

AEDP Exemplifies the Seamless Integration of Emotional Transformation and Dyadic Relatedness at Work

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A. THEORETICAL CONSTRUCTS

With its focus on facilitating healing emotional transformations within an emotionally engaged therapeutic relationship, AEDP (Accelerated Experiential-Dynamic Psychotherapy) seamlessly integrates previously disparate theoretical constructs, and previously disparate clinical strategies of intervention. AEDP's fundamental assumption that change can, and does, take place reliably in therapy is informed by an understanding of the non-gradual nature of affective change processes (Fosha, 2000b, 2002, 2004). The AEDP therapist seeks to catalyze a *state transformation* of the patient's emotional experience and harness the healing power of emotions. Key to achieving this goal is forming an affect-regulating attachment bond between patient and therapist from the get-go.

Conceptual Integration. A bottom-up model that emphasizes dyadic regulation of relatedness and emotional arousal, AEDP's conceptual framework integrates constructs, insights and findings from: attachment theory (e.g. Bowlby, 1982); clinical developmentalists' research into moment-to-moment mother-infant interaction (e.g. Beebe & Lachmann, 2002; Stern, 1985; Tronick, 1989); emotion theory and affective neuroscience (e.g. Damasio, 1999; Darwin, 1872; Panksepp, 1998; Tomkins, 1962-3); experiential short-term dynamic psychotherapies (e.g. McCullough Vaillant, 1997; Osimo, 2003); other experiential emotion-focused therapies (e.g. Greenberg & Paivio, 1997); and body- and trauma-focused therapies (e.g. Gendlin 1996; Levine, 1997). AEDP's understanding of the phenomenology and dynamics of healing transformation has been informed and inspired by studies that document its non-gradual, discontinuous quantum nature (James, 1902; Miller & C'de Baca, 2001; Person, 1988; Stern et al, 1998).

Dyadic regulation of relatedness. Attachment theory informs AEDP's focus on the patient-therapist relationship as a secure base from which to explore aversive experiences. Secure attachment enhances emotional resilience and optimizes the capacity to endure intense affective experiences without resorting to *defensive exclusion* (Bowlby, 1988). The establishment of a relationship where one dyadic partner operates as a secure base for the other is accomplished through optimal dyadic affect-regulation, i.e., the moment-to-moment coordination and dyadic regulation of affective states through psychobiological state attunement (Fosha, 2001; Schore, 2003). The process of moment-to-moment dyadic affect regulation is constituted of endless iterations of the sequence of *attunement* (the mutual coordination of affective states), *disruption* (the lapse of mutual coordination), and *repair* (reestablishment of mutual coordination under new conditions). In securely attached dyads, disruption motivates repair and negative emotions are metabolized rapidly while maintaining relational connection. By contrast, in pathogenic dyads, disruptions do not motivate dyadic repair efforts but instead lead to disconnection, withdrawal and aloneness, with a reliance on self- rather than dyadic regulatory strategies to cope with the stress of dysregulated emotion (Tronick & Weinberg, 1997). These dyadic interactions, whether optimal or compromised, become internalized as the individual's *affective competence*, i.e., the capacity to "feel and deal while relating" (Fosha, 2000b, 2001).

Dyadic regulation of emotional arousal. The paradigm-shifting revolution in emotion theory and affective neuroscience emphasizes the fundamentally adaptive nature of affects, and conceptualizes

them as complex, wired-in neurobiological programs with distinct arousal, appraisal, physiological patterns and adaptive action tendencies. Core affect (Fosha, 2000b), i.e., affect not blocked by defenses, or inhibited by anxiety, shame, or other aversive affects, is a powerful catalyst for healing transformation. Core affect, when (a) dyadically coordinated and regulated moment-to-moment with the therapist, (b) experienced viscerally, and (c) worked through to completion (Fosha, 2004), unleashes adaptive and self-righting capacities that are hard-wired in the patient's mind and body. The activation of these capacities, and the resources and resilience they entrain, translate into enhanced functioning and greater well-being for the patient; compromised access, on the other hand, sows the seeds of psychopathology.

Affective neuroscience demonstrates the centrality of the right cerebral hemisphere in emotional processing (Schore, 2003; Siegel, 2003; Trevarthen & Aiken, 1994). Dyadic affect regulation through psychobiological state attunement has been shown to be mediated through right brain to right brain communication between dyadic partners. Right brain language codes use gaze, play, vocal tones and rhythms, touch, visual imagery, and somatosensory experiences; right brain mediated processing of emotion and attachment occurs through this somatic, non-verbal lexicon. And this somatic lexicon is what must be engaged in the therapeutic interaction.

Technical Integration. 4 groups of strategies of intervention -- *relational, restructuring, experiential-affective*, and *integrative-reflective*—specify how the dyadic regulation of relatedness and emotion is technically effected in AEDP (Fosha, 2000b; Fosha & Slowiaczek, 1997). They reflect the integration of elements from experiential, psychodynamic, relational, cognitive, reflective, and narrative-based approaches into a transformation-based treatment. Echoes of existential- humanistic psychology are encountered in AEDP's affirming stance and belief in the patient as the expert of her/his experience. The influence of somatic and body-focused treatments is reflected in the emphasis on the rootedness of emotional experience in bodily processes, and thus the primacy of experiential interventions. Dyadic relational and affect-regulating strategies, somatic focusing strategies, and emotion processing strategies, all illustrated in the case vignette below, are AEDP techniques that are the focus of this chapter.

Psychopathology and Transformation: Representational Schemas. Difficulties in dyadic affect regulation and thus, the individual's resulting aloneness in the face of overwhelming emotional experience, are front and center in AEDP's understanding of how psychopathology develops. In dyads where the caregiver's affective competence is compromised, the child's intense emotions also disrupt the caregiver. The attachment bond gets dysregulated, as does the smooth operation of its affect regulatory function. Failed dyadic experiences themselves evoke a second wave of intense emotions, the *pathogenic affects* of fear, shame, and/or distress. As a result, (1) the disrupted initial emotional experience, (2) the experience of aloneness as a result of the disrupted attachment bond, and (3) the *pathogenic affects* of fear, shame, and distress combine to give rise to a yet a third wave of affects: the *unbearable emotional states of aloneness*: feeling helpless, worthless, empty, broken or lost are some of the wrenching feelings that characterize this "black hole of trauma" (van der Kolk, 2001), and that individuals will go to great lengths to avoid ever feeling again. Procedural learning thus deems emotions dangerous. Eventually just the hint of emotional activation evokes "*red signal*" affects, communicating to the individual that the direct experience of basic emotions needs to be defensively excluded . Subsequently, multiple defense mechanisms are used to (a) avoid the havoc wreaked by dysregulated emotion and (b) to, *at all costs*, maintain the attachment bond. While necessary to emotional survival in the short term, long term reliance on defensive mechanisms leads to constriction and distortion of the personality, compromised functioning, and the eventual emergence of psychopathology. This

understanding is schematically represented in the revised triangle of conflict (see Figure 1a), a schema initially derived from the experiential STDP tradition. It informs and guides moment-to-moment clinical work, whose aim is to (a) bypass defenses, (b) fully process previously evaded core affective experiences, and (c) reap their healing benefits.

However, AEDP's healing- and transformation-centered clinical understanding posits that, side by side with the psychopathology-engendering processes just described, there also operate powerful tendencies toward healing and self-righting (Emde, 1988; Gendlin, 1996). These psychic forces exist in each individual not only as potential dispositions awaiting awakening under the right facilitating conditions, but actually evident in those moments when s/he is at her/his best. Another schema is required to represent their operation (see Figure 1b). Briefly, in conditions of safety, the child's emotions are met with acceptance, empathy and a willingness to share, bear, and help. Dyadically regulated, emotions overwhelm neither child nor caregiver, and instead enhance the adaptive repertoire of each partner. Such dyadic experiences lead to the security-engendering expectation that one's emotions can be processed, and become procedurally internalized in positive unconscious attitudes toward one's own emotional experience. In such circumstances, hints of emotional activation evoke the "green signal" affects of hope, trust, curiosity, interest and anticipation: these communicate that it is OK to approach emotional experience with mindful openness rather than with defensive exclusion and the tendency to shut down. Alone and/or with a trusted other, emotions can then be processed to completion; the individual's functioning is enhanced.

Thus, AEDP features two schemas of the triangle of conflict: one schema, *the self-at-worst* represents pathological functioning (see Figure 1a), and another schema, *the self-at-best*, represents adaptive, resilient functioning (see Figure 1b). The nature of the emotional environment fundamentally contributes to which kind of functioning is accessed: emotionally-thwarting conditions are more likely to activate self-at-worst functioning, while emotionally-facilitating conditions make more likely the activation of self-at-best functioning. From the opening moments of the first session and from there on throughout the therapy, in AEDP, we seek to dyadically entrain patients' self-at-best configuration. In this way, we can do therapeutic work with difficult pathological experiences from within a therapeutic relationship where patients are maximally in touch with their strengths, resources, and resilience. In AEDP, we work with the self-at-worst from under the aegis of the self-at-best, striving to help patients "feel, deal, and heal (while relating)."

Transformational Work. Transformational work with an emotional episode is characterized by three states and two state transformations (see Figure 2). Therapeutic interventions are keyed to the state the patient is in, and the state transformation that is aimed for. When therapy proceeds optimally, the therapist can facilitate and expect the rapid emergence, hence acceleration, of all three states and two state transformations in a single session (as illustrated by the case in this chapter).

Pervasiveness and predominance of defenses mark the first state in AEDP. Here, the patient unconsciously employs a variety of cognitive, affective, and behavioral strategies to exclude emotional experience. Mindful and respectful of the once-but-no-longer adaptive defensive strategies, the therapist acts collaboratively with the patient in the here-and-now to bypass the defensive wall. The unwavering presence of a protective nurturing other is a startling anomaly, provoking an intrapsychic crisis (1st state

transformation): the patient's internal working model, with its unconscious dire predictions of aloneness in bearing negative emotional experiences, begins to implode. The *heralding affects*, understood to be the 'last hurrah of the resistance,' signal the first state transformation and draw the therapist's attention to a crucial window of therapeutic opportunity to facilitate the entrance into the second state of AEDP.

Unfettered access to visceral experience and expression of core affective experiences is the hallmark of the second state in AEDP. The moment-by-moment attunement and mutual coordination the therapeutic dyad engages in helps the patient feel safe and not alone with intense emotions. While disruptions in attunement are an inevitable reality of any deep dyadic interaction, the timely repair of disruption further deepens the therapeutic process (Fosha, 2003). As core affective experiences are processed, the therapeutic process unfolds; the patient's previously hidden emotional narrative emerges. Experiential affective strategies are most effective in this state to deepen and work through the experience of core affects.

With the completion of each wave of emotion, adaptive action tendencies are released: authentic relief (versus defensive avoidance) from intense negative experience is accompanied by a deep sense of joy, zest and exuberance. There is a definite shift in the somatic sensory experience, frequently felt as sensations in the area of the 'heart' or as a sense of warmth or energy emerging from the 'gut level'

As the patient feels better and increasingly resourced, *receptive affective experiences* (ie., feeling seen, understood, cared for) come to the fore, giving rise to the *healing affects* (Fosha, 2000a, 2000b) – the welling up tears of 'being moved' and 'being touched,' tears often accompanied by a deep experience of gratitude, love and tenderness towards the therapist. The release of both adaptive action tendencies and healing affects mark the second state transformation and the transition from *core affect* (State 2) to *core state* (State 3). The wave of core affective experience gradually recedes only to be followed by the next wave - core state experience. Core state, a phenomenon frequently ignored by other therapeutic approaches, is the grand finale and the crown jewel of an AEDP session.

Core state follows the full and complete experience of any core affect. Characterized by a heightened sense of authenticity – 'I feel at home with myself', 'I feel like myself' -- its affective marker is the *truth sense*, the sense the patient has of being in direct touch with the subjective truth of personal experience. Anxiety-free, core state is experienced somatically as openness, vitality, relaxation, ease, and flow. Rather than being rocked by any emotion, there is a prevailing sense of calm. Authentic core relational experiences of love, closeness, intimacy, and compassion predominate. Patients often have deeply spiritual experiences of being in touch with ultimate reality and eternal truths: here, AEDP crosses another boundary and integrates psychology with that which is at the roots of spirituality and aesthetic experience. The therapist, who often is also in core state by now, can act simply as a validating witness, being present with the patient, or as active participant. Reflective integrative strategies are useful in core state, as patients become capable of constructing coherent and meaningful autobiographical narratives, shown to be highly correlated with secure attachment and emotional resilience (Main, 2001; Siegel, 2003).

Brief Detour. Before going to the clinical case example, we wish to refer to a couple of questions often asked in workshops on AEDP: Given its emphasis on both the tender, affect-facilitating ministrations of the therapist and on the necessary emotional arousal of the patient, does the model privilege gender, i.e., is AEDP more suited to the allegedly more tender and more emotional nature of women? The cultural question is the other often-raised question.

In keeping with bottom-up orientation of our model, we address these questions through walking the

walk, rather than talking the talk (we'd love to talk the talk even more than we have, but space limitations don't permit us to do so): our AEDP case illustration features a male therapist (DY) with a male patient, both of them belonging to a culture—the Chinese culture—which is characterized by very different display rules for emotional expression than those that operate in the American or western culture.

B. CASE HISTORY AND CLINICAL FORMULATION

Having felt depressed every day for the last few years, Gary, a 30 year-old insurance broker, sought psychotherapeutic help for symptoms that included lack of concentration, motivation and confidence, short-term memory problems, hypersomnia, malaise, sluggishness, and paralyzing indecisiveness. Serious work impairment and moderate relational difficulties with his family of origin and in his marital life also plagued Gary. In addition to fully meeting criteria for a DSM IV Axis I diagnosis of dysthymia, obsessive compulsive, negative personality and dependent personality traits were also in evidence. On the positive side –and resource assessment is a fundamental aspect of assessment in AEDP-- Gary presented as very intelligent, highly motivated for change and possessing a high reflective self-function.

Psychodynamic formulation. Gary's history of negative dysregulated emotional interactions with caregivers with compromised affective competence, produced intense shame about emotions and needs. Their defensive exclusion – through mechanisms such as reaction formation, aggression turned against the self, dissociation and, most prominently, isolation of affect-- became necessary to avoid the excruciating emotional pain, self-loathing, despair, and unbearable loneliness that would follow in the wake of massive shame-driven dysregulation of affect and attachment experiences. Gary's chronic reliance on these defense mechanisms blocked his access to the adaptive categorical emotions of anger, sadness, and joy, as well as to the adaptive action tendencies which are released with the complete experience of each emotion, and eventually led to the development of the depressive symptoms for which Gary sought treatment.

The following clinical vignettes are edited excerpts from session 12 of an AEDP treatment carried out by one of us (DY). They are organized in three sections. The therapeutic work presented here illustrates AEDP's striven-for transformational journey involving 3 states and 2 state transformations taking place in a single session.

C. CASE ILLUSTRATION: Healing the Vulnerable Self's Wounded Heart[\[1\]](#)

State 1 (Toward State 2): Enlarging the Glimmers of Affective Experience Evident Despite Defenses in the Here-and-Now Presence of a Nurturing Other.

Gary describes a typical scene in his family of origin: his father, enraged, is yelling at him. The presence of such intense affect-laden material from the start is an opportunity that AEDP tries to capitalize on. The therapist immediately attempts to deepen the therapeutic change process by facilitating a felt-in-the-body affective experience. As often happens, in what follows, we see the moment-to-moment oscillation between defensive evasiveness and deepening affective expressiveness, which the therapist closely tracks, encouraging the latter.

Th: (*Tender and compassionate tone*) Are you having any feelings at this moment?

Pt: (*Gazes at therapist. Soft and vulnerable tone*) Some wounded-ness-at-heart... [**spontaneous somatic, affective language to express emergent emotional pain**]

Th: (*Soft and tender tone*) What are the feelings in your eyes...? [**facilitate experience of emotional pain**]

Pt: (*Maintains mutual gaze with therapist. Tender and vulnerable tone*) Somewhat moist...(I feel) my tears wanting to flow...(Blinks eyes frequently. Breathes quicker)...

Th: (*Very soft and tender*)...Blocked...? Are your tears blocked...? [**explicit labeling of the defense of isolation of affect**]

Pt: (*Maintains mutual gaze. Blinks eyes frequently. Nods head gently*)...Yes

Th: (*Very soft and tender tone*) Can I sit beside you...nearer to you...? [**asks permission**]

Pt: (*Maintains mutual gaze. Very tender*)...Okay... [**permission granted**]

Th: (*Moves and sits next to patient. Holds patient's right forearm gently and firmly*[\[2\]](#). *Very tender and soothing tone*) Try... [**implicit support through the body language of holding and being near; explicit exhortation**]

Seeking the patient's explicit consent, which he obtains, the therapist strategically intervenes to reduce interpersonal distance; as a contralateral right brain communication of emotional closeness, he moves from sitting opposite to sitting next to the patient. Through maintaining mutual gaze, and a steady protective nurturing presence, the therapist seeks to counteract the patient's aloneness with the painful experiences under exploration to help him regulate (dyadic affect regulation of unbearable states) rather than defensively exclude them.

Th: (*Very soft and tender tone*) Describe this scene to me...[**encourages elaboration and clarification of the specifics of the emotional scene**]

Pt: (*Looks up at the ceiling. Softly*) Once I asked my old man for money...(Nervous giggle) ...I don't know why I asked him for money...(Looks down. Appears dejected) My old man was speaking with my mother... I called out to him several times..."Pa, Pa" ... I was not sure whether he heard me or not... I was accused of interrupting their conversation... he yelled at me several times...then he said (*imitating father's demeaning and dismissive tone*)..."take it, take it"...

Simple self-expression leads to a humiliating, intensely negative experience with an emotionally dismissive parent. After repeatedly being the recipient of such "errors of commission" (Fosha, 2000b) from a rejecting caregiver, humiliation colors the experience of self; eventually shame functions as a red-signal affect, triggering the institution of defenses to prevent re-experiencing the unbearable emotional pain associated with expressions of emotion and need.

Th: (*Very soft and tender tone*) Are you having any feelings? Any feelings in the body? [**maintains moment-to-moment tracking of bodily experience of affect**]

Pt: (*Long pause*) ... (*Softly*) Somewhat tense in my chest... It was unfair...I called for him several times...He did not respond...I also felt humiliated... [**awareness of somatic correlates of anxiety; emergence of personal emotional narrative**]

Th: (*Very compassionate tone*) Are you blocked...? [**empathic resonance with emotional pain through tone, explicit defense work through words**]

Pt: (*Long pause*)... (*Looks down. Softly*) Last couple of minutes... I tried to let the tears flow...but I also felt as if my body was not listening...that it was blocked... [**recognizes defense and collaboratively joins with therapist to relinquish it**]

State 2: The Uncovering of Emotional Experience – Aiming to Experience the There-and-Then Unbearable Affects with the Here-and-Now Caring, Empathic Other

As the patient's defenses become ego-dystonic (i.e., aware that what was there-and-then adaptive is maladaptive here-and-now), his motivation to overcome them rises and patient and therapist are

increasingly joined in the therapeutic enterprise. The therapist helps the patient recall in vivid detail scenes of “family feuding” where “screaming” and “swearing” were the order of the day. The therapist continues to seek to heighten the patient’s emotional arousal by engaging highly specific imagery, sensation, and experience, i.e., speaking the language of the right brain. After a very long pause, the patient describes another scene, which turns out to be critical.

Pt: (*Maintains mutual gaze. Softly*) I remember when they came here as immigrants... They arrived at the airport... My old man was shouting how easy it was, passing customs... But I saw mom as somewhat like a zombie...zombie...rather crazy and insane...her hair turned all white...(hand gesturing toward head)... What a big contrast.

Th: (*Holds patient’s right forearm*)...[**non-verbal communication of support**]

Pt: (*Maintains mutual gaze. Blinks eyes frequently. Shakes head*) ... I wanted to cry just now when I described mom... [**on the threshold of core affective experience of grief**]

Th: (*Very tenderly*) Where is the feeling located? [**facilitating somatic correlates of affective experience**] (*The therapist touches patient’s sternum*)

Pt: (*Blinks eyes frequently. Nods head*) Yes...

Th: (*Very gently lays right hand on patient’s sternum. Applies pressure gradually*). Try...

Pt: (*Closes eyes. Breathing heavier*)... [**physiological activation, signaling the imminent emergence of previously blocked affects**]

The first state transformation is in progress: About to enter into the realm of core affect, the therapist strategically prompts the patient to focus on his mother’s eyes.

Th: (*Applies gentle pressure on patient’s solar plexus with each out-breath. Compassionate tone*) Look at her eyes...Look at your mom’s eyes...what do they look like?

Pt: (*Eyes closed. Facial melancholy. Soft voice*) Helpless...her eyes are helpless ... she’s looking at the new surroundings, but... [**facial expression of deepening grief**]

Th: (*Deeply compassionate tone*) Don’t block it...

Pt: (*Very long pause*) (*Eyes closed. Soft voice*) My heart hurts very much...[**somatic experience and expression of core affect of emotional pain**]

Th: (*Very compassionate tone*) Mmm... [**empathic attunement; non-verbal compassion to facilitate deepening of emotional experience.**]

Patient: (*Very long pause*) (*Eyes closed. Soft voice*) I am very afraid...(Starts crying, tears flowing freely and fully)...[**experience of painful emotions associated with witnessing his mother’s suffering: helplessly witnessing the trauma of a loved one is itself traumatic**]

Th: (*Very compassionate tone*) Mmmm....

Pt: (*Eyes closed. Tears flowing*) (*Long pause*)...

Th: (*Very tenderly*) Any feelings in your body? [**moment-to-moment tracking of shifts in the somatosensory correlates of emotional experience**]

Pt: (*Opens eyes*) I feel some relief ... After the tears flowed, the tense feeling in the chest seems to disappear [**Completion of 1st wave of adaptive grief. Unprompted, the patient elaborates and deepens the exploration**]...At first, I thought I thought it was the way I sat... I saw mom in the scene... The people in the background were fuzzy...

Th: (*Tenderly*) Seems like there is more... [**intuitive anticipation, encouraging the further unfolding of the affective experience**]

Pt: (*Tenderly*) She seemed so lost, walking towards me... It seemed on the surface like a family reunion...(but) there is such unhappiness...(More tears) [**absorbed in the experience**]

Pt: (*Deep sobbing*). (*Long pause*)

Th: (*Tenderly*) Any feelings in the body?...(*long pause*)...Don't block

Pt: (*Eyes closed. Tears flowing*) ... She did not used to have that much white hair..

Th: (*Tenderly*) Any feelings...that she did not used to have that much white hair...?

Pt: (*Eyes closed. Tears flowing. Tender voice*) Very sad.

Th: (*Very compassionate tone*) Mmm...

Pt: (*Very pained tone*) ... Very lonely.....she looked so lonely

Th: (*Intensely compassionate tone*) Mmm

Pt: (*Eyes closed. Tears flowing. Sniffs*)...

Th: (*Lays left hand behind patient's neck with gentle stroke*)...

Pt: (*Pause*) (*Eyes closed. Tears flowing. Cracking, trembling voice*) Why would no one care for her?

Th: (*Very tender and intensely compassionate tone*) Yes...*guai*. [**deep affirmation of the patient from the here-and-now attachment figure**]

Pt: (*Head bend down. Eyes closed. Tears flowing. Deep sobbing*) I could not...help her.

The breakthrough of terrible pain is a key moment: the most personal, subjectively important aspect of what made the situation so unbearable now fully comes to light. The patient's shame and pain about his helplessness and failure to alleviate his mother's suffering emerges immediately following the therapist's affirmation of the patient's value of as a human being, "guai" being a Chinese expression for the prizing of a younger person by an elder. Being affirmed in his fundamental goodness by an attachment figure, someone perceived as "older and wiser" (Bowlby, 1988), is a profound corrective emotional experience: the toxic shame of the self, til now a closely guarded secret, can now come out to be detoxified and healed.

Th: (*Very tender*) *Guai*...[**further undoing of shame experience through empathic affirmation**]

Th: (*Very tender*) Any other feelings?

Pt: (*Eyes closed. Dreamy voice*) My mother loved me so much...all these years...I miss her...

[**spontaneous emergence of positive receptive affective experience, i.e., feeling loved by his mother; the 1st marker of the emergent state transformation**]

Th: (*Tender*) Yea...*guai*. [**continued affirmation**]

Pt: (*Eyes closed. Tears flowing. Deep breathing*)...

Th: (*Very tender*) Any other feelings?

Pt: (*Eyes closed. Deep crying. Tender voice*) I remember she used to tell me to eat...I felt her care for me...she was worried that I might be hungry... (*More sobbing*) [**more memories of being cared for,**

congruent with a self worthy of being loved]

Pt: (*Eyes closed. Dreamy voice*) I feel warmth...[**sudden shift of bodily felt sense from negative to positive experience: 2nd marker of emergent state transformation**]

Th: (*Intrigued. Tender*) Where...where do you feel the warmth in your body?

Pt: (*Gestures towards his chest*) She is smiling at me... [**positive affective marker: the 3rd marker of emergent state transformation**]

Th: (*Tender. Lighter voice*) Really...!

Once the core affective experience is articulated and met with loving support, the 2nd state transformation –that from *core affect* to *core state*-- is heralded by the emergence of positive affect: "my mother loved me." The shame undone, the individual is now open to receptive affective experiences of feeling loved. The therapist, knowing that "nothing that feels bad is ever the last step" (Fosha, 2004; Gendlin, 1981), recognizes these positive affects as signaling the completion of the wave of grief and the emergence of the next state. The patient opens his eyes, maintains mutual gaze, and notices the tears in his therapist's eyes. This gives rise to the emergence of healing affects, here, gratitude for the therapist.

Pt: (*Tender*) Thank you! [**expression of healing affects**]

Th: (*Tender*) Not necessary...you are welcome! [**momentary defense on therapist's part; immediately corrected**]

Pt: (*Wipes tears off his face. ... Long pause*)

State 3: The Core State Experience and Its Revelations

The completion of the experience of core affect ushers in the experience of core state. The patient has a feeling of deep relaxation and expresses his wish for a good sleep, which the therapist accepts with continued care and tenderness. The session continues.

Th: (*Tender*) Yes...any other feelings...can you describe your state of mind?

Pt: (*Maintains eye contact with therapist. Declarative tone*) Two things popped into my mind...my burden is light and my yoke is easy. [**simple declarative tone as marker of core state. Spirituality as an aspect of core state experience**]

Th: (*Intrigued. Smiles*) Share with me.

Pt: (*Declarative. Matter of fact tone*) Usually...it would be many Sundays [of going to church] before I could hear such inspirations... I don't know why it would just pop up now.[\[3\]](#)

Th: (*Awed. Tender*) Amazing... Very amazing. And the other thing? [**affectively resonant affirmation; encourages continued experiential unfolding**]

Pt: (*Long pause*) (*Reflective and declarative tone*) The last few days, I tried to remember a saying...but I could not recall it clearly until just now... ..(*Gesturing towards his solar plexus*)..."the kingdom of heaven is in your heart"

Th: (*Startled tone*) Whoa! [**affectively resonant affirmation**]

Pt: (*Maintains eye contact. Nods head*)...

Th: (*Intrigued. Mesmerized tone*) Why is it that before you could not remember...and now you can?

Pt: (*Very long pause*)(*Puzzled tone*) I don't know why...

Th: (*Chuckles*) We seem to have difficulty with such dogma... that we are bombarded by it...

[authentic self-expression]

Pt: (*Smiles. Declarative matter-of-fact tone*) It seems like other people could experience it...but I couldn't

Th: (*Very tender*) And now...?

Pt: (*Long pause*) (*Calm, declarative and assertive tone*) It confirmed this experience...

Th: (*Softly*) What experience?

Pt: (*Calm, declarative and assertive*) I can let go of my suffering...**[from within core state, the patient reflects and offers a spontaneous acknowledgment of therapeutic impact]**

Th: (*Calm and intrigued tone*) What did you feel when I was pressing on your chest?

Pt: (*Calm, reflective, and declarative*) I was thinking of my mother's face...that was the most touching moment. **[unimpeded exercising of reflective self function]**

Th: (*Tender*) You saw my tears earlier too. **[explicitly exploration of the impact of the therapist's expressed emotional experience on the patient]**

Pt: (*Maintains eye contact. Nods head*)... Yes.

In core state, the therapeutic relationship is one of authentic reciprocity. The patient is no longer a 'patient' and a therapist is no longer a 'therapist'. They are mere human beings, fellow travelers sharing an authentic moment in this life journey. The True Self of the patient is actualized in this moment of meeting with a True Other, who responds to the real needs of the patient. True Self to True Other is AEDP's version of Buber's I/Thou relating.

Th: (*Tender*) I notice the redness in your eyes now...it seems that there are still some feelings...**[maintains moment-to-moment tracking of patient's affect]**

Pt: (*Softly*) Tears of sorrow are very tiring...but the tears at this moment seem to recover quickly. **[Indeed, the phenomenology of depression is different from the phenomenology of core grief which, in turn, is different from the phenomenology of healing and transformation. Though tears are common to all three, the patient, now deeply in touch with his own emotional experience, knows the difference and knows it in his body).**

Th: (*Gentle*) How would you describe these tears...at this moment?

Pt: (*Tender*) 'Healing tears' does not seem to fit close enough...**[the patient does not yet have the words for this affect, but his experience is his able guide]**

Th: (*Tender*) What pops into your mind now?

Pt: (*Calm and declarative tone*) Hope...I cannot visualize it...but I feel it... Hope!

These three segments document a therapeutic journey. In the first segment, working from a highly empathic stance which is maintained throughout, the therapist uses relational, restructuring and affective/experiential techniques to help the patient explore previously evaded feelings. The therapist's success in becoming a secure base for the patient renders the patient's defense mechanisms both anachronistic and ego-dystonic. The second segment illustrates State 2 work with core affect: the

therapist facilitates the patient's bodily experience and expression of deep emotional pain, helping him viscerally access his grief, all the while maintaining the moment-to-moment dyadic regulation of affect. In the last segment, the patient's completion of an intense but corrective affective experience leads to the emergence of healing affects; then, heralded and marked by several positive transformational affects, core state experiencing comes to the fore, as the experience of healing transformation becomes solidified.

D. CONCLUSION

The nature of the integration that AEDP exemplifies --seamless, synthetic, organic—is by no means the result of deliberate efforts to combine different clinical approaches. Instead, the drive toward optimal effectiveness and maximal efficacy, and the search for further ways to deepen, enhance and empower therapeutic work led to AEDP's *de facto* technical integration of different technical elements, each singly belonging to different therapeutic modalities.

Similarly with regard to the theoretical integration which informs clinical action in AEDP: Phenomena associated with the transformative affective experiences of relatedness and deep emotion were obtained initially by a conceptually psychodynamic therapy, stretching to use experiential techniques and an emotionally engaged stance to maximize therapeutic efficacy in a accelerated time frame. These transformative affective phenomena --sudden, discontinuous, sometime explosive quantum changes--transcended the explanatory bounds of psychodynamic theory and pleaded for an explanatory account that did justice to the dynamics by which they originated and operated. Different theoretical constructs from different disciplines --attachment research, emotion theory, neuroscience, transformational studies and developmental models—helped AEDP develop such an account. The phenomenon-driven emergent understanding of heretofore unilluminated aspects of the clinical process, in turn further extended AEDP's conceptual framework. The dialectic of phenomena in search of an explanatory theory, and the new evolving theory in turn informing, explicating. and sensitizing awareness to new phenomena and aspects of the clinical process describes integration achieved through praxis.

One last point: Our bodies, our brains, our minds, our psyches, and our selves are all seamless integration in action. They are entities in which the integration of emotion, cognition, relatedness, behavior, and communication is reflected in our moment-to-moment experience and functioning. It is these how these master integrators operate when the physiology and energy of mind are reflected in fluidity and resilience⁴. that AEDP has sought to emulate. We will continue to heed their integrative lessons.

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[1] In what follows, we will use the following typographical conventions: The italicized text in parentheses describes the non-verbal and paraverbal aspects of communication, i.e., tone of voice, body

posture, emotional expression, such as smiling or crying etc. The text in bold in brackets is our explication of the affective nature of the patient material which calls for particular interventions, and of the types of interventions used by the therapist.

[2] While discussions of the role of therapeutic touch are becoming increasingly frequent in psychodynamic circles (Bridges, 2003; McCullough, 2003), this is not an issue that we will address here. Suffice it to note that, in this case, the therapist is a family physician by training and had in fact been the patient's family physician prior to the undertaking of the therapy, thus the naturalness of physical touch in their relationship. This is the context within which therapeutic touch is used in this session.

[3] Spontaneous, unbidden, experience; the "passive" emergence as marker of quantum transformational experience of the mystical type (James, 1902; Miller & C' de Baca, 2001), core state phenomena with "a mind of their own" (Fosha, 2002)

[4. Kristi Foster \(2004\).](#)