THE ACTIVATION OF AFFECTIVE CHANGE PROCESSES IN ACCELERATED EXPERIENTIAL-DYNAMIC PSYCHOTHERAPY (AEDP)

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THEORETICAL CONSTRUCTS

Accelerated experiential-dynamic psychotherapy (AEDP) is a model of psychotherapy that integrates psychodynamic and experiential elements, and does so within a relational framework (Fosha, 2000a, 2000b, 2001b; Fosha & Osiason, 1996; Fosha & Slowiaczek, 1997). The fostering and provision of new emotional experiences is its method and its aim. This is achieved through harnessing the transformational power of the core affective experiences associated with naturally occurring change processes involving *emotion*, *relatedness, the self*, *the body,* and *the process of transformation itself*. In optimal circumstances, these processes develop in the context of affect-regulating attachment relationships with caregivers; they are blocked or derailed when psychopathology-engendering life experiences prevail. It is precisely these naturally occurring affective change processes that AEDP seeks to reactivate.

The notion of a *state transformation* is fundamental to AEDP. A particular emotional state has a characteristic organization of arousal, attention, motivation, affect, cognition, and communication; the principles by which these psychological functions operate differ from one state to another. For instance, different principles underlie the neurophysiological and psychological functions characteristic of sleeping and waking states, or of states of trauma-induced shock and relaxation. A "state transformation"

refers to a change which is neither gradual nor graded, but rather involves a quantum leap; there is a qualitative change to an altogether different organization which is discontinuous with the one that preceded it. Deep and direct emotional experiencing activates a *state transformation*, in which the body landscape and the concomitant psychic functions are organized according to a different principle. It is not just that the individual is feeling more or less: in this new state, body physiology, information-processing, affect, memory, cognition and communication, as well as subjective self-experience, are organized in a fashion that is optimally conducive to effective therapeutic work. The work proceeds differently, and better, than it does in states in which emotional experiencing is not in the visceral foreground or is actively blocked off.

The key mutative agent in AEDP is the state transformation leading to the visceral experience of core affective phenomena within an emotionally engaged dyad (Fosha, 2000b; Fosha & Slowiaczek, 1997). In turn, the visceral accessing of core affective experiences leads to a *further state transformation*: In the new state, referred to as the *core state*, intense, rapid, and mutative work readily takes place. The therapy goes faster, deeper, better; the patient has a subjective sense of "truth" and a heightened sense of authenticity and vitality; very often, so does the therapist (Fosha & Osiason, 1996). When we are outside these transforming affective states, therapeutic activities aim at getting access to them; when we are "there," therapeutic activities aim to make the most of the healing opportunities inherent within them. It is these state transformations the AEDP therapist seeks to bring about from the initial moments of the

first therapeutic encounter and, from then on, moment-to-moment throughout the entire course of the therapy.

AEDP is rooted in the tradition of the experiential short-term dynamic psychotherapies (STDPs, Alpert, 1992; Coughlin Della Selva, 1996; Davanloo, 1990; Fosha, 2000b; Magnavita, 1997; Malan, 1976; Malan & Osimo, 1992; McCullough Vaillant, 1997; also see Fosha, 2000b, appendix, and Osimo, in this volume, for a history of the experiential STDPs). A deceptively simple schematic representation, *the triangle of conflict* (Malan, 1976, 1979), captures the psychodynamic basics at the heart of the experiential STDPs (see Figure 13.1). The individual's experience and expression of basic impulses and feelings lead to conflict and become associated with anxiety. Defense mechanisms are

Figure 13.1 Here. The Basic Triangle of Conflict

instituted to ward off the negative emotional consequences associated with the direct experience of impulses and feelings, and of anxiety. However anxiety relieving in the short-run, long-term reliance on defense mechanisms restricts and distorts the personality, causing the life problems and psychopathology for which the patient seeks help.

The experiential STDPs have been distinguished by innovations in stance and technique to rapidly overcome defenses, minimize the impact of anxiety, and facilitate direct and visceral access to the experience of previously defended-against feelings and impulses in the here-and-now relationship with the therapist. The acceleration of the experiential STDPs is not achieved through selecting a focus à la Malan (1976) or Sifneos (1987), identifying a core theme à la Luborsky (Luborsky & Mark, 1991) or Mann

(1973), or setting a time limit in advance à la Malan (1976) or Mann (1983). Rather, accelerated change results from the deep and rapid transformations that occur in the wake of affective breakthroughs, and the full processing of viscerally experienced emotion.

A model of therapy needs in its essence to be a model of change. The metapsychology of the therapeutic process should not be derivative from a theory of psychopathology, but rather should function as a strong explanatory framework in its own right. However, because the psychoanalytic/psychodynamic tradition from which the experiential STDPs emerged did not do justice to the rapidly transformational phenomena yielded by the application of their innovative techniques, for many years the experiential STDPs were a therapy without a theory.

Traditional psychoanalytic theory has been unequaled in its understanding of the processes through which psychopathology develops and is maintained. However, this depth of understanding of psychopathology has not been matched by a depth of understanding of the phenomena of healing. Whether explicating therapeutic change or developmental change, the psychoanalytic theory of change remains wedded to pathology. For example, in the Kleinian tradition, stages of normal and universal development are given clinical names (e.g., the *schizoid* and *depressive* positions), and the depressive position is seen as being as good as it gets. A transformational model rooted in pathology is much better at explaining how and why things do not change (or get worse), than it is at explaining how and why things get better.

The deep and rapid transformations that can be observed in the wake of the affective breakthroughs of the experiential STDPs push us to develop a model for therapy that can explicate the phenomenology and dynamics of change. Several bodies of theory and research have proved useful in helping to restructure traditional psychodynamics. AEDP has evolved a model that integrates their findings and insights on (1) emotion, (2) the regulation of infant-caregiver affective interactions, (3) the empathic reflection of the self, (4) somatic focusing, and (5) transforming experiences, so as to be able to account for the therapeutic phenomena that emerge when the techniques of the experiential STDPs are applied.

EMOTION. Emotion theory and affective neuroscience offer an account of change intrinsic to the experience of the categorical emotions (Damasio, 1994, 1999; Darwin,1872; James, 1890; Lazarus, 1991; LeDoux, 1996; Siegel, 1999; Tomkins, 1962, 1963), universal phenomena characterized by specific neurophysiological and body signatures, and by the state transformations and adaptive action tendencies released on their experience and expression.

THE REGULATION OF INFANT-CAREGIVER AFFECTIVE INTERACTIONS. Attachment theory and the work of clinical developmentalists on moment-to-moment mother-infant interaction document how optimal development and life-long resilient functioning have their roots in child-caregiver dyadic processes, highlighting the changes that occur as the result of the processes by which infants and caregivers moment-to-moment mutually regulate affective states (Beebe & Lachmann, 1988, 1994; Emde, 1981, 1988; Schore, 1994; Stern, 1985; Trevarthen, 1993; Tronick, 1989, 1998) and

achieve safety and resonance despite the vicissitudes of attachment and relatedness (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1982, 1988; Fonagy, Steele, Steel, Moran, & Higgitt, 1991; Main, 1995, 1999).

THE EMPATHIC REFLECTION OF THE SELF. Empathy-based philosophical and therapeutic approaches (Buber, 1965; Greenberg, Rice, & Elliott, 1993; Kohut, 1984; Rogers, 1961), *attachment theory* (Fonagy, Steele, Steele, Higgitt, & Target, 1994; Main, 1995), and *affective neuroscience* (Schore, 1994; Siegel, 1999) all document the transformational impact of self-reflective processes (the capacity to reflect on one's self born out of engaging in a reflective relationship with an other) on optimal development in general and emotional resilience in particular. The resulting high self reflective capacity is a powerful protective factor against the development of trauma and has been shown to be one of the most powerful agents in stopping the intergenerational transmission of psychopathology.

SOMATIC FOCUSING. The somatic focusing experiential tradition has documented a process where the psyche is transformed through the simple shifting of focus away from in-the-head cognition and toward moment-to-moment in-the-body sensing and feeling, a process that restores access to natural healing processes rooted in the body's basic adaptive mechanisms (Gendlin, 1981, 1991; Kurtz, 1990; Levine, 1997).

TRANSFORMING EXPERIENCES. A study of experiences that lead to rapid and profound change [see James, 1902, on religious conversions, Person, 1988, on intense love experiences, and Buber, 1965, on authentic mutual communication] reveals that a

focus on the experience of change itself triggers a deep transformational process with far-reaching consequences.

These works offer ample evidence of the mechanisms through which naturally occurring affective phenomena lead to rapid, deep, and long-lasting change. By going back and forth between clinical process and experience, on one hand, and the empirical literature, on the other, a first approximation of a metapsychology of therapeutics emerges.

AFFECTIVE CHANGE PROCESSES AND OPTIMAL DEVELOPMENT

AEDP has elaborated five affective change processes that, when harnessed in the therapeutic process, lead to powerful therapeutic results: (1) the experience and expression of core emotion; (2) the dyadic regulation of affective states, where the experiential focus is on the relational process; (3) the empathic reflection of the self, where the focus of both partners is on the experience of the self (of the patient); (4) somatic focusing, where the experiential focus is on the body; and (5) the activation of metatherapeutic processes, where the focus is on the very experience of transformation itself. All the change processes documented here are dyadically constructed and regulated. The hallmark of each process is a characteristic *core affective experience*, associated with a transformation of state specific to its mode of action. These change processes operate moment-to-moment; have clear-cut affective markers; operate through transformations of state, in which the new state is characterized by greater

access to emotional resources to promote higher adaptive functioning; and thus, operate in quantum leaps rather than in a gradual and cumulative fashion.

A direct consequence of the focus on change and the study of affective change processes is an appreciation of the crucial role of positive emotional experiences in therapy. Because much of what has to be renegotiated in the course of treatment are difficult, painful experiences, at times of feared-to-be-unbearable proportions, therapy is commonly assumed to focus, of necessity, on the bad stuff; positive affective experiences are seen as the outcome of therapy, not inherent in and integral to the processes of therapy. There is no denying that the in-depth exploration of painful overwhelming matters is often excruciating, but the study of the features of processes of change has alerted us to previously ignored or misinterpreted phenomena. Not only are positive affective experiences part and parcel of the *moment-to-moment process* of transforming suffering, they are integral to a therapy that places a premium on effectiveness and efficiency, along with depth and thoroughness.

Naturally occurring affective change processes assume an affect-regulating emotional environment; they are rooted in an attachment matrix. The self's relationship with a caregiving other leads to the creation of the safe, affect-facilitating environment. Such an emotional environment allows these affective change processes to unfold, release their adaptive consequences, and access resources that are at the foundation of optimal functioning. Thus, the foundations of AEDP are in attachment theory. The attachment figure functions as a safe base (Ainsworth et al., 1978), a protection against danger, a presence that obviates fear. Alone, the immature organism is in danger, its

very survival at stake. With a safe base, instead of aloneness and fear, there is the feeling of safety. The attachment relationship becomes internalized; the child can maintain the feeling of safety even when the caregiver is not physically present. The greater the feeling of safety (i.e., the greater the security of attachment), the wider the range of exploration and the more exuberant the exploratory drive (i.e., the higher the threshold before novelty turns into anxiety and fear).

In optimal development, an affect-facilitating environment supports the unfolding of core affective phenomena, thereby releasing adaptive processes that are fundamental to our optimal functioning and well-being. Viscerally experiencing deep emotion within an affect-facilitating relationship induces a state transformation that helps patients master vital psychological processes with profound implications for their life. The affect-facilitating environment is dyadically constructed, internalized, recreated, and reconstructed throughout the life span. The attachment relationship is negotiated and becomes established, elaborated, and differentiated through the engagement of both partners in the crucial processes by which transformation (i.e., growth, development, and learning), takes place through the interaction of self and environment. And those crucial processes are the naturally occurring change processes detailed below.

Applying the attachment model to the therapy situation: it is essential to establish a patient-therapist relationship in which the patient feels safe. From within an attachment perspective, emotional safety is defined as not being alone with frightening experiences. The safer the patient feels with the therapist, the greater will be that patient's capacity to explore the inner worlds of disturbing, frightening, and painful emotional experiences. In

AEDP, we seek to proceed from a position of safety so as to be able to explore what is frightening, shameful, painful, and problematic. In both development and therapy, in a safe, affect-facilitating environment, affective change processes can be harnessed for the optimal adaptation of the individual. AEDP seeks to harness the power of these natural affective change processes to effect therapeutic results.

Therapeutic work with the affective change processes is thus a two stage process, involving three states (defense, core affect, and core state) and two state transformations (from defense-dominated state to core affect, and from core affect to core state):

The full visceral experience of a specific core affective phenomenon constitutes the first state transformation. When interventions aimed at counteracting defenses, anxiety, and shame are effective, *core affective experience* is accessed. The state that occurs under the aegis *of direct and visceral core affective experience* is discontinuous with the defense-dominated state that precedes it. There is deep access to experiences that are crucial to adaptation and the characteristic processing is right-brain mediated (i.e., largely sensorimotor, image-dominated, visceral, non-linear, etc., Siegel, 1999, 2001). There is also much greater access to previously unconscious material (i.e., emotionally-laden material previously inaccessible for dynamic reasons), a phenomenon referred to in the experiential STDP literature as "unlocking the unconscious" (Davanloo, 1990).

The shift from core affect to core state represents the second state transformation. This shift is invariably accompanied by positive affects. Thus, the full experience of core affect, unhampered by defense, culminates in the activation of another state, the *core state*, in which therapeutic work is at its most effective. In the core state, there is also no

anxiety or defensiveness. The body is not rocked by any particular emotion. Instead, there is openness, vitality, relaxation, ease, and clarity. Working through, integration and therapeutic consolidation optimally occur in the core state; here, therapeutic changes take root.

Core affect is like a spotlight, intensely illuminating a previously obscured segment of the emotional landscape that requires our attention. Once we attend to that segment, we gain a new perspective on our emotional life. In core state, the entirety of the emotional landscape is visible, and it is evenly illuminated.

The following example illustrates the difference between core affect and core state: In working with a patient's whose presenting problem involved anxiety-driven inhibitions in major areas of her life, experientially focusing on some current inhibitions led to memories, visual and somatic, of an earlier trauma. The patient became deeply immersed in the terror and grief associated with an accident she had been involved in when she was a teenager. The full experience of terror and grief (core affects) associated with the accident was followed by the visceral experience of rage (core affect) at her parents for dismissing her distress in their eagerness to restore the appearance of normality. Through completing the full experience of grief, terror, and rage together with a supportive other (the therapist), the patient accessed a core state, in which --with feeling and emotional conviction-- she articulated her newly emergent understanding: the events that led to the accident, the accident itself, and its aftermath, were a microcosm of a lifetime of parental neglect and a childhood where a "road map" was always lacking. Freely and meaningfully roaming between the past and the present, the patient was able

to articulate with startling clarity her life-long emotional experience, making sense of her current difficulties and putting them in perspective (core state). Furthermore, she was able to do so with greater self-empathy than she had ever been able to muster toward herself prior to this work.

The phenomenology characteristic of each affective change process is

Table 13.1 Here. The Phenomenology of Change Processes

described in Table 13.1. These change processes require an affect-facilitating emotional environment to support and emotionally engage the person who is activating, experiencing, and processing these phenomena and their sequelae.

The Experience of Core Emotion as a Process of Change

The experience and expression of emotion is a profound transformational experience. As William James (1902) wrote:

> "Emotional occasions . . . are extremely potent in precipitating mental rearrangements. The sudden and explosive ways in which love, jealousy, guilt, fear, remorse, or anger can seize upon one are known to everybody. Hope, happiness, security, resolve . . . can be equally explosive. And emotions that come in this explosive way seldom leave things as they found them" (p. 198).

Emotions are crucial vehicles for adaptation (Damasio, 1994; Darwin,1872; Fosha, 2000b; Greenberg & Paivio, 1997; Lazarus, 1991; Tomkins, 1962, 1963). Being aware of, in touch with, and able to express emotions help individuals access biologically adaptive

information that can assist them in negotiating life (Greenberg & Safran, 1987). Emotions convey information about the individual's appraisal of the environment, focus attention on what is most important to him or her, and thus motivate actions (in self) and responses (in others). Mediating interactions between self and environment, emotions are sources of information and personal meaning, and underlie experiences of authenticity and liveliness. The full cycle of experience and expression of emotion involves attention, appraisal, experience, information-processing, expression, and communication (Fosha, 2000b).

Categorical, or core, emotions are deep-rooted bodily responses with their own specific physiology and arousal pattern (Ekman, 1983; Zajonc, 1985). Fear, anger, sadness, joy, disgust, all core affective phenomena, are each characterized by their own "distinctive biological signatures" (Goleman, 1995, p. 6). Two state transformations emerge from the process of fully and viscerally experiencing core emotion in the absence of defenses, anxiety or shame:

The direct and visceral experience of core emotion involves a state transformation. Fully accessing a particular full emotion puts the spotlight on an area that requires the individual's heightened attention. The emotion is both spotlight and perceptual filter. The individual can thus address, appraise, become aware of, and understand the meaning of the situation arousing the emotion, and process its unique salience for him or her. Core emotions are also powerful motivators for action. Finally, core emotion constitutes a royal road to the unconscious (Fosha, 2000b, 2001a). Through the specific emotion, the individual gains access to the previously unconscious network of feelings, thoughts,

memories, and fantasies associated with the emotion. This is what allows the deep working through of dynamic material related to the roots of the patient's pathology. Thus, the experience of core affect reliably actualizes the fundamental psychoanalytic agenda of gaining access to the unconscious.

The second state transformation, from core affect to core state, is marked by the release of *adaptive action tendencies*. The very experience of the emotion activates emotional resources within the individual, essential to the resolution of the problem requiring heightened attention. Each emotion is associated with an adaptive action tendency: "Each emotion offers a distinctive readiness to act; each points us in a direction that has worked well to handle the recurrent challenges of human life" (Goleman, 1995, p. 4). With the release of the adaptive action tendencies, the individual (re)gains access to deep emotional resources, renewed energy, and an adaptive repertoire of behaviors, leading to enhanced functioning. The individual's new responses reflect access to new emotional information—about the self, the other, and the situation—that was not accessible prior to the full experience of the emotion. Even when the categorical emotion is itself negative and/or painful, as in the case of anger or grief, the core state that follows the release of the adaptive action tendencies is experientially highly positive. For example, the adaptive action tendencies released by fully experienced anger often include a sense of strength, assertiveness and power, which lead to the rediscovery of psychic strength, self-worth, and affective competence.

In normal development, and throughout the life cycle, emotions are regulated in a dyadic fashion. Through the dyadic process, the individual is are able to emotionally

process what he or she was not able to process alone, thus gaining access to the state-transformational potential of the core emotion described above (Fosha, 2001a, 2001b). Moreover, the dyadic process of affective regulation is a source of change in its own right; through coordinating emotions together, both partners are transformed. And this takes us to the second process of change, the dyadic regulation of affective states.

The Dyadic Regulation of Affective States as a Process of Change

Dyadic regulatory processes are involved in the optimal transformation of both relatedness and emotion, and thus of the self. As with emotion, adaptation is a central concept in understanding the function of dyadic regulatory processes.

The dyadic regulation of relatedness involves the attainment of coordination and collaboration between partners, allowing the simultaneous maintenance of connection and autonomy. Through emotional communication, we achieve equilibrium between self-regulation and mutual regulation. The regulation of affective states, when optimal, involves a moment-to-moment psychobiological process of *attunement* (the coordination of affective states), *disruption* (the lapse of mutual coordination), and *repair* (the reestablishment of coordination under new conditions). The coordinated state has positive affective markers and motivational properties; both partners experience pleasure on achieving coordination, strive to maintain it and work hard to restore it when it is disrupted. The disruption of coordination is associated with negative affect; in healthy dyads, it activates reparative tendencies, which kick into gear until the disruption and its negative affects are repaired and coordination and positive affects are regained.

Countless repetitions of the sequence of attunement, disruption, and repair lead to an affective competence, as the individual internalizes the affect-managing strategies of the dyad (Beebe & Lachmann, 1988, 1994; Fosha, 2000b, 2001a, 2001b; Tronick, 1989).

Experiences of attachment, connection, and mutuality lead to feelings of affective resonance, "in sync" states and experiences of trust, intimacy, and closeness. These, in turn, promote further security of attachment, feelings of safety, and trust. The experience of being able to repair the stress of disrupted relatedness (i.e., transform negative affects into positive affects and disconnection into reconnection), leads to the individual's confidence in his or her own abilities, and trust in the capacity of others to respond (Tronick, 1989). Success with efforts to repair dyadic disruptions leads to a certain emotional stick-to-itiveness which is at the heart of *resilience* (Fonagy et al, 1994) and *affective competence* (Fosha, 2000b). The process of moment-to-moment mutual coordination and affect regulation is considered to be the fundamental mechanism by which attachment is established (Schore, 2000). Furthermore, the maintenance of positive affective states associated with dyadic experiences of affective resonance has been shown to be crucial to optimal neurobiological development (Schore, 1996, p. 62; Siegel, 1999; Trevarthen & Aitken, 1994).

Here too we encounter the two-stage process of transformation:

The core affective experiences associated with the achievement of mutual coordination are affective resonance and "in sync" states, the "we" affects (Emde, 1988). Mutually acknowledging such experiences can “crescendo higher and higher,” leading to

"*peak experiences of resonance, exhilaration, awe and being on the same wavelength with the partner*" (Beebe & Lachmann, 1994, p. 157; italics added).

In the wake of these kinds of relational experiences—matching, affect sharing, and resonance—the core state comes to the experiential fore: relational experiences of openness, closeness, intimacy and mutuality, as well as an intensified sense of self predominate.

Thus, the dyadic regulation of both ordinary and intense affective experiences produces the changes that are essential for optimal development. This has uncannily precise parallels in treatment (Fosha, 2000b, 2001b). Research shows that the therapist's attunement to the patient's affective state and the patient's experience of feeling safe, understood, and affectively resonated with are probably the most powerful contributor to the achievement of positive therapeutic outcome (see also Rogers, 1957; Rosenzweig, 1936; Truax & Carkhuff, 1967). When both partners feel in sync—the experiential correlate of the coordinated state—and engage around their respective experiences, the individual feels deeply understood and mutative therapeutic work can take place.

The Empathic Reflection of the Self as a Process of Change

Reflecting the self through the empathy of the other is the next process of change and resource for deep therapeutic transformation that will be examined. Experiencing one's self reflected through the empathy of the other (Kohut, 1977, 1984) evokes change: making authentic contact with another, *a moment of meeting* (Buber, 1965), allows one

to go to a deeper place where something new and different happens (Stern et al., 1998) and the self is transformed.

Though this, too, is a dyadic process, here the focus is on the experience of the self, which both dyadic partners are engaged in fostering and elaborating. The dyadic process is in the background, the self is in the foreground, and the vehicle of transformation is the other's empathic reflection, mirroring, and understanding of the self's experience (Kohut, 1977, 1984). Openly exposing a self state to someone who meets it and welcomes it with understanding can indeed transform it (Rice & Greenberg, 1991). For example, the patient who can speak of his or her sense of inferiority to an empathic other end up feeling less inferior. In being responded to by an other who is emphatically attuned to the self, the individual changes, paradoxically becoming increasingly him or herself (Fosha, 2000b).

Empathically reflecting the self is yet another affective transformational process, with powerful affective markers for its two characteristic stages of transformation:

The experience of receiving empathy and having one's self experience mirrored, reflected, and empathically elaborated by the other gives rise to yet another class of core affective experiences, *receptive affective experiences*, the experiential correlates of feeling known, seen, loved, understood. Seligman (1998) notes: “Understanding is not *about* experience. It is itself an experience, and this experience involves the crucial presence of another person with whom one feels secure, in part by virtue of feeling understood by that person” (p. 84). McCullough Vaillant (1997) writes: “the receptive capacity is the substrate for vulnerability, openness, emotional connection, empathy, and

intimacy" (p. 294). The individual develops a deep sense of "existing in the heart and mind of the other" (Fonagy & Target, 1998; Fosha, 2000b). The therapeutic consequences of these receptive affective experiences of feeling deeply understood are profound: In addition to promoting authentic self experiences, such experiences are believed to be at the roots of secure attachment and emotional resilience (Fonagy et al., 1994) and to function as a major protective factor against the development of trauma (Main 1995, 2001; Siegel, 2001).

Fully experiencing and experientially processing receptive affective experiences facilitates the advent of the next stage, the emergence of *"true self" experiences*. True self experiences involve feeling "real," "alive," "authentic," and "like myself." Aspects of the core state, true self experiences may be accompanied by feelings of happiness, well-being, and relaxation, and by an almost aesthetic sense of simplicity, ease, and grace. One patient likened the true self experience to the sound of "a flute in a brass band." The experience of joy, authenticity, and aliveness, what the novelist Josephine Hart refers to as "the dazzling explosion into self" (1991, p. 41), echoes Fritz Perls's "explosion into joy, laughter, *joie de vivre* . . . [that] connect[s] the authentic personality with the true self" (1969, p. 60). The individual's sense of self is accompanied by vitality affects (Stern, 1985).

The therapeutic consequences of empathically reflecting the self and the affective transformations it elicits include a strengthening and consolidation of the sense of self; enhanced and more solid self esteem, and augmented empathy toward the self. When the individual's attention is focused on his or her self through the empathic

understanding and resonance of the other, the individual is presented with new opportunities for coping, mastery, and growth. Informed by growing self-empathy and self-acceptance, *adaptive self-action tendencies* are released: the individual realizes the nature of his or her basic needs and become committed to their realistic fulfillment.

Attachment research has shown that the parent's reflective ability is the key factor in the interruption of the intergenerational transmission of trauma (Fonagy et al., 1991, 1994; Main, 1995). Just one relationship with an attachment figure capable of engaging in a reflective relationship with the child promotes the child's development of his or her own reflective ability, which in turn is a major protective factor against the development of trauma (Fonagy & Target, 1998). These data provide empirical support for a core assumption of AEDP: The ability to process experience, together with an understanding other, is mutative; it transforms the experience, the self, and most likely the other (cf. Beebe & Lachmann, 1994; Beebe, Lachmann, & Jaffe, 1997; Tronick, 1989). There is also convincing evidence that it transforms what is interactionally communicated and intergenerationally transmitted.

Somatic Experience as a Process of Change

Somatic focusing theory also zooms in on adaptation and the organism's adaptive potential to self-regulate. Experiential clinicians, such as Eugene Gendlin (1981, 1991, 1996) and Peter Levine (1997), have documented the phenomenological shifts that occur when the focus moves from in-the-head cognition to in-the-body sensing (see also Kurtz, 1990). They argue that eons of evolution have built into the body the capacity to right

itself, what is referred to in the vernacular as the wisdom of the body. As with processes of core emotion and core relatedness, natural bodily processing of overwhelming events contain the seeds of healing within them (see also Emde, 1981, on self-reparative tendencies, and Winnicott, 1960, on the dogged search of the true self for conditions right for its emergence). "*The sense of what is wrong carries with it, inseparably, a sense of the direction toward what is right*" (Gendlin, 1981, p. 76).

The evolutionary development of, and human beings' increasing reliance on, the neocortex has led to the cortical overriding of more instinctual mechanisms in situations requiring reactions and skills that the cerebral cortex is not optimally suited to handle (LeDoux, 1996). Somatic experiencing aims to change the focus from intellectual and cognitive processes, and their experientially alienating consequences, to activating somatic processes by fostering a process of moment-to-moment tracking of the body's shifting experiences. Changes that involve shifting focus from the head (cognitive, intellectual, verbally dominated) to the body (somatic, sensory, visual) also lead to deep experiential results. Key to this is the *felt sense*, "the experience of being in a living body that understands the nuances of its environment by way of its responses to that environment" (Levine, 1997, p.69).

The process of somatic focusing -where there is an oscillation between experience and reflection, each feeding on the other- is a stepwise process that goes to the body.

The felt sense. The first state transformation involves finding *the felt sense*, "a bodily sense of some situation, problem, or aspect of one's life. …[A] felt sense must first be allowed to come; it is not already there. A felt sense is new. … It *comes* freshly, in

something like tearfulness or yawning *come* in on us" (Gendlin, 1996, p. 20; italics in original text).

The body shift. The next state transformation is brought about through then finding a *handle, i.e.,* the verbal expression that does justice to that felt sense. The joining of the experience with the label that accurately describes it -an invariably idiosyncratic and highly personal term- is accompanied by a *body shift*, a relaxation, a letting go, a release of tension.

> "With the emergence of such a single bodily sense comes relief, as if the body is grateful for being allowed to form its way of being as a whole…. When a step comes from a felt sense, it transforms the whole constellation.. in such a step or shift one sense oneself differently… When one has a felt sense, one becomes more deeply oneself" (Gendlin, 1996, p. 20-21).

The body shift, the state transformation associated with somatic focusing, is always in the direction of well-being.

Here, too, we see adaptive processes moving toward healing and positive changes, and the association of such processes with positive affective markers.

> "The irony is that the life-threatening events prehistoric people routinely faced molded our modern nervous system to respond powerfully and fully when we perceive our survival threatened. To this day, when we exercise this natural capacity, we feel exhilarated and alive, powerful, expanded, full of energy and ready to take on any challenge. Being threatened engages our deepest resources

and allows us to experience our fullest potential as human beings. In turn, our emotional and physical well-being is enhanced" (Levine, 1997, pp. 42-43).

Thus, by focusing on the sensations of the body with no agenda, another positive transformational process is activated in that a bodily core state marked by openness and relaxation is accessed. Even if the problem remains, the body is now in an optimal state where its capacities, its adaptive action tendencies, are maximally engaged. Furthermore, the very process of change itself, and not only its outcome, feels good. Therapists would do well to heed Gendlin's (1981) radical point, all the more profound for its simplicity: "Nothing that feels bad is ever the last step." (p. 25-26.)

Affective neuroscience provides further support. By having a process where there is an alternation of body-focused somatic experiencing (subcortical, right-brain mediated), with reflection on the somatic experience (cortical, left brain mediated), there is the opportunity for a comprehensive bilateral integration based on harnessing the information-processing potential and abilities of both sides of the brain, as well as of lower and higher brain functions deemed essential to optimal health (Schore, 2000; Shapiro, 2001; Siegel, 1999, 2001).

Metatherapeutic Processes and the Focus on Transformation Itself as a Process of Change

In the last change process to be examined, it is precisely the experience of healing and therapeutic success that becomes the experiential focus of the work. What is usually the end point of the therapeutic road is the starting point of this investigation. When successful therapeutic experiences themselves become the focus of therapeutic inquiry and work, it becomes possible to deepen and broaden the treatment's effectiveness (Fosha, 2000a).

The systematic exploration of the patient's experience of having a therapeutic experience activates highly reparative *metatherapeutic processes* associated with characteristic *transformational affects* (Fosha, 2000a). They are: (1) the *affective mastery process* and the transformational affects *of joy* and *pride*; (2) the *mourning-the-self process* and the transformational affect of *emotional pain*; and (3) the process of *affirming-the-self-and-its-transformation* and the transformational *healing affects*, i.e., feeling *moved*, *touched* or *emotional*, and feeling *gratitude*, *love*, *tenderness* and *appreciation* toward the affirming other. Thus, the very focus on the transformation in the context of the here-and-now of the therapeutic relationship releases mastery, mourning and receptive affirming experiences.

The transformational affects associated with the metatherapeutic processes -joy and pride, emotional pain and the healing affects- are all core affective phenomena. It is here that AEDP's specific therapeutic technique is most evident. Once these experiences emerge, they are privileged, focused on, enlarged, and explored with the same thoroughness and intensity as any of the other core affective experiences. The visceral experience of core affect produces a state transformation. In these cascading state

transformations, the deep experiential processing of one state becomes the trigger for the next wave. As in all other phases of AEDP, alternating waves of experiential and reflective work characterize the work with the metatherapeutic processes and their affective markers (Fosha, 2000b).

A focus on the process of transformation can be the catalyst for further transformations; experientially focusing on change that has already occurred activates further powerful changes. The process of transformation and healing is never-ending. The achievement of resolution at one level establishes a new plateau, which rapidly becomes the baseline from which the next cycle of transformation proceeds. By focusing on the patient's therapeutic experiences, we activate the metatherapeutic processes and their affective markers, the transformational affects. When fully experienced, these processes and affects in turn effect profound and beneficial transformations in our patients, consolidating and deepening already obtained therapeutic gains.

Summary of Change Processes: The Expansion of the Domain of Core Affective Experiences

AEDP focuses not only on the core emotions (labeled impulses/feelings in other experiential STDPs), but also includes the core affective phenomena associated with the affective processes of change, and the phenomena characteristic of core state functioning (see Figure 13.2).

Insert Figure 13.2 Here. The Expanded Domain of Core Affective Experience

The *core affective phenomena*, the results of the first state transformation, include: (1) core emotions, such as sadness, anger, fear, joy, disgust; (2) core relational experiences of and strivings for attachment, connection, intimacy, and closeness, including the "we" affects of affective resonance and "in sync" experiences; (3) vitality affects, self states, and receptive affective experiences of feeling seen, cared about and understood; (4) bodily states marked by the *felt sense* and (5) the healing affects, i.e., experiences of feeling moved, emotional, and touched.

The introduction of the concept of the core state has led to the phenomenological articulation of another set of affective experiences, all positive, that occur in the absence of defenses as well as of anxiety, fear, or shame. *Core state phenomena* include but are not limited (1) the sense of strength, clarity, and resourcefulness associated with the release of adaptive action tendencies; (2) core relational experiences of love, tenderness, compassion, generosity, and gratitude, relational experiences emergent from a state of *self*-possession; (3) core self experiences of what individuals subjectively consider to be their “true self"; (4) core bodily states of relaxation, openness and vitality that emerge in the wake of the *body shift*; and (5) states of clear and authentic knowing and communication about one’s subjective “truth.”

Access to core affective phenomena provides the conditions necessary for thorough therapeutic exploration and working through, and leads to the release of the enormous healing potential residing within these experiences. The core state which follows the experience of core affect is optimally suited for the therapeutic integration and consolidation that translate deep in-session changes into lasting therapeutic results.

THE DEVELOPMENT OF PSYCHOPATHOLOGY

In AEDP, adaptation is the central motivational construct, equally relevant to understanding pathology, as to understanding optimal development. Different emotional environments give rise to optimal and psychopathological developments. When emotional experience can be dyadically regulated, optimal development takes place; an affect-facilitating environment is co-created and it eventually becomes internalized in the individual's internal attitude toward emotional experience. Pathological development occurs when emotional experience cannot be dyadically regulated and has to be excluded to preserve the attachment bond. The co-created affect-intolerant emotional environment also becomes eventually internalized. These formulations are schematically depicted in Figure 13.3 (A & B). One version of the expanded triangle of conflict represents the structure underlying

Insert Figure 13.3 Here. The Two Versions of the Triangle of Conflict

the self-at-best functioning characteristic of optimal development (see Figure 13.3A). The other version of the expanded triangle of conflict represents the structure underlying the self-at-worst functioning characteristic of psychopathology (see Figure 13.3B).

In optimal development, affective change processes naturally unfold and the individual can reap their adaptive benefits. Deep emotional experiences -occurring in the presence of a supportive, affect-facilitating other- become associated with feeling good. To authentically and deeply express oneself feels good as does feeling emotionally connected with someone. To feel understood feels good as does being understanding

toward someone else who can receive it and is touched by it. Expressing painful feelings to a receptive partner also feels good. Positive affective states, markers for highly adaptive processes and experiences, are the way Mother Nature ensures that we pay attention to and keep engaging in psychic activities which foster our development, growth and expansion.

In optimal emotional environments, where the attachment figure is essentially accepting and supportive of the individual's emotions, core affective phenomena are paired with the *transformational affects*, positive experiences which mark the state transformation to the core state. The individual comes to expect that core emotional experience will lead to enhanced functioning, strengthening the integrity of self and/or of attachment ties. Over time, situations likely to arouse emotion will trigger the *green signal affects*, the signal version of the transformational affects. The green signal affects communicate essential safety and the go-ahead to feel. This is the self-at-best configuration which underlies optimal functioning represented in Figure 13.3A..

In pathogenic environments, the affective change processes, instead of bringing psychic gains, bring aversive results: The experience and expression of core affective phenomena meets with disruptive, non-facilitating responses from attachment figures. The caregiver is unable to maintain coordination in the face of the child's spontaneous emotional experience; some aspect of the child's emotional being triggers profound discomfort in the caregiver, who responds either inadequately, with errors of omission (e.g., withdrawal, distancing, neglect, denial). or aggressively, with errors of commission (e.g., blaming, shaming, punishing, attacking). The expression of distress meets with the

other's disdain or anxiety. The desire for contact meets with rejection or withdrawal. The offering of love is met with indifference or tension. Authentic self-expression meets with the other's anger or ridicule. These disruptive reactions on the part of the attachment figure (i.e., the errors of commission or omission), elicit a second wave of emotional reactions: fear and shame, *the pathogenic affects* (Fosha, 2001a). What should feel good ends up feeling bad; whereas transformational affects motivate further emotional experience, the pathogenic affects spur the exclusion of emotional experience.

Pathogenic affects arise when the response of the attachment figure to the individual's core affective experience is disturbing and disruptive. The disruption in mutual coordination caused by core affect cannot be dyadically repaired. The individual has to contend not only with the initial emotion-stimulating event and the overwhelming affective experiences it elicits; now he or she also has to contend with a second emotion-stimulating event, namely, the reaction of the figure of attachment, and the fear and/or shame it elicits.

There is a crucial distinction to be made between fear and shame as categorical emotions and fear and shame as pathogenic affects. As a categorical emotion, fear provides important adaptive information about the dangerous aspects of the situation that elicits it and kicks in the adaptive action tendencies associated with it. Fear triggers flight, immobility, but also notably, attachment-seeking behaviors. A child whose fear of a dog or of a stranger is overwhelming can seek out the caregiver for assistance. Similarly, shame as a categorical emotion about a specific event or behavior is an essential tool for social learning. That kind of shame can be metabolized in the context of an affect-

facilitating environment (Hughes, 1998; Schore, 1996). Handling disruptive emotions is the essence of the process of attunement, disruption, and repair (Fosha, 2001a).

Fear and shame become problematic only when they occur in reaction to the attachment relationship itself. It is then that they function as pathogenic affects. Fear about the very person who is supposed to be the safe base disrupts the attachment relationship and its essential protective function (Hesse & Main, 1999). Shame which is not about a specific behavior but which, instead, is about the essential nature of the self disrupts the very integrity of self experience and of the individual's ongoing sense of being (Hughes, 1998; Schore, 1996). When shame and fear are elicited by disruptive experiences with attachment figures *and* cannot be dyadically repaired, individuals find themselves alone, emotionally overwhelmed, unable to be real and unable to count on the safety of the emotional environment. Highly aversive, the hallmark of *the pathogenic affects* is that they are experienced by an individual who is alone, as the affect-regulating attachment relationship has collapsed.

The combination of (1) interrupted core affective experiences, (2) compromised self-integrity and disrupted attachment ties, and (3) the overwhelming experience of the pathogenic affects in the context of unwilled and unwanted aloneness lead to *unbearable emotional states*: these include experiences of helplessness, hopelessness, loneliness, confusion, fragmentation, emptiness, and despair, the "black hole" of human emotional experience. Hence, disrupted attachment and the compromised integrity of self result in unbearable emotional states which are to be avoided at all costs. If in the core state we encounter the *self-at-best*, in the unbearable emotional states, we have the *self-at-worst*.

this is the individual at his or her most depleted, the sense of self essentially compromised, with no safety and thus no access to emotional resources. No wonder individuals will literally do anything to escape these states! The attempts to escape the excruciating experience of these unbearable emotional states become the seeds for defensive strategies that, when chronically relied on, culminate in the development of psychopathological conditions (see Table 13.2).

Table 13.2 Here.

Affect Regulatory Difficulties and the Development of Psychopathology

In disrupted attachments, core affect becomes paired with pathogenic affects and the unbearable emotional states. The individual comes to expect that core emotional experience will be catastrophic, threatening the integrity of self and/or of attachment ties. Over time, any situation that threatens to arouse emotion will trigger the *red signal affects*, the signal version of the pathogenic affects. The red signal affects automatically trigger the institution of defense mechanisms that preclude the experience of core affects and their feared-to-be-unbearable emotional consequences. The red signal affects communicate the same information as the pathogenic affects, without full-blown psychic pain: they signal that feelings are quite dangerous in the current conditions and thus to be warded off through the application of defenses. This is the self-at-worst configuration which underlies pathological functioning (see Figure 13.3B).

The patient comes to rely upon defenses, denying, avoiding, numbing, or disavowing the affectively laden experiences that wreaked such havoc in the past and are expected to do so again. Psychic survival and a kind of secondary security (Main,

1995; Sandler, 1960) can be achieved only through the *defensive exclusion* (Bowlby, 1988) of the very processes that constitute optimal psychic health. Core affective experiences and their adaptive consequences are preempted, leaving the individual with terribly reduced resources to face the challenges of the world.

Some defenses are aimed at bodily experience, others at self or dyadic experiences, still others at particular emotions. A full taxonomy of the specific defenses associated with each change process is beyond the scope of this chapter. Some examples are: formal defenses, such as isolation of affect or denial, that prevent the experience of the categorical emotions; defenses in the realm of dyadic regulation that involve a hyperfocus on self or other, and are reflected in the types of insecure attachment; defenses against receptive affective experiences, the other side of the interpersonal wall, that are usually accompanied by denial of, or hypofocus on, the self; defenses against somatic processes that include numbing, body armoring, mannerisms, and postural distortions; and the denial of change, the failure to register it, and such phenomena as false modesty or hypernegativity that can be manifestations of defenses against the healing affects and the underlying vulnerability. However, once a defense becomes entrenched in the individual's repertoire, it can function against any aspect of emotional experiencing which might be threatening to the individual, regardless of the initial dynamic realm in which it arose.

These formulations are schematically represented in the two versions of the triangle of conflict represented in Figure 13.3, showing the interrelatedness of core affective

experiences, signal affects and defenses in affect-facilitating and affect-inhibiting emotional environments.

THE AIM OF TREATMENT

Treatment aims to undo the chronic reliance on defenses against core affective experiencing, thereby restoring the patient's natural healing and self reparative tendencies. *The ultimate goal of therapy is to change the structure of the patient's experience of what feels good*. We do this by restoring the association between safety and emotional experiencing.

In AEDP, the goal is *to lead with* (Fosha, 2000b) a corrective emotional experience (Alexander & French, 1946). The therapist seeks to create an affect-facilitating environment from the get-go and to activate a patient-therapist relationship in which the patient is in touch with his or her resources as much as possible. If this is accomplished, from the beginning, the patient will feel sufficiently safe to be willing to take the risks involved in doing deep and intensive emotional work (Fosha & Slowiaczek, 1997). The theory behind the stance of the AEDP therapist is grounded in attachment theory whereby the function of the therapist is to counteract the patient's aloneness by being a safe base so that exploration can begin. Pathogenic affects and previously unbearable emotional states become more tolerable and are eventually transformed as they are explored together with an other, from the position of the safe base. AEDP treatment seeks to (1) counteract the patient's aloneness and transform the experience of unbearable states; (2) minimize the impact of defenses and of the pathogenic affects of

fear and shame; (3) restore access to core emotions, and thus to the well-springs of adaptation and well being; and (4) facilitate the emergence of the core state.

The steps to restore access to core affective experiencing are:

1. Through a *therapeutic stance* that is actively and explicitly empathic and actively and explicitly emotionally engaged. The therapist facilitates the patient's affective experience through being affirming, supportive and authentic. There is a high premium on the use of the self in the form of making use of the therapist's authentic emotions,

2. Through active, specific and systematic therapeutic activities designed to *melt or breakthrough defenses*,

3. Through active, specific and systematic therapeutic activities aimed at countering the pathogenic affects,

4. Through active specific and systematic therapeutic aimed *at facilitating core affective experiences*, releasing adaptive action tendencies, and allowing the seeds of healing contained within the visceral experience of core affect to come to the fore, thus activating the core state, where maximal therapeutic healing takes place. Essential to the carrying out of AEDP is the grounding in the phenomenology of affective experience. The therapist's familiarity with the phenomena associated with change processes and pathological processes will enable them to be firmly grounded in the patient's experience, using that experience as constant guide regarding the state of the patent, the state of the relationship, and the state of the therapeutic process. Through a moment-to-moment immersion in experience and its fluctuations, patient and therapist are able to engage in what is the hallmark of AEDP: an experiential dyadic process informed by an affect-

centered psychodynamic understanding devoted to promoting full visceral experience of core affective phenomena, thus unleashing the transformational power of the processes of change.

HISTORY OF THE THERAPEUTIC APPROACH

The history of the experiential STDPs is discussed elsewhere (see Osimo, this volume), so this section will only briefly highlight the differences between AEDP and the other experiential STDPs that emerge as a result of the theoretical framework outlined above. Healing processes, rather than psychopathology, are at the very center of the affective model of change, the metapsychology that informs AEDP (Fosha, 2000b).

1. There is an expansion of the phenomenological realm of core affective phenomena as a result of the theoretical grounding in multiple processes of change (and thus not just one change process). This includes core affective phenomena associated with each affective change process, core state phenomena, and the affective experiences that arise in non affect-facilitating environments, i.e., the pathogenic affects and the unbearable emotional states.

2. The emphasis on the differential nature of the co-constructed environment in optimal and pathogenic development has led to the awareness of multiple configurations of core affect, signal affect and defense within the same individual underlying quite different levels of functioning. This has led to the elaboration of different versions of the

triangle of conflict -the self-at-best and self-at-worst configurations- and the respective role of positive and negative environmental experiences, which become differentially encoded in signal form in the green signal affects and the red signal affects.

3. In AEDP, the therapeutic stance is seen as a dyadic construction and thus unique to each dyad. Although empathy, compassion, and affirmation always characterize the genotype of the AEDP therapist's stance, its phenotype is always unique and idiosyncratic, inasmuch as it is a stance grounded in dyadic construction (Tronick, 2001).

4. From within an affirming and emotionally engaged stance, the AEDP therapist seeks to lead with a corrective emotional experience, aiming to engage the patient's least defensive, most emotionally resourceful self state, represented by the self-at-best configuration. Through the process of mutual coordination of affective states, patient and therapist coconstruct an affect-facilitating therapeutic environment in which the defended against painful and intense core affective experiences, encoded in the self-at-worst configuration, can be accessed, experienced, worked through and reintegrated within the personality in a more adaptive fashion.

The techniques that follow assume all of these developments.

METHODS OF ASSESSMENT AND INTERVENTION

THE TRIAL THERAPY

The trial therapy (Davanloo, 1990; Malan, 1976) is the major assessment tool in AEDP, as it is in the other experiential STDPs. Tracking affect and relatedness from the get-go, the therapist is primed to co-create an affect-facilitating environment and a

corrective relationship within which to begin the therapeutic work. The AEDP therapist does not wait for the material to unfold but actively fosters the kind of interaction the model defines as optimal. As the patient begins to tell the therapist his or her story (or not tell it), the therapist has access to two potent sources of dynamic and diagnostic information: the content of the story, manifest and latent, and the interactive process between patient and therapist. Taking whatever the patient offers, the therapist uses it as starting point for an affective experiential interaction. At the first sign of affect, the therapist stops the action and shifts the focus to the affect; the message is: This is what we do here. The moment-to-moment experiential tracking of the flow of the session has begun. Severity of functional disturbance, chronicity of the problem, or the point in development at which the problem is thought to have arisen in the patient's genetic past do not play an automatic role in determining suitability for AEDP. Showing a capacity to engage and work experientially augurs well and is heavily weighted against other factors. The patient's capacity to respond affectively and engage relationally is a major selection criterion, as it indicates the patient's capacity to make use of the therapy being offered.

AEDP trial therapy always begins with the present situation. “The precipitating event is, in truth, the final blow that simply cannot be tolerated” (Mann & Goldman, 1982, p. 24). In the presenting complaint and the specific example are the patient’s response to the therapist’s first and second questions: What brings you here now? followed by Can you give me a specific example? The presenting complaint represents a “final common pathway” (p. 20) of core conflicts, anxieties they elicit, defenses deployed, and consequences of those defenses. The request for a specific example announces the

departure from vagueness: The work of therapy has begun. The emotionally charged atmosphere of the first minutes of the first session offers tremendous opportunities as the first set of dynamics that underlie the suffering the patient is seeking to remedy is exposed. Two further explorations are a desired feature in every trial therapy: There needs to be a somatic/experiential/affective exploration (grounded in a specific example: How do you feel? How do you experience that? Where in your body?), as well as a relational exploration of the here-and-now experience with the therapist: What is it like for you to do this with me? How do you feel when you have eye contact [or avoid eye contact] with me?).

By following the patient's affect, it is possible to see how it links present and past, and how it becomes manifest in the evolving patient-therapist relationship. The relationship with the therapist evokes intense feelings; from the first minutes of the first session, the therapist declares that he or she wishes to relate to the patient. By focusing on the patient's feelings, asking for specifics, and responding empathically and emotionally, the therapist activates the patient's complex feelings about intimacy and closeness.

That the first session presents a unique opportunity is recognized by many STDP therapists (e.g., Coughlin Della Selva, 1996; Davanloo, 1990; Magnavita, 1997; Malan, 1976, 1979; Mann & Goldman, 1982; McCullough Vaillant, 1997). Gustafson (1986) writes about the "sacred nature of the first session" and how important it is to focus on what brought the patient to treatment. If the precipitating event is a "common pathway,"

hope and dread inspired by the encounter with the therapist shape the dyadic interaction, making their encounter the second common pathway.

The greater the crisis, the greater the opportunity. Affective charge creates an intrapsychic crisis and therefore fluidity (Lindemann, 1944); the result is an unmatched opportunity to get past the patient's customary defenses. During such a crisis, the patient's customary ways of handling intense feelings becomes evident, as does his or her ability to respond differently as the therapist engages the patient in new ways of relating.

In this first session, patient and therapist, as members of a brand-new dyad, are creating their own unique patterns. As both bring best and worst configurations, much is possible and nothing is yet determined. Such a fortuitous chance for creation might never arise again in the course of their relationship. Another source of dynamic information is the moment-to-moment therapeutic process. Making interventions and observing their impact is a form of hypothesis testing.

In keeping with AEDP's healing-centered orientation and adaptation-based framework for understanding psychopathology, the therapist is always on the lookout for evidence of strength, ease, and resourcefulness. Areas of psychic health are as important to a thorough psychodynamic assessment as areas of difficulties. The following are some questions for therapists to ask themselves during the initial interview:

Has contact been made? If the therapist thinks so, does the patient? If the patient thinks so, does the therapist?

What are areas of defensiveness and areas of ease? What are areas of difficulty in the patient's life and areas of pleasure?

What defenses does the patient use, and what resources are available?

What makes the session flow? What makes the session get stuck?

How does the patient respond to empathy, validation, and support? To confrontation?

How does the patient respond to his or her own emotionality, or to the lack thereof?

What are the patterns of relational repetition, and what kinds of environments trigger them? What are the exceptions?

What feelings are difficult for the patient, and what feelings not so hard? Can the patient experience, for example, sadness but not anger, or anger but not vulnerability? Are positive feelings more difficult than negative feelings (or vice versa)? Are all feelings difficult?

How does the patient handle negative feelings such as anger, pain, and disgust? How does the patient handle positive feelings such as joy, love, pleasure, and tenderness?

Can the patient tolerate negative aspects of the session, that is, areas of stuckness, disagreement, confrontation, or disappointment? Can the patient tolerate positive aspects of the therapeutic interaction, that is, empathy, collaboration, closeness, contact, and hope?

What brings out the worst in the patient? What is he or she like at worst? What brings out the best in the patient? What is he or she like at best?

The first interview has several purposes: to establish contact with the patient; to learn the story of what brings the patient to treatment; and to uncover the way the patient's seemingly excessive or incomprehensible reactions make complete sense. The most important goal for the first session, however, is that *the patient should have a therapeutic experience,* a visceral feeling for at least a moment of self-at-best in the context of a dyadic relationship. From the beginning, the therapist begins to share with the patient his or her empathic understanding of the patient's experience and of the therapeutic interaction. A therapeutic aim is to give the patient experiential access to healing affects that unlock access to other corrective affect-facilitating experiences, which, for whatever dynamic reason, were relegated to marginality or to dynamic oblivion, or have been accessible but robbed of their reparative restorative potential. If, in the initial session, the patient has some moments of core affect and then core state experiencing, he or she will have had a taste of the freedom that comes with emotional access and will have had a visceral experience of their own resources and positive qualities. Such experiences are intensely motivating (Davanloo, 1990). This is why we seek to proceed from strength to face vulnerability and seek to lead with a corrective emotional experience.

METHODS OF INTERVENTION

Essential to all AEDP methods of intervention is the moment-to-moment experiential tracking of the patient's state in the context of the dyadic interaction. It is what determines and guides the selection of interventions, what gives the therapist precise feedback

about the patient's response to each intervention, and what provides the precise raw data necessary for an accurate and thorough psychodynamic understanding both of the moment-to-moment therapeutic process and of the patient's personality organization as a whole. The work is approached from a stance of affirmation and empathy, and support and valuation of the patient: the understanding of clinical phenomena is informed by an adaptation-focused and healing-centered approach.

The phenomenology of the states of defense, core affect, and core state, and the therapist's ability to read and interpret them correctly are crucial because the entire AEDP approach is rooted in the patient's experience. What strategies the therapist uses at any specific time depends on being able to accurately sense the patient's state, for each state is characterized by a different therapeutic goal.

The first state. In a *state where defenses predominate*, the goal is to help patients relinquish their defensive reliance. Unless transformed, in the top-of-the-triangle-of-conflict state, nothing deeply therapeutic happens. There are highly confrontational ways to work with defenses and there are deeply accepting, removing-the-pressure, paradoxical ways to proceed (little-step-by-little-step attunement). Enhancing the patient's experience of safety and thus rendering defenses vestigial is another strategy. But the goal of all interventions aimed at defense is the same: to foster the state transformation from top-of-the-triangle-of-conflict functioning to core affect in which the impact of defenses is neutralized (i.e., the state transformation from defensive functioning to core affective experiencing).

The second state. When dealing with the *affective phenomena represented at the bottom of the triangle of conflict*, a major focus is the promotion of embodied, visceral experiencing. There are different goals and thus different therapeutic interventions tailored to the different types of affective phenomena represented at the bottom of the triangle of conflict. *Core affective experiences* require a type of therapeutic work different from that needed for the *pathogenic affects* and *unbearable emotional states*. All three are categories of affective experience that come to the fore in the absence of anxiety and defense, yet there are different therapeutic goals with each.

(a) With the *pathogenic affects* and the *unbearable emotional states*, the goal is to ultimately eliminate them from the patient's emotional repertoire. They serve no adaptive function for the individual. In fact, they both reflect, and are a consequence of, the disintegration and depletion of adaptive resources. Merely reexperiencing them proffers no therapeutic benefit (see also Levine, 1997, on this point). Therapeutic benefits accrue only if the patient's emotional aloneness is counteracted. Originally, the pathogenic affects and unbearable states arose in an individual deprived of the benefits of dyadic regulation when sorely in need of help, and further overwhelmed by the onslaught of aversive affects associated with attachment disruptions. What is transformational and therapeutic here and now is the sharing of these experiences with a supportive, helpful, emotionally-engaged other. At stake here is restoring the matrix of affect-regulating attachment. It is not enough for the therapist to "*be with*" the patient; active therapeutic work *also* needs to take place to make sure that the patient takes in (i.e., registers and processes) the therapist's presence and involvement (see Fosha, 2001b, for elaboration

of this point). In order for the experience of emotional aloneness to be therapeutically transformed, it is essential that defenses against receptive affective experience not be in operation.

(b) The work with *core affective phenomena* is different from the work with the pathogenic affects and the unbearable states. Emotional access to these phenomena assumes an affect-facilitating environment already in place. It is either internalized and reflected in the affective competence of the individual, and/or is being actively coconstructed dyadically and is operating in the background at that moment. Given a solid affect-regulating attachment environment, it is the therapeutic and adaptive benefits that emerge upon the full visceral experiencing of core affects themselves that are the therapeutic goal. When the adaptive action tendencies kick in, the next experiential depth level is activated and the transformation to core state is under way.

The third state. The most important therapeutic goal in working with the third state, the core state, is for the therapist to recognize it and promote its unfolding. Once core state is achieved, the therapy runs itself. With patients in core state, the therapist's activities can be reflective, collaborative, experiential, mirroring, or witnessing. The therapist can validate and receive, and participate in deep collaborative dialogue that is simple, essential and "true." Just being present and listening deeply is sometimes precisely what is needed. Often, the most powerful work can be done when both patient and therapist are in core state (which is not unusual). At those peak moments, characterized as I-Thou relating (Buber, 1965) or true-self/true-other relating (Fosha, 2001a), some of the deepest therapeutic work can take place.

Technically, all AEDP techniques aim to (1) undo emotional aloneness, (2) bypass defenses, (3) neutralize and reverse the inhibiting impact of the pathogenic affects, and (4) promote visceral embodied experience of core affect and core state. There are specific techniques that focus on getting there (i.e., effecting the state transformations) and specific techniques for doing the therapeutic work once one actually gets there (i.e., regulating, deepening and working through techniques for working with core affect and core state). These techniques are outlined in Table 13.3. A detailed discussion of each technique is beyond the scope of this chapter. [For a more detailed discussion, see Fosha & Slowiaczek, 1997, and Fosha, 2000b, chapters 10-13].

Insert Table 13.3 about Here. AEDP Strategies of Intervention

With an understanding reflecting the integration of the psychodynamic, relational, and experiential therapeutic traditions, the therapist's activities are rooted in the moment-to-moment tracking of the patient's experiential access to these sources of transformation. The AEDP therapist helps the patient bypass defenses (psychodynamic contribution) and enhance embodied visceral experience (experiential contribution) in the context of an affirming affect-facilitating relationship (relational component). AEDP treatment harnesses the transformations arising from (1) the experiencing of core emotion, (2) the dyadic regulation of affective states, (3) the empathic reflection of the patient's self experience, (4) somatic focusing, and (5) a focus on the very experience of transformation. Focusing on affect transformation helps patients heal, thrive, and increasingly approach becoming who they are.

MAJOR SYNDROMES, SYMPTOMS, PROBLEMS TREATED USING AEDP

AEDP can be utilized with a wide variety of outpatients. It is suitable for patients presenting with Axis I symptomatology (i.e., anxiety disorders, dysthymia, etc.) as well as for patients with Axis II personality disorders (e.g., Avoidant, Dependent, and Histrionic personality disorders). AEDP is particularly suited to pathology where issues of loss (e.g., pathological mourning) are central. Exclusion criteria include all psychotic disorders, bipolar disorders, Major Depression, impulse disorders, marked acting-out behavior and substance abuse disorders. Generally, disorders resulting from the overregulation of affect are more suitable for AEDP than disorders resulting from its underregulation.

For more severely disturbed patients, such as those with Somatoform, Dissociative and/or Borderline Disorders, rather than rigid selection/exclusion criteria, the trial therapy plays a major role in determining suitabilitily for treatment. Response to trial therapy is weighed heavily against other considerations. If the patient responds to the trial therapy with deepening rapport and increased motivation resulting from affective engagement, the patient is likely to be taken into therapy even in the face of other concerns. However, if in the course of the trial therapy, the patient exhibits disorganizing anxiety, fragmentation, identity confusion, paranoid ideation, thought blocking, and/or other signs of a fragile personality structure, even in the absence of other exclusion considerations, AEDP is not the treatment of choice. A less affectively arousing and relationally-stimulating treatment approach, such as cognitive or supportive therapy, would be recommended.

There is however, one diagnostic group usually considered difficult to treat that AEDP has had success with: patients with Narcissistic Personality Disorders (see also Trujillo, this volume). They often present with subclinical Axis I disorders of anxiety and/or depression (dysthymia). Stress-related somatic disorders (somatoform disorders) are common, as are substance abuse tendencies (though that is not the primary diagnosis). Their disorder of self experience can be severe and quite debilitating. Though these patients often work, have relationships, families, and *appear* high functioning, they are propelled into treatment by frightening dysphoria, emptiness, despair, and deadness (Eigen, 1996). These latter experiences are the long-term legacy of the personality disorder and where AEDP interventions can be quite effective.

Included here under the rubric of disorders of the self are both frank Narcissistic Personality Disorders and personalities constructed around significant narcissistic vulnerabilities, usually referred to as disorders of the self. These two subgroups are referred to by Magnavita (2000) as patients manifesting either *the narcissistic dysfunctional personologic system or the covertly narcissistic dysfunctional personologic system*. According to Magnavita's description, the patient manifesting a *narcissistic personologic system*

> …manifests a reversal of the parent-child subsystem, with either spouse or children catering to the unmet needs of one or more family members. A sense of entitlement often predominates the family system and an air of superiority covers an essential emotional defect. Members of these systems appear to “have it all” and elicit admiration from those who are not too close to them. Achievement is

expected of all members regardless of cost. This description fits families in American society that have been placed on a pedestal, but whose succeeding generations manifested a litany of substance abuse, unethical conduct, and so forth that indicated a deep emotional void (p. 135).

The patient manifesting a *covertly narcissistic dysfunctional personologic system*

… is characterized by narcissistic dynamics but in a more hidden fashion than the [covertly narcissistic dysfunctional personologic system]. The reversal of the parent-child subsystem has a much more subtle feel to it; it is not out in the open. The basic dynamic is that the children, but most often one child, becomes a mirror for the incomplete identity of a parent. This process is discussed in the writings of Miller (1981) and Kohut (1977) who [spoke of the] "not good enough mother" to refer to *a maternal-child relationship that does not sufficiently fulfill the needs of the child*. *There is a deficiency in the nurturing, mirroring capacity of the parental figures and an expectation that the child will inordinately satisfy the validation needs of the parental figures*. Some members of these systems may appear to be highly functional and productive members of society; others, however, may function only marginally and are often described as the black sheep of the family*. Emotion, if recognized, is not adequately processed or assimilated* so that family members seem emotionally underdeveloped or with well-developed false selves. (p. 138; italics, added).

Noteworthy in the histories of patients manifesting covertly narcissistic personologic systems is a parent with a history of major trauma, unresolved loss, or often undiagnosed

but significant metal illness. The impact on the second generation of unresolved loss and trauma in the parent is currently the focus of intensive empirical investigations (Hesse & Main, 1999; Lyons-Ruth, 2001; Main 2001). These patients also have recently been characterized as manifesting a disorganized attachment style, which overlaps with or is identical to dissociative disorders (Liotti, 1995, 1999). In these parent-child constellations, those aspects of the child's emotional experience that serve the parent's well-being are highlighted and co-opted for the parent's self-regulation; those that fall outside it are ignored or ridiculed. Usually, the child's needs heighten the parent's own anxiety, shame, and feelings of inadequacy, triggering the parent's need to defend against these aversive affects and the traumatic experiences in which they are rooted. Thus, the child is shamed and humiliated for needing what the parent is incapable of providing. Adaptive, healthy aspects of the self become not only excluded, but drenched in shame.

For patients with narcissistic vulnerability, basic adaptive functions, including needs and yearnings for contact and attachment, are rejected and cast in shame. Thus the narcissist's defensive self-reliance. The apparently high functioning of these patients is deceptive: the high functioning is compensatory. Its aim is to regulate self-cohesion, self-vitality and self-esteem. Without consistent success, or in the face of ordinary setbacks or ups and downs, these strategies collapse. When external buttressing of the self fails, there is tremendous shame and many aspects of the previously high functioning collapse.

Patients manifesting covertly narcissistic personologic systems have been described by Eigen (1996), Ferenczi (1931, 1933), Guntrip (1969), Kohut (1977), Alice

Miller (1981), Winnicott (1949, 1960), and others. As Ferenczi, Winnicott and Miller note, these patients are often encountered in the caregiving professions. At the mild end of the continuum, we see narcissistic vulnerabilities in the regulation of self-esteem; at the severe end, there are more severe dissociative disorders, with self-cutting, sexual perversions, and other acting-out behaviors as pathological means of self-care and maintaining aliveness and integrity of self. Attempts to regulate self-experience and self-esteem through dysfunctional self-other interpersonal patterns result in phenotypes that can appear as grandiose, (defensively) self-sufficient, or else self-effacing and overly-dependent. The pathogenic affect of shame plays a major role in these patients, and defensive self-reliance is often the result of the massive dissociation of needs, vulnerabilities and yearnings which are too drenched in shame to be tolerated and thus need to be disowned. The result is the depletion, flatness, and deadness that bring patients into treatment.

ILLUSTRATIVE CASE: THE TRAPPED SELF

Diagnosis and Assessment

Yves, a 55-year-old account executive, entered treatment after his wife's discovery of his extra-marital affair. In the marital crisis that ensued, the patient and his wife sought couples' therapy; Yves was referred for individual therapy by the couples' therapist, a referral he readily accepted. His presenting complaint, uttered in despair, was "I feel trapped." He presented with acute and intense depression, an exacerbation of a chronic depression he had had for most of his adult life. Suicidality was carefully assessed, as

the patient's father suicided when in his 60s: although passive suicidal ideation was present, the patient was not and had never been actively suicidal. In addition to the chronic, unaddressed marital difficulties that exploded to the forefront, the patient had a multitude of difficulties: deep dissatisfaction with a job that did not engage his considerable intelligence and talents, accompanied by an inability to mobilize resources to find a different job, despite a humiliating demotion; a sense, dating to his 20s, of being adrift and "at a loss" about what to do with his life; and a proneness to verbally losing control of his temper with his children, which was deeply distressing to him, as he perceived it as damaging to them. He met DSM-IV criteria for Dysthymic Disorder (Axis I) and for Passive (or Passive-Aggressive) Personality Disorder (Axis II) and showed a pronounced tendency to somatization. Using Magnavita's (2000) diagnostic system, the patient's personality organization is best described as a *covertly narcissistic dysfunctional personologic system.* Yves evidenced a profound dissociation between his "true self" experience and his day-to-day experience. He covered up his anger but also his needs, yearnings, and painful disappointments. His passive-aggressive interpersonal style came to the fore in situations of conflict, most blatantly so in his relationship with his controlling, dismissive wife. At work, he was in a similarly submissive relationship with an irascible, demanding boss, with whom he felt unable to assert himself. He felt trapped by obligations, duties, and unsatisfactory relationships. Seeing himself as "a hopeless underachiever," he felt distressed, ashamed -and yet resigned- that he had never been able to do justice to his talents. However, in isolated areas of his life, he felt alive and engaged: this was true in his love of jazz, in his deep commitment for over 20 years to

the study, practice, and teaching of chess, and in his occasional affairs, which were invariably with warm, sensitive women. He also enjoyed "hanging out" with good friends. In music, chess, affairs, and occasionally with friends, he felt himself, he felt free, and he experienced a sense of ease.

Case Formulation

Yves grew up in an intact middle-class family with a deep commitment to education, radical causes, and the arts. Very loving with his son, Yves's father had nevertheless been a highly ineffective man. His outbursts of temper were frightening and destabilizing to his son, though he was invariably remorseful and concerned with reparation afterward. Yves's father was dominated by his wife, who ran over him with her words. To escape her, he immersed himself in increasingly quixotic causes, until he committed suicide in his 60s.

Yves's mother had been supportive, involved, and emotionally engaged with Yves; however, she had to be in control and she was always right. Yves never heard her say “I’m sorry” or admit to making a mistake, particularly in the emotional realm, where she was very proud of her prowess in reading and understanding people. In subtle and not so subtle ways, Yves's mother sought to control his every emotional tremor. She took over at the slightest sign of trouble. Yves came to rely on her and submitted to her agenda for how he should proceed, relinquishing his autonomy.

His difficulties began after he left home. Previously an excellent student, at college he felt "lost" and performed poorly. Despite graduating with a degree from one of the nation's top universities, he moved from job to job, unable to devote himself to any

particular career. He was attracted to his wife in part because of how structured, definite, and down-to-earth he perceived her to be. In spite of her having a tin ear for emotional nuance and dismissing his emotional concerns as evidence of wanting to be pampered, in her contempt for an emotional inner life, she was refreshingly unlike his mother, and in her practical engagement in

real-world matters, she was most unlike his father. But the unconscious is not so easily fooled: Yves replaced his mother with his wife, and he became his father.

In his parents, Yves had two models of dyadic regulation, neither of which included empathic reflection of *his* self. With mother, there was no room for his autonomous authentic experience; she behaved as if his emotional reactions were valid only when she deemed them to be so. Although his mother did acknowledge his qualities and talents, these were co-opted in the service of her narcissistic needs. His wonderfulness reflected *her*. Though there was genuine and mutual love in Yves's relationship with his father, his father was too preoccupied with his struggle to maintain his own self to have much energy to attend to his son's experience. Furthermore, in that model of dyadic regulation, the capacity to metabolize and modulate emotions was clearly compromised.

As a result, from an early age, Yves learned to dissociate major aspects of his real self. He thus protected those very precious aspects of himself (Winnicott, 1960), yet, in his actual existence, he lost access to vital resources, energy, and thus direction. His actions required effort, and nothing flowed; thus the despair of feeling "trapped" in a life robbed of joy. The depletion he experienced became overwhelming in the crisis precipitated by the discovery of his affair; he needed to make a choice he felt incapable

of making. The acuteness of the situation so stressed his already anemic resources that he yearned for the peace that death would bring.

Treatment Approach and Rationale for Its Selection

As is often typical for these patients, Yves was all too good at attacking himself for all his personality flaws. He had genuine remorse and guilt for causing his wife pain; capable of deep empathy, the distress he felt about the suffering he would bring on his children if the family were to dissolve approached the unbearable (it was something he literally could not bear to think about prior to treatment, and so he did not). What was almost completely absent was any empathy for himself.

From the beginning, starting with the trial therapy, the therapist validated the importance of the patient's needs and framed the current crisis as an opportunity to understand and eventually restore access to dissociated aspects of his emotional experience. The AEDP therapist's actively and explicitly empathic, affirming, and nonjudgmental stance had an immediate impact on the patient: He felt deeply understood. He was all the more moved as he had expected the condemnation he felt he deserved. The focus on the patient's *experience* of being heard and understood (receptive affective experience) and then of feeling deeply himself (core self experience) here and now with the therapist led to a breakthrough of healing affects, a phenomenon the patient, in the initial trial therapy, dubbed "truth tears." With the therapeutic alliance strong and the patient's emotional resources activated, the current crisis and the patient's chronic difficulties could now be dealt with from a position of resourcefulness. Together with the therapist, Yves was now in a position where he could experientially explore the

various life options available to him. A portrayal was used to explore his feelings about saying goodbye to his family, were he to choose to end his marriage. The deepest feelings, a major breakthrough of grief, occurred as he imagined saying goodbye to Matthew, his oldest son. Previously unconscious material flowed; deeply identified with this child, the overwhelming grief he had about how hurt Matthew would be, accessed previously unprocessed grief and fear about his own experiences as a boy with his own father. In the core state that followed, strengthened by having borne the grief he had been so afraid of being destroyed by, he felt increasing clarity about what he needed - and wanted- to do. And he started to feel compassion for himself.

The AEDP aim of leading with a corrective experience and viscerally accessing core affective experiences so that the patient could benefit from the emotional resources accessed through the emergent state transformations was met. From the first session on, the patient had visceral access to a "new experience," a deep resonant sense of "true self," a state in which he felt strong, vital, feelingful, relaxed, clear and in touch with his own subjective "truth." From that point on and throughout the therapy, the patient had a visceral knowledge of the state that he was striving for. The patient's deep response during the trial therapy suggested that AEDP had the potential to be of substantive help.

The Course of Therapy

The patient was seen weekly, for sixty minute sessions. During the course of the AEDP therapy, *all five affective change processes* were activated. Work with the core emotions of fear, grief and rage in the context of Yves's relationships with his mother, father, and wife allowed Yves to relinquish his habits of passivity (defenses). His

passivity diminished in direct proportion to the satisfaction he experienced in speaking directly. It became clear that his explosiveness with his children covered up intense feelings of helplessness and being at a loss (unbearable states). As his extensive shame about his helplessness diminished, the patient came to realize how linked it was with his (defensive) attempts to deal with his experiences with his father, whom he had deeply loved; that, in turn, led him to recover the enormous fear he experienced in reaction to his own father's loss of control, which inhibited the development of his own aggression. This work led to an extensive phase of mourning; he mourned the damage he had done to his children and he mourned for himself -what he himself lost out on as a result of his father's difficulties. The exploration of interpersonal patterns of dyadic regulation showed them to be severely skewed in the direction of his accommodating to the other and letting go of his own experience. This work was also crucial in undoing his life-long passivity and promoting the development of his self-assertion. The path of somatic experiencing was relatively undefended; leading from strength, the patient's easy access to his bodily experience helped the experiential work. But the aspects of the work the patient deemed most mutative involved the empathic reflection of his self and the activation of the metatherapeutic process of affirming the (transformation of) the self.

A few weeks into the treatment Yves decisively ended his affair and recommitted himself to his marriage and to working out the difficulties in it. The therapeutic goal was to replace his seeming acquiescence to his wife with honest communication about his dissatisfaction in the marriage, as both sexually and emotionally, he felt quite unresponded to. Renouncing his previous strategy of seemingly capitulating to his wife's

forceful point of view while seeking responsiveness elsewhere, he became increasingly assertive and declarative. Time and again, he discovered how well he felt when he declared openly what he thought and felt, independent of the interpersonal consequences of his declaration. Experientially focusing on the positive sequelae of often difficult instances of self-assertion solidified his gains. The patient eventually became quite able to take responsibility for his behavior, owning the damaging impact it had on his wife's ability to feel safe with him, and *at the same time*, not lose sight of his own experience. It became of paramount importance to Yves that he betray neither his wife (outside of the marriage) nor himself (within the marriage relationship). Similar issues around declarative self-assertion were also worked on in the context of his relationships at work.

After 15 months, Yves terminated his treatment (the couple therapy had ended approximately 6 months before). The communication between him and his wife was excellent. With visceral access to his authentic self experience, he had much more energy in his daily life; the feeling of despair and feeling trapped disappeared as his actual lived life increasingly reflected *his* choices. His passive-aggressive personality was largely restructured, and those patterns largely disappeared from his repertoire. The key to the treatment was the visceral experiencing of the true self state (core state). That became the experiential guide both in and outside of sessions. Even when his behavior fell short, he always knew whether he was being true to himself or whether his determination was slipping and he was at-risk for resorting to old patterns (i.e., hiding

behind passivity and seeming compliance instead of directly dealing with what he thought and felt).

Posttermination Synopsis and Effectiveness Data

The patient has been seen for yearly follow-ups since his treatment ended four years prior to this writing. He has maintained his gains. His relationship with his wife continues to be based on a high level of communication. The marriage remains a difficult one for the patient, but he feels unconflicted, having discovered a deep commitment to making it work as best he can. No longer ashamed of his needs and yearnings for greater responsiveness and intimacy, he has become increasingly aware of how his wife's inability to respond to his yearnings for contact are rooted in her own painful history (e.g., two mentally ill parents). This represents ongoing work for him, being able to feel the validity of his own experience has made him much more able to deal with the frustrations in his marriage. At work, he has been increasingly assertive, gaining greater recognition. His demotion was rescinded and he has received further promotions. Like his marital situation, his situation at work is far from ideal; yet within the situation, his affective competence is high. In addition to the fading of his passive-aggressive patterns, Yves's depression has lifted. The remaining area of difficulty is that of occasional somatic difficulties, which the patient has framed as his body's way of reminding him when he is not taking care of emotional business; these disappear as soon as he attends to the emotional matters requiring his attention.

The following vignette comes from a session that took place a few weeks prior to termination. It is a beautiful example of core state (and true self) experiencing, gracefully

captured in the idea of "the unencumbered moment." The experience of being unencumbered is all the more significant in light of the patient's having come into treatment "feeling trapped." I chose this passage because the patient so eloquently articulates the nature of core state experiencing and contrasts it with the defense-dominated state: Very different ways of being oneself in the world emerge from those different orientations.

The patient's italicized words capture the essence of his in-the-moment core state experiencing. In parentheses are the descriptions of the nonverbal aspects of the communication, and in brackets are my moment-to-moment microprocessing comments:

Pt: *There are no miracles, there's just this..... that there's not really that much that's disturbing me*.....

Th: Yes

Pt: There's nothing really bothering me about the way things are at home... 'cuz I used to come in and invariably some aspect of Patti's [his wife] behavior would upset me. Either something we went through. Or something we didn't go through….

Th: Uh huh

Pt: ... or something that bothered me that I either I didn't bring up with her or did bring up with her and...

Th: .. right

Pt: You know, one of those little cobwebs and stuff. I don't really feel that*... there doesn't seem to be any lingering unfinished business* **["cobwebs:" a symbolic expression of the consequences of defense-based living]**

Th: Wow

Pt: (sigh) (pause) So... I don't feel as if things haven't been taken care of.... There is always something that worried me, whether it's money or this or that...

Th: right

Pt: ...or my mother, you know, things with that. I don't know, things seem to be... pretty good actually

Th: mmm (pause)... What's that like, internally? **[encouraging exploration of the somatic/visceral correlates of emotional experience]**

Pt: It's just grrreat!

Th: hmmmm

Pt: (hand over solar plexus, over the center of his being)...It reminds me of this habit of mine of carrying around little pieces of paper with notes about various things I have to do, you know. There are not too many notes in my pocket... **[another metaphor for the simplicity of core state functioning]**

Th: uh huh

Pt: But I don't feel like there is all this unfinished business … around me (expansive gesture), so *I feel kind of clean*

Th: uh huh

Pt: You know, *feels kind of good.* ... *Feels clean*.. That's really what it is

Th: hmm

Pt: *Unencumbered, no strings* (brushes imaginary stuff off of him, reference to the cobwebs)

Th: I love the way you said "feels grreat"

Pt: Did I say it that way? (laughs) I thought I said it very quietly, in my usually subdued manner **[reparative efforts: patient is correcting the therapist's mirroring, which in fact was slightly off]**

Th: You're right, it was quiet, but with a whole lot of 'oomph' **[acceptance of patient's reparative efforts and re-establishment of coordination after mini-disruption]**

Pt: Yeah, you know, it's not as though I was thinking about this before I came in or even in the last few days or anything like that... But that's the truth There aren't any kind of things that really left me disturbed. I can't remember yelling at the kids in a while…

Th: uh huh

Pt: Patti and I are very similar in certain respects, although we have very different styles. I think we're very critical people... I think in certain areas we demand a lot from ourselves

Th: mm hmm

Pt: ... and we demand a lot from each other. Demand... well, we expect..

Th: ...expect

Pt: ...expect a lot from each other. and.... hm, it's funny, she called me up yesterday and said (gives example of wife confronting him about a particular incident with one of their children, and his directly describing what happened without being either defensive or

self- derisive). So Patti said "Oh, I see" and that was basically it. It didn't leave any kind of aftertaste… There is nothing left over about that thing

Th: uh huh

Pt: There would be times when Patti would call me and afterward I would be stewing that whole day and come home and have an attitude and maybe not say it anything... just….

Th: This time it got taken care of....

Pt: Yeah, and I probably thought "why is she calling me about *that*?" but it didn't really bother me ... it didn't take hold, inside, you know..... because little things like that, I would say, in the past ..... in the past we both would have remembered something of it... So I think these things haven't taken hold anymore, these negative accusatory things, or critical things or stuff like that.... We seem to be working pretty well, you know...

Th: mmmm (very affirming noise, with wonder) **[empathic affirmation and amplification; admiring]**

Pt: .... and a lot of the same things may be happening

Th: Just with a different spirit inside. And very different ways of dealing **[empathic elaboration].**

Pt: Yeah... yeah... yeah... (pause)... A lot of the old language of criticism, of accusation is withering away ... and life seems a lot more normal, you know

Th: Wow.. it's strange to think it was only a year ago that things were so different…. and how it must feel to you now to feel like this..... **[explicit focus on the process of change]**

Pt: Yeah. Well, last November ... we were in the thick of it. That wasn't an easy time.. It was very uncomfortable then so … that might be another reason why I have *this feeling of being clean*, like I do

Th: Yes

Pt: It has so many implications in light of what happened in the last year, that, given our whole history, that I can go through days and times like this and *feel the vitality of the moment, unencumbered*... *The unencumbered moment*, you know **[core state: the straightforward declaration of subjective emotional truth]**

Th: Hmmm **[appreciation]**

Pt: It's really terrific. *In a way, that's all I want*. I'm not that ambitious

Th: That's so beautiful, the unencumbered moment.... **[empathic reflection]**

Pt: But because things happen, I guess, again, it's been such a short time but...But one can tend to forget how close it all was, how nearby all this bad feeling and difficult living and all this encumbered living used to be... just how close it really was... it was here so recently... (pause)

Th: (sigh)

Pt: I don't need any great charge or any great high.... this is fine.... (pause)
That's right, that's all that's really needed - Obviously, there are also joyful moments.... *but this is joyful as it is* **[positive affects as markers of core state experience]**

Thus, from the patient who described the healing affects accompanying the recognition of change as "truth tears," now comes yet another phrase capturing an

experiential essence: the "unencumbered moment," the moment of feeling free of the sticky cobwebs of defense-driven living, a perfect characterization of the subjective simplicity of core state experiencing. This material comes from the session in which the patient and I set the termination date for our treatment; it seems a fitting way to end this chapter on AEDP, a treatment whose goal is to create opportunities for unencumbered moments from which a patient can experience and examine the emotional truth of his or her existence.

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