement, disruption, and then, through repair, the re-establishment of coordination at a higher level. Though invariably accompanied by negative affects, the disruption of coordination, if repaired, is a major source of transformation. Disruption occurs when experiences that are outside the coordinated state burst forth. If attunement is where self and other resonate, disruption is the realm of being on disturbingly different wavelengths. Repair involves establishing a new, expanded coordinated state where differences can be encompassed and integrated. "The flow of energy expands as states of brain organization in the two partners expand their complexity into new and more inclusive states of coherent organization, enabling the infant to do what it would not be able to do alone" (Sander, 2002, p. 38). The achievement of the new coordinated state is a vitalizing energizing human experience. It gives rise to new emergent phenomena which transform and expand both dyadic experience, and the experience of each dyadic partner,

reflecting how being together changes each of them (Fosha, 2001, 2003; Hughes, 2006; Sander, 1995, 2002; Schore, 2001; Tronick, 2003; Tunnell, 2006).

3. The Experiential Method: Precise Phenomenology and Moment-to-Moment Tracking of Affective Experience, *The aim of AEDP treatment is to provide the patient with a new experience*, and that *that experience should be good*. By good, I do not mean necessarily pleasant, but rather an experience that even when painful or difficult, feels right and true, and is accompanied by increasing coherence, relaxation and/or flow. We track moment-to-moment fluctuations of the emotional experience of patient, therapist, and the dyad. All interventions are grounded in moment-to-moment experience and aim for phenomenological precision. Thus, they are informed by a sense of where we are and where we (phenomenologically) want to go. The steady somatic focus on the patient's experience and its felt sense (Gendlin, 1981) accomplishes three therapeutic goals: it reduces anxiety; it lets the patient drop from a defensive position to one more connected with emotion; and, finally, it increases access to right-brain-dominated, affectively loaded experiencing (Fosha, 2003; Fosha & Yeung, 2006).

The transformational process is guided by the somatic markers of healing transformational processes. Invariably positive, these somatic markers--e.g., smiles, deep in-and-out breaths, dyadically coordinated head nods, sideways head tilts, upward gazes--signal moment-to-moment that the therapeutic process is on the right track.

4. Emotion and the Body: Working with Deep Emotions to Completion: Nothing that Feels Bad Is Ever the Last Step. Adaptive, transformational emotional experiences involve the body. Emotion is both the target and the agent of change. The processing to completion of the somatically-rooted experience of previously unbearable core affects in

the here-and-now of the patient-therapist relationship is the central agent of change in AEDP. After defensive blocks are removed and the inhibiting impact of pathogenic shame and fear has been alleviated, we work to facilitate access to the direct somatic experience of subcortically generated and right-hemisphere-mediated categorical emotions and other adaptive core affective experiences (Damasio, 1999). We seek to deepen patients' experience, and work it through to completion until their adaptive action tendencies are released and the patient's access to resources and resilience opens up (Fosha, 2000b; 2004b, 2005).

5. Focusing on the Experience of Transformation Itself Becomes a Transformational Process: As all experientialists know, focusing on an experience transforms it (e.g., Gendlin, 1981). Having processed emotional experience to completion, and thus effected a transformation, we do not stop. A major aspect of AEDP is the focus on, and the affirmation of, the *experience* of transformation itself, particularly *the experience of the transformation of the self in the context of a healing dyadic relationship*. We call this activity *metatherapeutic processing* since we are experientially exploring what is therapeutic about the therapeutic process and we call the affects that result from this metatherapeutic exploration of the *transformational affects* (see page 13-14 below for a description). Metatherapeutic processing involves alternating between experience and reflection on experience, and then continuing to experientially explore the patient's changing experience upon having articulated something about the experience through having reflected on it. Once each new experience is elaborated through this going back and forth between experience and reflection, it becomes the departure point for the

next round of exploration. Thus we unleash a *cascade of transformations* (Fosha, 2004b, 2005, 2006; Fosha & Yeung, 2006; Russell & Fosha, in press).

6. Receptive Affective Experiences. It is not sufficient that empathy, care, love, or help be given: to work their potent magic, they must be taken in and used. *Receptive affective experiences* of feeling seen, held, understood, helped or recognized are also rooted in the body, and have a felt sense specific to them: exploring them allows us to know whether, and how, what is being relationally given is being received. Thus, we explicitly explore the patient's *experience* of receiving empathy, or care, or delight. Once we address defenses and fears that stand in the way of the patient's capacity to take in and use good stuff, we then work to deepen the patient's receptive capacities. Being able to receive emotionally is necessary if the vitality and security that are the aim of attachment and joyful intersubjective contact are to become integrated mainstays of the patient's core identity and sense of self.

7. Vitalizing Positive Somatic Markers Associated with Transformance. A felt sense of vitality and energy characterizes transformance-based emergent phenomena. AEDP, along with others interested in exploring the progressive motivational forces of transformance operating in development and in therapy (e.g.,. Buber, 1965; Eigen, 1996; Gendlin, 1981; Ghent, 1990, 2002; Sander, 1995, 2002; Schore, 2001; Trevarthen, 2001), recognizes these very positive phenomena as energizing developmental growth, glorious development and expansive, enriching exploration. Rooted in the body, they mark transformational processes on an optimizing path: going beyond symptom relief and stress reduction, we are in the realm of thriving, flourishing and resilient functioning (Frederickson & Losada, 1995; Tugade & Frederickson, 2004; Russell & Fosha, in

press). Moreover, these positive vitalizing experiences are the affective correlates of a neurochemical environment in the brain which is maximally conducive to optimal learning, development, and brain growth (Schore, 2001).

The Three States and Two State Transformations.

> "*The existentialists teach us that both [creatureliness and godlikeness] are ... defining characteristics of human nature... And any philosophy which leaves out either cannot be considered to be comprehensiv*e" (Maslow, 1968, quoted in Schneider & May, 1995, p. 92).

In AEDP, we neither leave out "creatureliness," i.e., biologically based, processes like emotion and attachment, rooted in our mammalian brains and bodies, nor "godlikeness," i.e., the transcendent aspects, equally biologically based, of our selves-at-best. The two are organically and inextricably connected in the transformational process by which emotion in the context of attachment safety is experientially processed to completion (Fosha, 2005). Three states bridged by two state transformations (see Figure 1) characterize that process:

Insert Figure 1 about here

State 1: State 1 functioning is dominated by defenses and inhibiting affects, such as shame and fear, which block the person's direct contact with his/her own emotional experience. Interventions here aim at building the experience of safety through establishing relatedness, bypassing defenses, and alleviating fear and shame. The secure attachment bond obviates the need for defenses through undoing the patient's aloneness.

The first state transformation. The first state transformation reflects the disruption of old and dysfunctional patterns as a result of the new experiences generated by the therapeutic dyad. All the while staying with the patient, so that he/she does not feel alone,

we seek to amplify the glimmers of affect that herald previously warded off intense emotional experiences. Here, dyadic affect regulation is achieved through right-brain-to-right-brain communication: Through eye contact, tone of voice, gaze, tone, rhythm etc., and the use of simple, evocative, sensory-laden, imagistic language, we seek to entrain (and facilitate nontraumatic access to) right-brain-mediated, somatically rooted emotional experience. The secure base is being co-constructed as old patterns are being de-constructed.

State 2. With defenses and inhibiting affects out of the way, the patient is viscerally in touch with bodily-rooted emotional experience, most notably, the categorical emotions, the essence of "creatureliness." Again, the key here is the attachment relationship: once it is in place, emotional processing work can be launched. State 2 dyadic affect regulation has patient and therapist working together to help the patient access, deepen, regulate, and work through subcortically initiated and right-brain-mediated emotional experiences, so that the seeds of healing contained in such experiences can be released.

The second state transformation: What in most therapies is often seen as a natural endpoint of experiential work, i.e., the completion of a round of processing of emotion, is for AEDP the herald of another round of work. In *metatherapeutic processing*, the focus shifts to the patient's *experience* of transformation. Using alternating waves of (right-brain-mediated) experience and (left-brain-mediated) reflection, here the goal is to integrate the fruits of intense emotional experience into the personality organization. Through exploring the experience and meaning of what has just gone on for each partner,

we also further strengthen attachment security which is rooted in difficult experience, successfully traversed together.

The dyadic affect regulation characteristic of metatherapeutic processing entrains the integrative structures of the brain, i.e., the corpus callosum, the prefrontal cortex (especially the right prefrontal cortex shown to mediate emotionally loaded autobiographical narrative, Siegel, 2003), the insula and the anterior cingulate (van der Kolk, 2006). These structures have been shown to be adversely affected by trauma (Teicher, 2002), and to play a significant role in the healing from trauma through the coordination of left-brain and right brain aspects of emotional experience (Lanius et al., 2004; van der Kolk, in press). Entraining them through metatherapeutic processing is both a one-brain process and a two-brain process: while the dyad supports the integrative work that takes place within the individual's neural processing, it also supports a dyadic brain-to-brain communication process involving the integrative brain structures of the dyadic partners. The result is the patient's nascent capacity to generate a coherent and cohesive autobiographical narrative, the single best predictor of security of attachment and resilience in the face of trauma (Main, 1999; Siegel, 2003).

The focus on the experience of healing transformation evokes one or more of the six types of phenomenologically distinct transformational affects (see Figure 1) identified to date: 1. *the post breakthrough affects*, i.e., feeling relief, as well as feeling lighter, clearer, stronger, after an intense emotional experience processed to completion; 2. *the mastery affects*, i.e., pride and joy, that come to the fore when fear and shame respectively are transformed; 3. *emotional pain*, the transformational affect associated with the process of mourning-the-self; 4. *the healing affects*, i.e., gratitude and tenderness

toward the other, and feeling moved within oneself in response to affirming recognition of the self and its transformation, as well as of the role of the other in the process; 5. *the tremulous affects*, i.e., fear/excitement, startle/surprise, curiosity/interest, and a feeling of positive vulnerability, associated with traversing the crisis of healing change ; and finally, 6. *the healing vortex*, i.e., oscillating and vibrating sensations, associated with how the body proper processes quantum transformation (Fosha, 2006).

State 3: The processing of an emotion to completion ushers in a third state. In *core state*, the patient has a subjective sense of "truth" and a heightened sense of authenticity and vitality; almost always, so does the therapist. Like in State 2, defenses and anxiety are absent in core state. But whereas the turbulence of intense emotions defines State 2, calm, clarity, confidence, centeredness, curiosity, compassion, courage, and creativity, Schwartz's (2003) eight Cs, catchily capture the defining qualities of core state.

Work with core state phenomena culminates in the assertion of personal truth and strengthening of the individual's core identity. In this "state of assurance" (James, 1902), the patient contacts a confidence that naturally translates into effective action. The patient's true self declares itself (Osiason, 2006). A strong sense of self and the capacity for effective action on behalf of the self are inextricably intertwined.

In core state, the patient experiences a sense of expansion and liberation of the self, as well as openness to and capacity for deep contact and interrelatedness. Fully able to move back and forth between compassion and self-compassion, between wisdom and generosity, True-Self-True-Other relating --AEDP's equivalent of I-Thou relating-- is a quintessential core state phenomenon. Thus, the transcendent qualities Maslow associates with "godlikeness," are front and center in core state.

Processing intense emotion to completion describes an *arc of transformation* (Fosha, 2005). It goes from (a) defenses against, and anxiety and shame about, both creatureliness and godlikeness, to (b) creatureliness, i.e., the bodily rooted, subcortically-initiated categorical emotions, to (c) godlikeness, i.e., core state, where through a sense of the sacred and the effective, we become most deeply human, and most ourselves. The time-honored dichotomy between creatureliness and godlikeness is bridged in one fell continuous moment-to-moment experientially tracked swoop.

SECTION 2. "WHEELS ON THE PAVEMENT:" A FIRST SESSION

I have chosen to use a single session, the first initial contact, to show how healing is possible from the first moment. The session illustrates how, in this case in less than 45 minutes, we can get from the depths of despair and self loathing to a resilience which feels authentic and real. The patient is a man who, before being able to engage in I-Thou relating, first has to become an "I." By the end of this piece of work, his "I" is firmly in place: so much so, that it evokes the patient's own sense of awe with respect to himself.

In this example of AEDP work, all clinical choices are informed by an overarching goal: to buttress and foster the forces of transformance, while minimizing the forces of resistance. The clinical material shows how the focus on the e*xperience* of transformation solidifies, deepens and fosters its ongoing emergence. The transformational process is not finite: the sense of self and of effectiveness keep on evolving and changing. True to the existential moment, not only can we have "a world in a grain of sand, eternity in an hour" (Blake, 1863), but also the treatment in a session.

The patient is a 30-something professional recently married man I shall call Lee. Lee recently relocated to the city where I practice, and seeks therapy following a relapse of his sexual addiction suffered over the course of a week preceding this session. As I learned subsequent to the session which is presented below, the patient's early history is notable for emotional and sexual abuse, as well as emotional neglect, in his family of origin, and a 10-15 year history of struggling with a sexual addiction, which had been under control for over a year prior to the current episode.

Vignette 1. Achieving safety through honoring defenses, counteracting anxiety and shame, and inviting deeper bodily-based emotional experience

The session begins in the waiting room. Without even waiting to come in, while we are walking toward my office, Lee tells me that his being more than 15 minutes late is evidence of his tendency toward "self-sabotage:"

Th: (*welcoming, smiling*) I am eager to hear why you were late
Pt: (*fidgety, uncomfortable smile*) I think purposefully not on purpose I didn't leave myself enough time because I think I was nervous about coming here and starting... I had a very good working relationship with Dr M. And initially I was looking at coming to New York as an opportunity to take a break from therapy, and kind of trying it on my own and quickly realizing that was not a good idea... and I guess I had a lot of hope about coming to New York, but also a lot of anxiety. And all of that sort of came together so that at 2 o'clock, when I could have gotten up and left my office and gotten here with 15 minutes to spare, I instead decided to leave and not wait until 2:30.... I looked at the clock at the time that I could have come, but I guess I even said in my head "that's too early" or something like "What are you, a goody two shoes, showing up 15 minutes early"
Th: (*big smile*) First of all, I'm very impressed ....
Pt: (*giggles, taken aback; sweating*; *shallow breathing*)
Th: ..... with your self awareness and openness with me [**therapist "surprises the unconscious," disconfirming patient's expectations of being met critically**]
Pt: Thanks
Th: That's the first thing that's very very striking as we launch in. But secondly (*concerned tone*), that you have a lot of anxiety
Pt: Yeah
Th: ... and *had* a lot of anxiety about being here [**shift focus from defenses to anxiety powering them**]
Pt: Yeah

Here we see a combination of affirmation, on one hand, and keeping the pressure toward deepening experiencing on the other. If the deepening is to take place, then anxiety has to be regulated.

Th: Tell me what you‘re aware of, what you’re experiencing **[experiential focus]**
Pt: ....Ummm, I guess it's more like I'm kind of insulating myself from the experience, to an extent
Th: Pushing back, pushing away (*makes motion with hands of pushing away from oneself*) **[therapist's right brain speaking to the patient's right brain]**
Pt: Yeah, like thinking of cute things to say, you know, questions that would be irrelevant like "where did you get the mike?" and dodge 'em type things which I know are not emotions ... You know, I've seen a lot of therapists and first sessions have gotten kind of old hat for me ... Not that I am a pro or anything, but it’s very easy to come in and rattle off my little script and that is another way of ... not being in the moment. But as to the original question of “what am I feeling, anxietywise?” you know, I am <u>not</u> feeling the anxiety (*his emphasis*), which is probably the problem **[the patient's insight is hard to separate from self-criticism, or intellectualization, or anxiety]**
Th: What <u>are</u> you aware of feeling? **[going for what he is feeling, rather than for what he is not feeling]**.... Let’s stay with that because the issue of coming here is very very loaded ...
Pt: Yeah ... yeah (*patient looks away, looks perplexed, confused, at a loss*)
Th: Just when I said that, what was your experience? [**entry point into experiential exploration of relatedness**]
Pt: (*uncomfortable smile*) Umm ... expectation, like "come up with something to say" **[intervention evokes more harsh self judgment, projected outwards]**
Th: Is that what the smile is covering up? **[away from the head, focus on the body]**
Pt: No, that was uh ... What did you say? [**anxiety interfering**]
Th: I said “It’s very loaded ... You have a lot of feelings about coming here”
Pt: Oh yeah, (*patient is sweating, wiping his brow, holding his head*)...Ummmmm... I think.. . The laugh was like ... “tee-hee, I got lot of problems” **[more self-deprecation; shame]** and uh .... I think some of this is nervousness about working with you... Dr. M was a very good experience for me. Easily my best therapy experience. Most progress, most work [**explicit focus on anxiety and the therapist's willingness to help with confusion brings down anxiety; the patient can now articulate his basic conflict**] =She ... So, I kind of think I am missing that. I mean, this is like a funny dynamic here, where you pay some one to help you....
Th: No, but what you are saying here is very very important [**honoring the patient's true communication; cutting through defensive subterfuges, self-deprecations**]. That you had a very positive experience with her, felt very helped by her, did a lot of work ... And that, in a way, coming to see me brings home that you are not going to see her anymore.

It is seven minutes into the session and we have shifted the focus from self sabotage and what's bad about what the patient is doing, to starting to elaborate the context in which the patient's efforts can be understood as adaptive.

Pt: Yeah
Th: (*very empathic tone*) So that right off the bat, there is an experience of the loss of something very precious
Pt: Yeah, absolutely,... Ummm.... Yeah .... She ... I think I was aware while I was doing it of how helpful it was, but also ... **[his anxiety visibly less, he is looking sad]**
Th: And you know, I just feel.... I feel your feelings about it. That there's a lot of sadness [**pressuring toward core affect; anticipatory mirroring: the therapist already feels the affect the patient is struggling against**]
Pt: Yeah (*sighs deeply, twice*) Yeah, yeah and that's a lot of... I mean she was kind of describing some of your techniques, I don't know how fairly she can represent them, and I was thinking "oh, probably that wouldn't work for me," you know so I was kind of figuring out ways of not doing this and just sitting around and missing not working with Martha [**very clear articulation of dynamic; rise in therapeutic alliance**]. Mmmm ....
Th: Mmhmm ...

The aim has changed from first undoing the patient's self-deprecation, and then regulating his anxiety. Now with a clear dynamic emerging, the aim is to get past defensive blocks and help the patient access a core affect, which, at this point in the session appears to be his sadness over loss.

Pt: And it was weird ... in the lead up to the end, I didn't really... We did some end closure type things, but I didn't go into the last sessions with this kind of mentality
Th: Of missing or sadness?
Pt: Yeah... it was there some .. and she kind of expressed like, you know, the professional version of having a patient leave or whatever ... It was weird ... It was almost like .... I didn't just let myself feel it ... I had to use that as a cue to like "oh yeah ... this is ending, so I should probably feel something about it."
Th: [**therapist doesn't take bait of all negative self statements, but goes after the gist of the communication, refocusing on the here-and-now in the context of what was just elaborated**] ... In a way, I could understand why you wouldn't want to come to see me ... You put it in terms of sabotage... but there is this kind of a huge loss of a very important relationship with someone who has helped you a great deal [**i.e., a positive attachment figure**] ...
Pt: Yeah (*head nod*)

Dyadic affect regulation is now in operation: there is an entrainment of our respective rhythms as the oscillations of our head nods become increasingly yoked and synchronous. Also, the tempo of our speech has slowed. There is a lot of space between the words. We pick up the action 8 minutes later.

Th: ... Now, you said to me you felt very insulated from these feelings about really having a loss in your life
Pt: Yeah
Th: I don't know what you're experiencing, but you look mighty sad to me
Pt: (*laughs, nods his head, pauses, looks away, bites his lip*) Yeah.... I might be more depressed than sad
Th: You laughed again....
Pt: (*shoulder shrug*)
Th: What was your reaction to my saying that [i.e., that you look sad]?
Pt: Uh, I don't know ... I don't know (*seems shy, is giggling*)
Th: Go ahead (*encouraging tone*)
Pt: It just seemed funny, you know... your therapist telling you you look sad ... I know that it would be a valuable thing for me to feel.....
Th: When you say "it's a funny thing for your therapist to say," in what way? [**Note that I have become *his* therapist and not just *a* therapist**]
Pt: From the point of view of trying to feel better and get better, it's like ironic.... you want your therapist to say you look good, or that you're doing better ... I mean, I know I've been here (*looks at his watch*) all of 20 minutes, so that would be a stretch, but**…**
Th: So my saying that you looked sad felt like something negative....... See, to my mind, sadness, though it's a painful feeling, is very adaptive .... I mean, if you have a loss, you feel sadness ... It's not a failure, it's not a weakness, it's not a bad thing
Pt: (*smiles*)
Th: (*empathic, curious*) That smile tells me the entry points, about how this is getting in and how you're reacting to it. Tell me ... (*inviting*)
Pt: (*sobering, thoughtful*) Now I actually feel like there is a lot of sadness, like I want to cry or something ... It's like a relief ... You know, it's very easy to come and sense the expectation, not from you, but just in my own head, of me needing to do something or perform here or do whatever ... It's almost like a relieving giggle... Like oh yeah...
Th: (*encouraging*) Uh hmmm
Pt: Like this is safe or something, you know

The patient begins full of self attack, defensiveness, anxiety, and shame, with no access to the deeper experiences motivating his behavior. Instead of pointing out various destructive aspects of his moment-to-moment behavior, and getting hooked into an enactment where attachment figures tend to respond to his vulnerability with criticism, I

consistently attend to the glimmers of transformance: I offer support and empathy, while simultaneously maintaining a tight experiential focus, encouraging Lee to attend to his internal experience. Lee's belief is that getting connected with me as his new therapist means needing to relinquish his attachment to his previous therapist. As that assumption becomes increasingly articulated and clarified, he is able to relax into being in the session. We go from detachment and sabotaging of the new therapeutic relationship, to an implicit acceptance and settling in, as he talks about “you want your therapist to tell you that...’ implying that I have become his therapist. A few minutes later, he spontaneously declares “this is safe or something,” a strong green light for proceeding to deep affect work.

Vignette 2. Dropping Down: Sadness, grief, and unbearable loneliness.

This vignette illustrates the process of working with intense emotion, using the attachment relationship and dyadic affect regulation to help the patient through suffering. Here the therapeutic work consists of (i) somatically accessing the previously feared-to-be unbearable affective experiences, (ii) holding them and dyadically regulating them until they can be (iii) worked through to completion and (iv) their adaptive action tendencies, resources, and resilience, are released. In the process, the experience of unwilled aloneness in the face of feared-to-be-unbearable emotions has been procedurally alleviated: Lee feels not only not alone, but safe; and emotions, far from being unbearable for him, when processed together, turn out to lead to good stuff (Fosha, 2004b).

Pt:.... I cried some with Martha ... I cried a decent amount .. but then you know…
Th: But in a way, if you let yourself…just…more than anything else, if you allow something to happen ... And I am glad that you’re feeling some sense of safety [**the language of permission**]
Pt: Yeah
Th: That some of the performance aspects have at least for the moment been allayed or ...

Pt: Yeah
Th: So, if you were to imagine .... let yourself from this place, from here, say goodbye to Martha, and put into words to her what she meant to you and what you're giving up and what you're losing

Here, I am using the technique of portrayal to deepen and elaborate Lee's experience of grief (Fosha, 2000). Our attachment relationship is implicit and is what allows him to do the work he needs to do, i.e., grieving the loss of his previous attachment figure, while being himself and having my support.

Pt: I tried to write something, I did write something when I sent her the last payment... yeah... it was very valuable to me.... I could...
Th: What would you say to her? [**keeps focus, re-directs**]
Pt: I would say: "Thank you for getting me as close as I have ever been to the real regular old normal me." I was close enough to see it and be it for a little bit.
Th: Um hmmmuh
Pt: And you know... yeah...
Th: (*empathic tone*) So, it's upsetting to have to say goodbye to that
Pt: Yeah ... yeah ... she was ...she knew how to...
Th: (*making very supportive sympathetic noises and sounds as the patient is talking)*
Pt: She never like gave up on the whole thing [**left and right brain integration: the articulation deepens the feeling, and the deepening of the feeling allows for the deeper meaning and significance to emerge**]... which is frankly something ... it may sound very trite... but I think I find the ways in real life to get people to give up on me.
Th: (*echoes the patient, repeating some of his words*) ... to give up on you
Pt: Yeah
Th: So can you tell her... that?
Pt: (*with a giggle and a looking away, but still very very sad*) Yeah. "Thank you for not giving up... (*trying to hold back sobs*) ... and just always helping me realize that....
Th: .. and always.... [**helping: dyadic affect regulation**]
Pt: ... and always kind of bringing back to this focus on realizing a lot of what I am doing is to get off track, to give up on myself....yeah, I mean, I think I basically tried to spend two years to get her to give up on me and she never did
Th: Mmmmm (*appreciative*)
Pt: So I thank her for that. "Thank you for that."
Th: How does that feel to acknowledge that? I mean, it's very moving to me... [**metaprocessing remark, i.e., having done a piece of work, here saying goodbye to the former therapist, how does it feel to have done it?**]
Pt: Mmm.... Yeah, it feels sad... it feels lonely and scary... (*crying deeply*) ... [**as the meaning of the affective experience emerges, it further deepens the experience**]
Th: Um huh [**non-verbally being with the patient**]
Pt: ..... Coming up here and some of the things I want to do.....
Th: Stay with lonely and scary [**gentle redirection to remain connected to deep affect**]

Pt: Like ... at this stage, you're a very nice person but the alternative of me just trying it on my own doesn't feel very different than this at this second... It kind of feels like....
Th:.... kind of feels like.... [**helping, being with, empathic**]
Pt: .... like I am totally alone (*crying, voice breaking)*

Paradoxically, by Lee's being able to share with me his experience of aloneness, Lee is not alone; the secure attachment and dyadic regulation are operating implicitly as he is finally feeling held and helped enough so that he can articulate this true experience, which is of tremendous loneliness.

Th: (*very sympathetic sad non-verbal communication through sympathetic noises*).... That's a very old feeling.
Pt: Yeah, I felt that for a long time (*crying, but calmer*)
Th: Mmmmm (*more sympathetic noises*)
Pt: (*deep sighs, more crying*)
Th: It comes from a deep painful place
Pt: Yep..... I've been alone for my whole life, basically, and just trying to make it.... and now I have a couple of major things that mean that I am not alone but....
Th: But I am so struck that this touches this level of deep, life-long loneliness [**re-focus on deepest affect**]
Pt: Frankly, I've worked with not-so-hot therapists where I still felt lonely afterwards because you get used to it (*voice cracks again*)... To work with someone who was ...
Th: ... really there....
Pt: Yeah... good and productive, it makes it a lot more difficult. You know, I am married now, and that means I am not alone, and, you know I don't have tons and tons of friends, I could have a lot more friends, but I figured out ways to reinforce this lonely feeling because that's what like normal is to me.
Th: So then with Martha, in a way, there, for a couple of years you weren't alone [**de-facto, procedurally re-focusing the patient**]
Pt: Yeah, absolutely (*vigorous head shaking in emphatic assent; declarative tone of voice*)
Th: You had someone on your side
Pt: (*vigorous head shaking in assent*) Totally... (*long pause*).. So yeah, it is sad, and lonely and scary [**an integrative statement, with patient clear-voiced and no longer crying; declarative and feelingful, a marker for me that we had reached the end of one wave and that we were starting to come up**]
Th: The more I am feeling what I am feeling (*touching heart/chest area*), the huger the loss seems
Pt: Yeah
Th: Can you tell her, in your mind... If you were to imagine yourself talking to her from this place [**having reached a plateau, and worked through the unbearable feelings of aloneness, we return to a second round of the portrayal of grief with patient more resourced and resilient**] ... tell her what it means losing her, what it means saying

goodbye to her, what you will most miss about her? [**helping the patient not be alone with previously feared-to-be unbearable feelings: using the technique of portrayal to work through the previously warded-off grief**]
Pt: (*lighter now, head nodding*) It .... Yeah.... I'm not always good at the "pretend you're talking to her" thing... but uh .... (*very sad again, young voice*) I just feel like I had training wheels that are gone... that you know ... I very much felt like I was doing the work but it was a lot different than being alone
Th: Uh huh
Pt: So...
Th: And I gather that other people in your early life did not make you feel that way
Pt: No, no ... I guess that's another thing. With her I realized the depths of how absolutely chaotic my life has been and f'ed up (sic) everyone around me was and continues to be ..... I guess it is an interesting dynamic that the one who... that I am now losing the person who has helped me go all the way down to the real brass tacks or whatever of what I've been going through [**coherent, integrated narrative**]
Pt: .....(*the patient takes a deep breath, looks down, takes another deep cleansing breath, looks like* ***he's*** *absorbed in thinking something through, and then comes up: his gaze comes up, and he makes eye contact with the therapist, as he smiles*)
Th: You smile... what??
Pt: I guess now I am ready to do something else (*with a big genuine easy smile*) [**the affect wave is over. Having worked through his mourning, the patient is ready to now engage the world. It is very important to read this as a marker of completion of the wave and support the rise of the adaptive action tendencies and transformational affects, and not treat this as a defense against the depths].**

A beautiful and profound moment, somatically marked by two deep exhaling breaths, and a lifting of the eyes to make clear, direct, open contact. The essence of the mourning process is that when a wave of the grief is processed to completion (Freud, 1917; Lindemann. 1944), the self emerges out of its absorption in the loss ("The shadow of the object falls upon the ego") and energy is once again available for life -- for engagement with the world, and more specifically, for engaging with others.

The focus in this vignette is exclusively on the patient's emotional experiences which he was previously unable to process on his own. Dyadic affect regulation through right-brain to right-brain communication --non-verbal, attunement, affect sharing, echoing, and empathic elaboration -- helps him stay with deeply painful experience. As Lee is able, with help, to stay with and surrender to the experience of emotion, his

anxiety over the emotion decreases; the emergent phenomenon is integration. As one wave of emotional experiencing is completed, another comes forth. The worked through grief, first inaccessible, and then emergent, is now the new achievement. It becomes the platform for the next level of emotional processing, which involves the emergence of frightening feelings of loneliness, poignantly expressed: "I just feel like I had training wheels that are gone," an evocative image suggesting loss of control, *and* loss of support, coming from a very young self state (circa age 3 -- 6, whenever kids learn to ride a two-wheeler). And again, once that experience is processed and transformed through sharing, we see the upswing of the wave; the wave over, the patient comes up, so to speak, and liberated from under the yoke of unprocessed emotional experience, the adaptive action tendencies kick in. Deep sighs, uplifted gaze, and positive affect are the somatic markers that signal a state transformation is in progress.

Having dealt with the there-and-then, Lee is ready to be in the here-and-now. I take his statement of “Now I'm ready to do something else" at face value. So we do.

Vignette 3: Metatherapeutic Processing: The Transformational Spiral

> "*The notion of self here: "... is intensely alive and active... It is experienced in an aura of power.. The respite here is not passivity in the womb, not asleep, but an active seeing stillness, compact and electrifying.*" (Eigen (1973) quoted in Ghent, 1990**,** p. 220)

Now that the two waves of core affective experience have been processed fully, and that we have a green light to proceed, we can begin the metatherapeutic processing of the just undergone therapeutic experience. Alternating between experience and reflection, we move toward further deepening, solidification and integration of the gains we have made and the gains we will make along the way. We deflect the "soft" defenses

that come up (see Fosha, 2000). They need to be minded and attended to, for they are important; but like a good parent, we pay attention to issues of timing and we set limits-- *de facto* saying something like "not now, later." If these "obstructions," which are nothing more than heralds of what further needs to be addressed, are honored and respected (Schwartz, 2003), the process can continue to unfold.

There are three parts to the balance of this case study, capturing different aspects of the metatherapeutic process. In the vignette below, and the next two to follow, patient statements that are underlined document the progression of the transformational spiral:

3a. "The real me:" "Innate," "natural, " "wheels on the pavement"

Th: How are you feeling?
Pt: I feel some of the release of having felt that emotion [**post affective breakthrough affects**]
Th: Tell me
Pt: It's a little freeing [**post affective breakthrough affects]**
Th: A little more relaxed
Pt: Yeah (*head nodding*) [**the head nodding is a somatic marker of being on the right track, of being in sync]**
Th: How does it [**i.e., the work we have done**] make you feel about *you?*
Pt: (*long reflective pause*) (*moved, with tears*) Kind of reminds me of the real me **[healing affects: affirming recognition of self by self**]
Th: Mm huh
Pt: That the real me is like not necessarily this performer,... has all those attributes and skills but is a little more incisive than just always trying to be jokey
Th: So what's it like to make contact with the real you? [**further metaprocessing, the next rung of the spiral; having reached a new experience "the real me," that experience becomes the platform for the next wave of exploration**]
Pt: That always feel really good (*nice relaxed smile*) .... **[vitalizing positive affective marker associated with healing adaptive experience**] ...There is something very real about it.. You're right there.... [**the language of affective transformation tends to be simple, from the heart**]
Th: Right
Pt: Kind of like getting pissed at people, you're feeling it and you're doing it (*motions with his fists muscled motion*) And there is something empowering about that [**declarative expression of experiencing an adaptive action tendency; vitalizing positive affective marker**]
Th: Right

Pt: (*declarative tone*) The wheels are on the pavement [**very significant statement, given that he described his experience of loss and aloneness as "the training wheels came off": this current experience is a direct healing of that experience**]
Th: Which means what? [**the spiral of transformation**: **more exploration of newly articulated experience of 'the wheels being on the pavement"**]
Pt: Yeah (*big, strong, declarative "yeah*")... yeah... cuz the wheels haven't been on the pavement for about the last seven days
Th: And from this place of the real me, when you say "I'm in touch with the real me," again it touches something deep in you [**positive affects are also deep inside, not only negative affects like grief and rage**], there's a sense of the real me, there's a sense of control, the wheels are on the pavement, what's the feeling that goes with that? Because there's a lot of relief, you say it's good.....
Pt: Mmmmm..... (*pause*) mmmm....
Th: Hmmmmmm.... Just let yourself notice [**encouraging inner exploration**]
Pt: Notice?
Th: Notice...
Pt: It feels good.... It's the real me, but there is still ... It's all still very new... I still feel some skepticism about the real me version sitting here, which is like the first real me appearance kind of thing..... But uh..... [**the newly achieved experience of a positive sense of self is followed by the appearance of some old defenses**]
Th: But if you put the skeptic to the side for a little bit, I mean we will address that part of you too, because there's something to that part of you too, but if the skeptic doesn't mind stepping aside for the moment and just allow you to have this experience, and share it with me, 'cuz, again, it touches something .... inside you [**honoring defenses; respectfully asking them to step to the side**]
Pt: (*deep breath*)
Th: (*deep breath, matching and mirroring his*)... Yes ....yes....
Pt: It feels good ... It feels trite .... See, the skeptic has a hard time stepping aside... But that said, I feel confident and uh... **[patient moves past his defenses on his own**]
Th: (*affirming*) Mmmhuh ... you feel confident [**mirroring, echoing**].....
Pt: I feel confident and uh... like, ready to act...... [**declarative expression of experiencing an adaptive action tendency; vitalizing positive affective marker**] This is like 50% genuine
Th: OK, so within this kind of 50%, staying with that first, and then we'll address the other 50%, ...but to just stay here, because it feel very important.... When you touch this and when you feel and when you have the sense of authentic, the sense of real me inside, there's release, there's relief, it feels good, and then you say something else that's very important ... that you feel confident... confident, wheels on the pavement, ready to act
Pt: Yeah
Th: And what does that feel like?
Pt: It feels good... ..it feels ....it almost feels like I don't need to describe it, I know that that's the helpful thing to do, but it just feels innate, [**core state assertion of experiential truth: state of assurance**] it just feels like .. you know.... I think it's the basis of something that makes me go off in not the greatest direction all the time but... (*sits up straight*) ... I feel like I got a lot of strong abilities and qualities that I am still trying to get on the pavement and when I feel this way, in touch, all that just feels...

Th: Natural
Pt: Natural and do-able and like ...... (*voice shifts to a more certain tone of voice*) .... [**declarative assertion of subjective truth; state of assurance; translating into confidence about being able to take effective action on behalf of the self; the declaration of self by self and its accompanying positive consequences**] Being creative (*direct, declarative here*)
Th: So that's the part that feels base rock, solid, like this kind of innate, natural kind of native creativity.

Through the transformational process, the sense of self is becoming increasingly positive and solid (Fosha, 2006, Russell & Fosha, in press). When the patient says "innate," it is like he has been reading the AEDP manual, except of course for the fact that he is, so to speak, writing the manual. Innate, natural, confident, ready to act. Indeed!

3b. "More like myself, rather than less like myself"

This vignette begins with the therapist summarizing what the patient has said about his feelings about working with Martha, and about having said goodbye to her.

Th: Even though you haven't used the word, I sense your gratitude toward her
Pt: ... Yes, I am (*moved to tears*)...... And I am also having this feeling of appreciation of myself, too [**healing affects of feeling moved by spontaneous recognition, affirmation, and appreciation of self by self]**
Th: Yes, yes

A few minutes later:

Th: Uh huh.... but that in recognizing Martha and what she's meant to you and what she has contributed to your life, you're also recognizing what you have done...that you too have participated... and that it's something that you've done together... that she may have been a wonderful guide, and wonderful in unprecedented ways
Pt: Totally
Th: But that you too worked with your sleeves rolled up, side by side with her....
Pt: Yeah.... yeah [**deep affirmation**]
Th: .... and that acknowledging that sort of puts you in touch with your feelings (*patient nods*) ... What's coming up for you?
Pt: More of the same
Th: Well then, let's stay with it
Pt: I never ...... I kind of never thought I would get that close... There were certain days and certain points that I could see it really happening and I could see me as a fully actualized person... still coming to therapy, or not... you know, being the way I am in a good session, like as a normal thing… like that would be my regular life... and that just

feels like constant home runs......*the whole critical thing goes away* (moved, tears in his voice)... because when I am in one of those moods, there is no critical [**patient's own awareness that core state being is pure: no defenses, no self-attack**]... Everything can be figured out in some way [**assertive declaration of competence, mastery, adaptive action tendency**]..... yeah, I used to use this example with her.... I used to smoke cigarettes. And there was a point where I didn't think I was going to be able to quit. I just ... and I was disappointed by that. .... when I imagined quitting, I imagined waking up and being a different kind of person.... and you know, realizing that I was the same person, I just didn't smoke." Which is kind of a good thing.
Th: So that you succeeded
Pt: ..... so I wouldn't be something different, I wouldn't have to necessarily re-invent myself.... it's not like the fixed me is going to feel different or.....or think about things differently
Th: But rather that it's finding you, more than....
Pt: I guess I would be more like myself, rather than less like myself [**declaration of self, more recognition of self by self; core state truth**]

This vignette illustrates the clear link between effectiveness and self-efficacy, and core positive self identity**--**and the dialectical amplification between the two. The patient goes back and forth between the theme of control, competence and mastery, on one hand, and the solidity of himself as an authentic person, on the other. When fully in contact with these experiences, the critic does not have anything to say: in touch with "the real me," there is no critic.

It is interesting to note how this comes about: As we do a last round of processing his loss of a positive attachment figure, acknowledging her contribution to him and exploring his gratitude towards her, he spontaneously asserts that he also appreciates himself, a beautiful example of what I mean by an emergent phenomenon. Through the other, arises the self. Finally, in the next vignette, one last round of metaprocessing yields another wave of healing affects, expressed with an almost biblical eloquence.

Vignette 3c: "The gratefulness of me"

Th: So far, just how does it feel to share this with me?

Pt: It's definitely a relief... yeah, I mean, like all the things we've been saying [**notice the "we"**] I really felt sad .... I kind of feel this gratefulness of me kind of thing.... [**healing affects, stated with extraordinary, spontaneous eloquence**]
Th: That's beautiful
Pt: It's still new, I'm still in New York, for 10 minutes in there I was like hanging on to myself, so like ... OK we're still there kind of thing
Th: (*low, deep, moved voice*) The gratefulness of me..... that's wonderful
Pt: (*pleased, touched, serious*) Yeah

The Phenomenology of Healing

The sequence that is to follow, a summary of the phrases underlined above, documents the phenomenology of healing. Once the healing transformational process is activated, and supported, its progression has an inexorable quality. Note the simplicity of language, whether straightforward, direct and declarative, or else elegiac.

"I feel some of the release; It's a little freeing ---> Kind of reminds me of the real me. That always feels really good ---> You're feeling it and you're doing it; And there is something empowering about that ---> The wheels are on the pavement. It feels good ---> It's the real me. ---> "I feel confident, ready to act. It feels good." ---> "Innate." ---> "Natural and do-able. ---> Creative. ---> I also feel an appreciation of myself ---> Obviously I *do* have a great deal of control over exactly how I do all of this stuff. It's very empowering. ---> Everything can be figured out in some way. ---> More like myself, rather than less like myself ---> This gratefulness of me.

As a result of not being alone, and a relentless therapeutic focus on his own capacities for healing, Lee is able to process his grief about an attachment loss, and share his deep feelings of aloneness, thus paradoxically transforming them. The foundational process by which changes become self is almost palpable.

Following this session, the patient regained his control over his sexual addiction, which he has maintained, with only very occasional mild, and largely mindful, single episode lapses.

SECTION 3. DISCUSSION, SUMMARY, AND CONCLUSIONS: AEDP AND EXISTENTIAL-INTEGRATIVE THERAPY

We are living in exciting times. Body, mind, heart, attachment, identity, and healing are seamlessly being integrated into a discourse where practitioners of affective neuroscience, psychotherapy, philosophy, and mindful Eastern practices are actively engaged in lively interdisciplinary exchanges. Integration is not something we strive to achieve but is a condition of the very phenomena and processes that we as psychotherapists are concerned with. Our models of mind, body, and development, of suffering and stress, and of treatment and healing are finally catching up with their intrinsic rich complexity.

This chapter has been concerned with describing the arc of transformation that characterizes the processing of intense emotion to completion in AEDP. It naturally links "creatureliness" with "godlikeness" through a moment-to-moment experiential journey taken together with a caring, affirming, affect-facilitating true other. I also wanted to document the unfolding phenomenology of the process of healing, once previously disowned emotion is processed and (re)-owned.

Being invited to contribute a chapter to this august collection was not only an honor, but also an opportunity to learn, a gift for which I am grateful. In reading the works of existential writers, the experience I have had has been one of unbroken head-nodding (cf., rhythmic oscillation as a marker of dyadic resonance) at the extraordinary resonance between AEDP and the writings of existential clinicians and philosophers, with of course the powerful vitalizing energy that accompanies experiences of recognition (both recognizing and feeling recognized). My first reaction was "How uncanny!" My second reaction was "How validating!" And my third reaction was "Of course!" The "of course" has to do with a shared passionate interest in and humbleness before the power and richness of healing transformation. My contribution here is an ode, and a testimonial, to that power.

We are not in the realm of invention here. We are in the realm of mining what is there and learning how to best access it. It is not surprising that phenomena (a phenomenological bent and a respect for phenomena is deeply shared by both AEDP and existential therapy) carefully focused on and respected, should yield their secrets to different explorers. The gold is there and it has certain properties. Seeking it, many of us have found it. Some of us have found it looking for gold, for others of us it's been serendipitous, finding it while looking for something else, as often happens with progress in science. The phenomena will continue to instruct us and guide us, as our ability to see and inquire becomes more sophisticated as we gain experience and learn from one another.

I chose the session presented above because it is a wonderful illustration of how we can swing from the depths of despair and self loathing to the accessing of deep

resources which feel like the fundamental essential self. But since this is an integrative experiential psychotherapy casebook, I also chose it to foster the explorations between AEDP and integrative existential therapy as I am beginning to understand it.

The dialectical tension between opposite poles of existence and experience -- between the individual and the dialogic/dyadic, between the anxiety and dread at the root of human existence and the actualization of potential equally at the root, between biology, and thus the body, on one hand, and the spiritual and the mystery of being on the other-- is deeply and broadly acknowledged by existential writers (Schneider, this volume). I am well aware that the efforts to bridge these dichotomies are precisely what the integrative existential sprit is about and I hope to learn more. And yet, it seems to me that while in theory, the idea of dialectically connected opposites is strongly held, in clinical writings, different writers tend to focus on and identify with one pole or the other. The embrace of either hope and healing potential or the inevitability of dread tend to be differentially emphasized, and rarely connected together through the transformational arc where these phenomena are intrinsically linked through how we are wired and what happens when emotions can be regulated and processed to completion. Similarly, the tension between the individual's personal quest and the realm of mutual discovery appear more polarized in practice than in the dialectical existential theory.

What I hope to contribute to the discussion is yet another integration and transcendence of these dichotomies by shifting to a complementary conceptual framework, one that mother nature provides in an already integrated form. And that is the attachment & emotion & transformation model that informs AEDP theory and practice. AEDP embraces both aspects of all these polarities and does so organically, and not as a

result of integrative effort. What allows it to do so is an attachment-based stance, a grounding in the bodily-rooted experiential method, the focus on the dyadic regulation of intense affects within a dyadic relationship, and the notion of working with the self-at-worst from under the aegis of the self-at-best.

There are two aspects of AEDP that I offer as possible ways of promoting the integrative dialogue that this volume seeks:

1. The idea of dyadic affect regulation of intense emotions within an attachment relationship bridges the dependence/independence dichotomy: a central tenet of attachment theory, and one that has received robust empirical validation from countless studies is that the safety of attachment promotes an expanded range of exploration. The safer we feel, the more we are willing to take growth-promoting risks. Another unnecessary polarization, that between positive and negative affects, is also seamlessly bridged. As discussed above, optimal dyadic affect regulation is not achieved via uninterrupted blissful attunement, but rather is the result of countless cycles of attunement, disruption, and hard-won repair. Like Schneider (2006, personal communication) says: "The temporary and often inadvertent suspension of safety, disappointment, terror and the like, can often be gem-like in their power to transmute and to heal." It is precisely through actively engaging these moments dyadically that expansive growth takes place. The safety of the firmly established, and re-established therapeutic bond allows the exploration of emotional experience in a much deeper way than leaving the individual, a fortiori the traumatized individual, to his own devices.

The dyadic experience contributes to the greater coherence of the self organization of each dyadic partner. In turn, the expanded consciousness of each dyadic partner

contributes to the richness of the dyadic interaction and its emergent phenomena. At any one moment, one of these elements is in the experiential, exploratory foreground, while the others are in the background, but they are all in operation integratively, moment-to-moment, and at all moments. Dyadic affect regulation is a way by which the dyad can help the individual process intense, otherwise overwhelming and potentially traumatizing, emotions. But through the dyadic processing of emotion, as I discussed at some length above, the bond between dyadic partners is strengthened, deepened, and enriched. Thus the dichotomy between the relational/interactive/dialogic/intersubjective dimension (a horizontal dimension) and the emotion/depth/exploratory/intrapsychic dimension (a vertical dimension) is bridged through the intrinsic properties of the dyadic affect regulation process.

2. The moment-to-moment processing of emotional experience to completion, guided by somatic transformational markers, in the context of dyadic safety, empathy, and help, describes a transformational arc, as we saw above. This arc naturally and organically links suffering and flourishing, pathology and healing, action and grace, and biology and transcendence. In addition, through the further metatherapeutic processing of transformational experience, we are able to deepen and expand transformation and organically promote integration from the inside out.

In closing, the idea of transformance as the healing motivational counterpart of resistance can function as an organizing construct for the various strivings--be they dialogic or identity-questing, biologic or transpersonal, emotional or relational, for meaning or well-being-- by which we seek to transform ourselves. The construct of transformance, in other words, gathers under its aegis progressive motivational forces

that, when engaged, promote authenticity in relation to ourselves and others, and foster effective and meaningful lives.

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