

Of the Self, by the Self, and for the Self: An Intra-relational Perspective on Intra-psychic Attunement and Psychological Change

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This article explores the concept of self-relatedness, integrating ideas drawn from attachment theory, developmental studies, object relations, and interpersonal neurobiology with a multiplicity model of self. I suggest that because self-regulation begins as a dyadic interpersonal process between child and attachment figure, the mind renders such regulatory abilities across the life span via an analogous, intra-relational dyad. This “internal attachment system,” comprising states representing our subjective experience and states reflecting on and appraising that experience coordinates its activity in ways that best regulate the individual’s affects, thoughts, perceptions, and behavior. Chronic trauma and neglect create patterns of intrapsychic relatedness that compromise connection, receptivity, adaptive engagement, and harmony among elements of the self system, thereby disrupting the mind’s development toward greater coherence and complexity (Siegel, 2007). This article will also discuss the clinical application of intra-relational principles with pervasively maltreated people using a method called Intra-relational (I-R) Accelerated Experiential Dynamic Psychotherapy (Lamagna & Gleiser, 2007). Applying Accelerated Experiential Dynamic Psychotherapy’s use of dyadic affect regulation, the tracking of emergent somatic experience, and the processing positive effects associated with transformation to inner work with various internal parts of the self, I-R seeks to foster attunement and receptivity among previously dissociated parts of the individual. Creating intrapsychic safety provides an opening through which defensively excluded memories and associated emotions, thoughts, and impulses can be processed and integrated and increasingly coherent and complex forms of self-organization can be achieved.

Keywords: self states, attachment, emotion, psychotherapy, experiential, trauma, neglect

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Attunement is an essential mechanism in all healthy forms of human relating. It is a process that involves the cultivation of a *receptive stance*, a state of openness through which we come to understand the intentions that arise within us and in those around us (Fonagy, Gergely, Jurist, & Target, 2002). Attunement also helps us to respond to these various intentions with understanding, empathy, and care (Cassidy, 2001). Such capacities first form in early life, as a caregiver's sensitive and contingent responses to the child's emotional expressions allow for both the intersubjective sharing of feeling, motivation, and interest (Main, Kaplan, & Cassidy, 1985; Stern, 1985; Trevarthen, 1993) and the repair of interactive ruptures (Beebe & Lachmann, 2002; Tronick, 2007). Through this attachment relationship, dispositional capacities for psycho-biological organization, integration, and regulation (Schore, 1994, 2003; Siegel, 1999) are taken in and interpersonal (Bowlby, 1973, 1980, 1982; Cassidy, 2001; Lyons-Ruth, 2000) and intrapersonal (Fairbairn, 1952; Jacobson, 1964; Lamagna & Gleiser, 2007; Schwartz, 1995) patterns of relating are forged.

This article will explore one important legacy of our attachment history, namely the development of our capacity to attune and adaptively respond to the moment-to-moment emotions, thoughts, perceptions and impulses that make us who we are (Fonagy et al., 2002; Izard, Ackerman, Schoff, & Fine, 2000). This ability to perceive one's own beliefs, desires, plans, and goals constitutes a "self-mentalization" or "intrasubjectivity," which grows from "good-enough" attachment experiences (Bowlby, 1973, 1982; Fonagy et al., 2002; Schore, 1994, 2003). Seen as the foundation of mental health (Allen, 2005; McCullough, 1997), it underlies our capacity to create coherent maps of the world (Adolphs, 2004; Epstein, 1991), regulate and assimilate emotional experience (Siegel, 2007), maintain a realistically favorable sense of self worth (Cassidy, 2001; Harter, 1999), and take in the emotions and actions of others (i.e., receiving love from another) (Fosha, 2000b, 2003; McCullough, 1997). In attachment environments where abuse and neglect are prevalent, the quality of relatedness with our selves tends to be punitive, devaluing, and/or distant (Allen, 2005). The resulting disruption in self-attunement promotes emotional vulnerability, the suppression of protective and self-caring action tendencies (Fosha, 2000a; McCullough, 1997; Van der Hart, Nijenhuis & Steele, 2006), identity fragmentation (Harter, 1999; Janet, 1887; Jung, 1936; Putnam, 1997; Watkins & Watkins, 1997), and a chronic reliance on psychological defenses (Firestone, 1988; Schwartz, 1995). Without the ability to comprehend our inner experiences, we become unable to engage in self-compassion or come to terms with painful aspects of our autobiographical narrative.

In addition to examining internal relatedness from the perspectives of emotional wellbeing and psychopathology, this article will focus on applying intra-relational principles to clinical practice using a method called

Intra-relational Accelerated Experiential Dynamic Psychotherapy (AEDP) (I-R) (Lamagna & Gleiser, 2007). I-R is an integrative approach that blends Accelerated Experiential Dynamic Psychotherapy's attachment-relatedness-experiential model (Fosha, 2000a, 2000b, 2002, 2004, 2008; Russell & Fosha, 2008) and concepts from internalized object relations (Fairbairn, 1952) with ideas on fostering self-compassion and relatedness between aspects of the mind originally pioneered by Richard Schwartz and Internal Family Systems therapy (Schwartz, 1995). Like psychodrama (Moreno, 1946), gestalt therapy (Perls, 1951), psychosynthesis (Assagioli, 1971), transactional analysis (Berne, 1975), Ego state therapy (EST) (Watkins & Watkins, 1997), emotions focused therapy (Whelton & Greenberg, 2004; Elliot & Greenberg, 1997), voice therapy (Firestone, 1988), voice dialogue (Stone & Winkleman, 1989), and dialogical psychotherapy (Hermans, 2004), I-R embraces direct work with various parts of the psyche. However, by blending Accelerated Experiential Dynamic Psychotherapy with its metapsychology drawn from attachment theory (Bowlby, 1973, 1980, 1982; Cassidy, 2001; Fonagy et al., 2002; Main et al., 1985), developmental studies (Beebe & Lachmann, 2002; Schore, 1994, 2003; Trevarthen, 1993; Tronick, 2007), affective neuroscience (Panksepp, 1998; Porges, 2001), and positive affect and flourishing (Fitzpatrick & Stalikas, 2008; Fredrickson, 2001; Russell & Fosha, 2008), with so-called "parts work," I-R constitutes a new clinical synthesis of recent developments in the fields of relatedness, emotion, positive psychology, and somatic-focused psychotherapy.

Normative Multiplicity

I-R views the psyche as an intricate mosaic of relatively discrete yet interdependent self-states (Federn, 1952; James, 1890; Jung, 1936; Ornstein, 1991; Putnam, 1997; LeDoux, 2003) or action systems (Janet, 1887; Van der Hart, et al., 2006), interacting within a complex, emergently constructed, dynamic system (Bromberg, 2003; Lamagna & Gleiser, 2007; Schwartz, 1990, 1995). Each state, possessing a unique pattern of emotion, thought, sensation, and associated action tendencies (Bromberg, 2003; Jung, 1936; Putnam, 1997; Schwartz, 1995; Watkins & Watkins, 1997) serves as a procedural template for bringing the mind's mental processes into cohesive, efficient, and effective states of activity (Izard et al., 2000; Siegel, 1999; Whelton & Greenberg, 2004). As parts of the psyche, these self states can be seen as mentally reconstructed approximations of some aspect of an individual's lived subjectivity, each a locus of experience occupying a particular position in mental time and space (Hermans, 2004). As such, one's inner mental life resembles Julian Jaynes' idea of "mind-

space” (1976), where the intrapsychic field represents a “spatial analogue of the world and mental acts are analogues of bodily acts” (Quoted from Hermans, 2004, p.18). Sometimes self-state activity represents a momentary need or adaptive action tendency (i.e., self-assertion), while at other times it may be derived from one’s own or another’s perception of the self (i.e., a state that adopts father’s view of self as a “disappointment”) (Spitz, 1957; Tronick, 2007).

Given the variety of life circumstances and the multiple needs we humans experience, managing and integrating the often contradictory imperatives that compel us to act requires a mind capable of maintaining unity among its constituent parts, while operating in a flexible and relatively harmonious manner (Siegel, 1999, 2007). Sander (2002) describes how natural systems maintain harmony “. . . not because of the strength of individual members [within the system] but because of the way *the entire structure* contains and manages to distribute and balance stresses. *Tension is continually transmitted across all structural members*” (p. 18) (italics added). Applying this principle to self-organization, we can propose that stresses are “transmitted” and mental functions coordinated across parts of the mind through the process of attunement and resonance (Lamagna & Gleiser, 2007; Siegel, 2007). In other words, the self-system requires reciprocal connection among its subsystems (self-states) to maintain its integrity over time. Self systems which support the adaptive integration of information held in one state with other states containing corresponding functions and information (Siegel, 1999; Chefetz & Bromberg, 2004; Sander, 2002) are able to increase its complexity and coherence, thereby fostering response flexibility and a general sense of well being (Siegel, 2007). This ability to share information across different contexts or discrete mental contents also allows for constructive abstraction, whereby internal contradictions are brought together to create new, higher order truths (Pascual-Leone, 1990).

In contrast, self-systems that fail to register or actively reject salient information held in other aspects of self cannot achieve states that are adaptively variable and harmoniously unified. With the exception of moments where one is “single mindedly” focused on an object or activity of interest or brief instances where immediate survival is at stake, reasonably accurate maps of self and the world cannot be constructed from any single position within the mind (Gadamer, 1989). Each on its own can incorporate only so much information, and the limits of any particular configuration would place significant constraints on the level of complexity the mind-system could attain. Most often what is needed to navigate our complex social world is an assimilation of a variety of internal perspectives.

Let us now discuss some speculations on these coherence-engendering self-organizing mechanisms and how they might be realized in the mind.

Internalized Attachment System

Developmentalists like Bowlby (1973, 1980, 1982), Stern (1985), Schore (1994, 2003), Tronick (2007), Beebe and Lachmann (2002), and Trevarthen (2001) have all emphasized the idea that self-organization occurs in interaction with another self. It is essentially a *dyadic* not monadic process. The intra-relational perspective holds that because capacities for attunement, integration, and repair are transmitted through the medium of interactive engagement between child and caregiver, the mind renders such abilities through an analogous *internally interactive representational process* (Fairbairn, 1952; Guntrip, 1961; Jacobson, 1964; Lamagna & Gleiser, 2007). Specifically, I-R posits that our psyches generate two simultaneous frames of reference—one representing one’s moment-to-moment body sense, emotions, thoughts, behavioral impulses, and images (“subjective states”—or in attachment terms, working models of self; Bowlby, 1989) and the other, reflecting on, appraising, and organizing our responses to that experience (“reflective states” or working models of others (Bowlby, 1989; James, 1890; Grotstein, 2004; Lamagna & Gleiser, 2007; Pascual-Leone, 1990; Siegel, 2007; Spitz, 1957). Together, through the interplay and mutual coordination of their respective mental activity, this intrapsychic dyad coalesces to form an internalized attachment system (Guntrip, 1961; Jacobson, 1964; Fairbairn, 1952; Lamagna & Gleiser, 2007). The level of wellbeing that an individual is capable of achieving will be dependent upon the degree of harmonious interplay between parts of the self occupying these two intrapsychic positions.

Attuned communication between subjective and reflective elements of one’s self- system is crucial to the ongoing maintenance of adaptive regulatory processes (Sander, 2002; Lyons-Ruth, 2000). This involves a relationship with self that is characterized by connection, openness, harmony, engagement, receptivity, emergence, noesis (“deep authentic knowing”), compassion, and empathy (Siegel, 2007). Siegel (2007) writes:

An attuned system is one in which two components begin to resonate with each other . . . Within self-reflection and internal attunement, we come to resonate with our own state of being. Before long, the influence of a clear and open receptivity to direct experience creates internal resonance, an entrainment of lived and observing states with each other. Our observing self needs to be open to our “self-as-living.” With the attention to intention, we then develop an integrated state of coherence” (p. 206).

This resonance within the self system is necessary for what I describe as the intrapsychic version of “interactive repair” (Tronick, 2007) which, from an intra-relational perspective, plays an important role in the development of psychological resilience and the cultivation of a “feel and deal” stance toward life. Tronick states that infant and caregiver need to be

connected in ways that allow them to comprehend each other's state of consciousness. In the case of the caregiver, he or she must be able to perceive and register the infant's distress to intervene and regulate it. Securely attached dyads engage in countless sequences of disruption and repair whereby equilibrium and positively valenced affective states are restored following negative events (Bowlby, 1973, 1979, 1980; Main, 1985; Schore, 1994, 2003; Beebe and Lachmann, 2002). This reparative process teaches the child that negative circumstances can be endured and transcended (Malatesta-Magai, 1991). The intra-relational version of this rupture and repair process involves rapid and usually unconscious sequences where, after one's sense of well being or psychobiological balance becomes disrupted (i.e., "distress"), it is reestablished "from the inside" in a reasonably prompt manner.

For example, I recall my youngest daughter going on an amusement park ride when she was four years old. As the ride jerked into motion, she looked fearful for a brief instant, sensing her momentary loss of balance. In less than a second, she turned to her sister with a smile and laughingly said "I feel like I'm going to fall off but I'm not *really*." She proceeded to enjoy her ride. The first part of her utterance, "I feel like I'm going to fall off" conveyed the fear that came with her initial loss of balance. The latter "but I'm not *really*" represented the rapid inclusion of additional information from another part of the mind, whose timely "intervention" altered the trajectory of her initial state. I believe that had she not registered this second stream of information, she would have likely had a disturbing ride. These intra-relational interactions, which occur countless times each day, become the mechanism through which trust in one's capacity to cope and maintain one's safety are born.

Note that the above example illustrates how these moments of self attunement can occur in milliseconds and can take place below the threshold of consciousness. At other times, this regulatory mechanism may be subjectively experienced as an inner voice, image, or felt sense. For instance, take a nervous first-time public speaker who weathered her anxiety after registering internally generated thoughts or images reminding her that "You (Or "I") can do this! "You've worked so hard preparing for this and people will really get something from what you have to say." Input from a part of the mind lying "outside" of the distress turns negative affect into positive affect. This process engendering the stabilization of moods and the relatively prompt shifting from distress to positively toned emotional states is the "hallmark of a developmentally and functionally evolved superego" (Schore, 2003, p. 183).

I contend that individuals on the healthy end of the functionality continuum possess reflective self states whose attunement, empathy, and intrapsychic proximity (akin to "sympathetic companionship," Trevarthen,

2001) help calm overwhelming emotions, mitigate overzealous activation of shame and anxiety and trigger positive affects that encourage an optimal flow of information and energy within the mind (Fitzpatrick & Stalikas, 2008; Fredrickson, 2001; Siegel, 1999). Such individuals can be “by themselves” without subjectively feeling “alone” or “empty” and are able to register and realistically reflect on their own acts of mastery with delight (a sense of “Damn, I’m good!”). Overall, internal attachment dyads that offer much in the way of attunement, vitalization, and consistent interactive repair bias the psyche toward perceived inner safety, allowing multiple affective truths and adaptive strivings to be welcomed, communicated, acknowledged, experienced, and assimilated into one’s identity (Bromberg, 1998). Feeling and dealing with one’s internal and external realities in this manner leaves the person free to channel their energies into being fully alive, fully present, and grounded in true self (Fosha, 2008; Ghent, 1990; Winnecott, 1960/1965). Adaptive inhibition remains intact, but defensive reactions to one’s innermost feelings, perceptions, and impulses are relatively subdued because full faith in the individual’s worthiness and capacity to cope means there is little to fear from this knowledge.

Adaptation to Pathogenic Environments: The Suppression of Self-experience

In attachment relationships where the caregiver’s typical behavior is excessively negative, defensive, intrusive, inconsistent, neglectful, and/or abusive, children suffer from the lack of opportunities for interactive resonance, recognition, or repair (Bowlby, 1973, 1980; Cassidy, 2001). Without such wellbeing-engendering experiences, they must instead adapt to disruptive forms of relating by defensively excluding and segregating self-states that would put their life or attachment relationships at risk (Bowlby, 1973). Though the qualitative character and severity of maltreatment can vary widely along a spectrum from “inconsistent” to “abusive,” one fundamental commonality is the lack of reliable attunement and communication between caregiver and child (Sander, 2002). In each case, the caregiver’s ability to connect with the child is hindered by the relative vehemence of their own subjective experience —whether immersed in addictive preoccupation, a psychotic or depressive episode, pathogenic characterological imperatives, or unresolved trauma. The caregiver’s preoccupation unfortunately does not lessen the child’s need for deep contact, which in this case sows the seeds for later dysfunction. For example, Tronick (2007) writes:

What happens to children when the establishment of dyadic states of consciousness is chronically denied? . . . Given that the infant’s system functions to expand its

complexity and coherence, one way open for the infant of a depressed mother to accomplish this expansion is to take on elements of the mother's state of consciousness. These elements will be negative—sad and hostile affect, withdrawal, and disengagement. However, by taking them on the infant and the mother may form a dyadic state of consciousness, but one that is negative at its core. . . . This dyadic state of consciousness contains painful elements, but its painfulness does not override the need for expansion (p. 409).

Developing such a pathogenic, “negative core” does several things: First, it compromises the development of adequate self-regulatory abilities (Schorer, 1994, 2003). Second, it creates internal working models that defensively exclude vital information about our inner states and the states of others (Bowlby, 1980, 1989). Third, the dysregulated affect that results from poor affect regulation and self-understanding impinges upon the flow of information needed to maintain states of coherent wholeness (Sander, 2002).

Internalizing parts of an inadequate attachment figure's consciousness creates reflective self states that, like the caregiver, are unable to attune to, recognize, or engage in interactive repair with parts of the self representing the individual's subjective experience. So, when such a person experiences the inevitable losses, rejections, disappointments, and frustrations of life, in addition to the disturbing “raw affect” and painful memories evoked by these events, they also have to contend with them “alone”; that is, without adequate inner sources of solace. In some instances, where regulatory capacities are seemingly nonexistent, intense anxiety may motivate the person to desperately seek out and cling to others for comfort and affirmation of worth (Ghent, 1990; Holmes, 2001). In other patients, the presence of reflective states of a persecutory nature may trigger inhibitory anxiety and/or shame affect to dampen ecologically valid feelings of sadness, anger, and so forth. For example:

An avoidant male patient described how, in his prior therapy he would ask the therapist to “turn out the lights” when he sensed he was going to cry. After she complied with this request, he would finally allow himself to sob. When I asked whether he felt any relief or healing as a result of his crying, he stated that despite the therapist's presence and support he experienced it as “totally humiliating.” This man obviously felt the intention to cry within himself, but from some reflective position within his mind that need was viewed as a “pathetic sign of weakness” or as an unacceptable act of vulnerability. His need to express his true emotions with the therapist was a striving that this part of the self reflexively inhibited by internally evoking shame. From an intra-relational perspective, we can say that self-contempt was the means used to ward off feared-to-be unbearable grief and to down-regulate the affect system (Tompkins, 1963). As a result, the part of self “holding” the initial sadness also experienced itself as

helpless and utterly alone in the wake of its rejection by the “contemptuous” reflective state.

The internal experience of aloneness-in-the-face-of-distress is an example of the intrapsychic analogue to attachment rupture without repair or to posttraumatic abandonment by others (Lamagna & Gleiser, 2007). Here, emotional abandonment and negative appraisals by reflective self states follow the triggering of subjective states of distress, creating even greater distress. I hypothesize that like social abandonment after intense distress, this form of internal abandonment plays a key role in the development, maintenance, and exacerbation of pervasive traumatic stress (Allen, 2005) and character disorders (Schore, 1994, 2003). I would argue that the lack of proximity to inner “sympathetic companions” (Trevarthen, 2001) could also be at the heart of the existential emptiness, lack of vitality, and intolerance to solitude seen in many chronically maltreated patients.

Without the capacity to comprehend and regulate their emotional experience, individuals with dissonant, pain-evoking, inner attachment systems actively avoid experiential contact with their authentic emotions, strivings, and memories, leading to an ongoing disavowal and dissociation of self experience (Janet, 1887/2005; Putnam, 1997; Winnecott, 1960/1965). As such, excluding emotional information associated with the autobiographical narratives contained within dis-identified parts of self mitigates the development of self-compassion and understanding. For instance, one male patient of mine harbored intense hatred toward himself for weighing more than 400 pounds. While he had no trouble registering contempt for his body and dietary failures, his avoidance of effects associated with formative events of his life prevented him from fully appreciating what led to his need to medicate his loneliness and perceived inadequacy. As a witness to his own life, this man could make no meaningful, caring connection with himself as protagonist because he shunned access to the underlying emotions that organize and elaborate the meanings of his story. From an I-R standpoint, we might say that his pervasive sense of shame is a manifestation of empathic failure by reflective elements of the internal attachment system.

Resistance to having direct, authentic experiences of self can be seen as a primary source of mental suffering (Siegel, 2007) with the person’s defensive operations and the internal evocation of inhibitory affect (i.e., shame and anxiety) keeping them from adaptively responding to the realities of their lives. Consequently, such individuals become ill equipped to face, accept, and effectively respond to what is real and true within and around them (Cassidy, 2001; Grotstein, 1999; Winnecott, 1960/1965). Furthermore, dysfunctional internal dynamics, which often involve self-states organized around pathological roles (i.e., “victim,” “persecutor,” or “res-

ducer” roles) (Karpman, 1968) threaten to spill over into the person’s engagement with outside world via transference and projective processes.

We will now look at one way intra-relational concepts can be applied to psychotherapy, returning again to our original focus on attunement, receptivity, and self-regulation. I will do this by introducing the reader to Intra-relational AEDP (I-R) (Lamagna & Gleiser, 2007). Because so much of the I-R approach has grown out of the metapsychology and methodology of AEDP (Fosha, 2000a, 2000b, 2002, 2004, 2008), and its integration of techniques from Internal Family Systems therapy (Schwartz, 1995; Watkins and Watkins, 1997), the author wishes to state that *only the concept of a self-organizing, internalized attachment system presented earlier and the parts-oriented modification of AEDP techniques are original to I-R.*

CLINICAL PRACTICE

Intra-relational AEDP (I-R) (Lamagna & Gleiser, 2007) is a healing-based, affect-centered clinical approach derived from Accelerated Experiential Dynamic Psychotherapy (AEDP) (Fosha, 2000a, 2000b, 2002, 2004, 2008). It was developed to address the emotional dysregulation, identity fragmentation, impulsivity, self-loathing, existential emptiness (McCann & Pearlman, 1990; Van der Hart et al., 2006), and deficits in reflective function (Allen, 2005; Fonagy et al., 2002; Fonagy & Target, 1997) commonly seen in adult survivors of pervasive maltreatment. From an I-R perspective, these symptoms result from the chronic segregation of various subsystems that make up “the mind” (Janet, 1887/2005; Putnam, 1997; Van der Hart et al., 2006;). These systems are responsible for creating reasonably accurate maps of the person’s environment (Adolphs, 2004; Epstein, 1991), processing and integrating implicit (emotional/somatic) memory (Siegel, 1999; Schore, 2003; Van der Kolk & Van der Hart, 1991), constructing adaptive personal realities (Janoff-Bulman, 1985), and organizing coherent responses to environmental challenges (Ornstein, 1991; Siegel, 1999). If achieving states of wholeness is the “motivating force” behind self-regulation in living systems (Sander, 2002), then the dissolution of this intrapsychic wholeness (i.e., chronic dissociation) represents the primary pathogenic process disrupting the patient’s innate propensities for optimal self-organization, self-righting, and adaptive action (Fosha, 2000a; Bromberg, 1998). From this perspective, one can view the self system’s capacity for functionality (or dysfunctionality) as being predicated on the notion that “United we stand, divided we fall.”

As mentioned earlier, such divisions are a consequence of living in chronically traumatizing and neglectful family environments that induce

pain and supply little in the way of solace, mirroring, empathy, and interactive repair (Allen, 2005; Fonagy et al, 2002; Van der Hart et al., 2006). Without exposure to attachment figures capable of effectively regulating the child's affect and sense of self worth, his or her mind is left to modulate distressing states through a combination of negative self-inhibitory processes (i.e., self-punishment, obsessive anxiety) and avoidance of intrapsychic and interpersonal experience. These regulatory processes "protect" the child by quelling adaptive feelings that could have overwhelmed them and made them increasingly vulnerable to emotional or physical injury or threatened their connections to needed attachment figures. However, over the long term, they compromise the patient's ability to "take in," "receive," or "resonate to their own internal signals of wants, needs, and self-value" (McCullough et al., 2003, p. 245). The resulting "receptive impairment" constitutes the greatest hindrance to character change (McCullough, 1997) by hampering the patient's efforts to alter pathological inner representations, act on behalf of true self (Winnecott, 1960/1965), and respond positively to the therapist's encouragement, care, and interventions (McCullough, 1997; Fosha, 2000a).

Intra-relational AEDP was developed to provide a method for developing receptive capacity, harnessing psychological resources for self-regulation and fostering emotional wellbeing in chronically traumatized patients. By adopting a parts-oriented, heuristic approach that speaks to the patient's subjective experience of internal fragmentation and conflict, I-R offers ways to regulate the process of self-understanding and change by 1) Promoting attunement between the client, therapist, and various internal parts of self and facilitating the experiential tracking of the resulting states of shared resonance and recognition, 2) Using the positive emotions intrinsic to this process of "fitting together" (Sander, 2002) to evoke "upward spirals" of positively toned states that broaden and build mental capacities (Fitzpatrick & Stalikas, 2008; Fredrickson, 2001; Russell & Fosha, 2008), and 3) Explicitly developing self-reflective abilities ("metaprocessing" Fosha, 2000b) to deepen, reinforce, and integrate these therapeutic changes. For the pervasively maltreated, building resources and mental coherence in this manner paves the way for deeper, more comprehensive emotional processing of traumatic material down the road.

Experiential Attunement to Self

Fosha (2002) writes: "A model of therapy needs in its essence to be a model of change" (p. 2). For I-R as for AEDP, the key agent of this

therapeutic change involves the accessing and complete emotional processing of *core affective experience*, defined as naturally occurring emotions that arouse both adaptive action tendencies and innate psychological self-righting mechanisms (Fosha, 2000a). The AEDP model hypothesizes that helping patients attune to and process various forms of core affect via alternating waves of experience and reflection upon experience propels the patient through a series of state transformations. Specifically, the transformational process involves moving patients from states of *defense & distress* (psychological defenses like projection, denial, etc., dysregulated and/or inhibitory emotions such as shame, anxiety) to full engagement with one's adaptive emotional experience/impulses, (*core affect*). After fully working through *core affect*, interventions using *metatherapeutic processing* move the clinical focus to the experience of change itself (Fosha, 2000a, 2000b). This yields feelings of joy, pride, mourning, affirmation-of-the-self, gratitude, love, tenderness, and appreciation of self and therapist (*transformational affect*). Further work around these affects leads to the fourth and final state, *core state*, which engenders deeply integrated states characterized by calm, flow, well-being, vitality, and wisdom (Fosha, in press). Altogether, movement through this sequence of state shifts fosters change by increasing the patient's sense of vitality and meaning, generating a sense of mastery, harnessing adaptive action tendencies and accessing deeper, previously unconscious psychic material (Fosha, 2000a).

So what types of affective experiences are believed to bring about the progressive movement from defense and distress to core state? According to Fosha (2000a), core affective experiences include adaptive forms of categorical emotions like sadness, joy, fear, and anger, which have long been the focus of experiential therapies (Elliot & Greenberg, 1997; Perls et al., 1951; Moreno, 1946). However, she includes two other types of experiences under the rubric of core affect as well. Both rooted in the process of attunement and relatedness, they are dubbed *core relational experiences*, involving states of dyadic attunement, resonance, coordination, and rupture and repair (Beebe & Lachmann, 2002; Tronick, 2007), and *receptive affective experiences* that impart empathy, validation, and a sense of feeling known, seen, & understood (Fosha, 2000a, 2002). These two affective phenomena lie at the core of intra-relational change processes.

Though AEDP recognizes the existence of self-states and the importance of intrapsychic phenomena in wellness and psychopathology, core relational, and receptive affective experiences are most often viewed as processes that occur *between patient and therapist*. In formulating the notion that the mind itself operates dyadically (Lamagna & Gleiser, 2007; James, 1890; Fairbairn, 1952; Grotstein, 1999), I-R extends the mutative power of core affect by fostering relatedness between the patient and intrapsychic aspects of his or her mind. In other words, in addition to using

emotions that manifest through positive connections with others, emotional experiences associated with coherence and coordination within the self, empathy for the self, and validation and deep recognition of the self can also be experientially processed in ways that catalyze therapeutic change. Siegel (2007) alludes to the essence of this process in his book “The Mindful Brain”: “Attunement means sensing things just as they are within awareness. Our “lived” self resonates in a direct, clear manner with our awareness of self, *and we “feel felt” by our own mind*” (p. 78) (italics added). Interestingly, Siegel goes on to suggest that such intra-relational contact activates the same “social resonance circuits” in the brain (including mirror neuron system, prefrontal cortex, and anterior cingulate gyrus) that are active during interpersonal contact. This view is very much in line with Guntrip’s observation that inner representations are called “internal objects” precisely because we respond to them emotionally and behaviorally in the same ways we do with “externally real persons” (Guntrip, 1961; p. 226).

The reason for developing an intra-relational approach lies in the dissolution of systemic wholeness described earlier. For patients whose attachment relationships involved pervasive abuse, intrusiveness, and/or neglect, negotiating the passage from defensive states to core state is particularly challenging. Many such patients cannot seem to find enough inner safety or regulate their emotions well enough to “go there” nor can they generate enough trust in the therapist to avail themselves of opportunities for dyadic regulation and empathy. Often when such patients DO happen to make contact with righteous anger or adaptive sorrow, they respond not with therapeutic change but rather with emotional flooding, self-attack, dissociation (and afterward), depressive symptoms, compulsive behavior, and/or partial amnesia (i.e., dissociated memory). I believe that one reason this is so is because attuning to categorical emotions and interpersonal experience associated with core affect involves being open and vulnerable—a state long associated with predation or abandonment. Contact with dissociated mental contents can, therefore, heighten the potential for kindling traumatic memories and long forbidden emotions and impulses. In intra-relational terms, such procedures activate malignant patterns of self relatedness by exacerbating divisions between parts of the self striving to express aspects of “true self” (Winnecott, 1960/65), and other, archaically “protective” parts that automatically inhibit the revelation and expression of authentic self experience (Lamagna & Gleiser, 2007; Schwartz, 1995; Van der Hart et al., 2006).

I-R interventions seek to make the intra-relational domain reasonably secure (i.e., emotionally safe and responsive) and open to dyadic regulation and/or the adaptive auto-regulation of intense emotions to effectively

address painful emotional material.¹ Deeply processing the somatic and emotional components of this progressive move toward greater safety and intrapsychic contact engenders a reciprocal opening to disparate perspectives existing within the psyche; a collation process that ultimately leads to a richer, more inclusive autobiographical narrative (Chefetz & Bromberg, 2004; Siegel, 2007) and increases in the mind's capacity for harmony and adaptive flexibility (i.e., well-being) (Siegel, 1999, 2007). It should be noted that the process begins but does not end with the development of deep connection between parts of self as described in this article. For survivors of persistent maltreatment, however, it is a necessary preliminary step in readying the self system for ultimately addressing the unresolved pathogenic experiences that brought the patient to therapy in the first place.

Processing Positive Affects Linked to Self-attunement and Self-recognition

Informed by AEDP's belief that individuals possess a deep need for interpersonal attunement and recognition, I-R posits that parts of self possess similar needs at the intrapsychic level (Lamagna & Gleiser, 2007). Meeting these needs by fostering a compassionate stance toward oneself allows the ongoing process of self-organization to manifest in new and novel ways (Fosha, in press; Ghent, 1990; Lyons-Ruth, 2000; Sander, 2002; Siegel, 2007); ways that give rise to many and varied positive affective states (Fosha, in press; Fosha, 2008; Russell & Fosha, 2008). This affective shift marks a profound and sought-after psychobiological change from self-configurations based on threat and defense to configurations associated with engagement with the world (Porges, 2001). At the same time, these positively toned experiences provide a potent means for further catalyzing affective change processes in their own right (Fitzpatrick & Stalikas, 2008; Russell & Fosha, 2008).

It should be noted that as Fosha (2008) observed, not all "positive" emotions feel pleasurable when processing them (p. 9). Often times initially facing one's emotional truths is an ordeal that is both painful and feared to be overwhelming. However, unlike pain that is self-inflicted or evoked by reenactments/transference, the processing of pain that comes with the recognition of some essential truth, regulated within the context of a caring, supportive relationship with the therapist facilitates change. So, such affective states are deemed "positive" because processing them ulti-

¹ This is akin to the IFS process of establishing "Self leadership" in which the patient cultivates a curious, compassionate stance towards their inner experience (Schwartz, 1995).

mately increases psychological coherence, expands mental functioning, and activates adaptive action tendencies (Fredrickson, 2001; Russell & Fosha, 2008; Siegel, 2007) that are instrumental to the healing process (Fosha, 2008).

Core Intra-relational Experiences

One source of positive emotion that can be experientially processed is the felt sense of attunement and resonance occurring within the mind. Representing the *intrapsychic* counterpart to interpersonal *vitality affects* (Stern, 1985), these “affects of attunement” signify the feeling of what happens when there is a movement toward greater inclusiveness, coherence, and complexity among constituents of the mind (Sander, 2002; Siegel, 2007). As attuning parts of self join to create a coordinated superstate, the expansion and increased flow of energy strengthens and vitalizes the patient (Fosha, in press; Sander, 2002). Patients are invited to notice where they viscerally experience this shift in perceived strength or vitality, and to track the sensations, thus reinforcing and deepening them. Heightening contact with these positive states as described also leads to the reassociation of affectively congruent memories, symbolic images, and metaphors, which provide forward momentum to transformational processes (Leeds, 1999).

Another aspect of this heightened intrapsychic coordination is the actual sense of “feeling felt within the mind” (Siegel, 2007). In a process that parallels attachment interactions, reflective aspects of the mind become receptive to material represented by other, previously estranged parts. Instead of reflexively reacting to them based on archaic imperatives to inhibit emotion and action, patients anchored in the here-and-now begin rediscovering themselves through these remnants of lived subjectivity (Siegel, 2007). Patients often use words like “soothing,” “comforting,” “grounding,” or “warm” to describe the experience, hinting at the developing capacity for self-containment that appears to be at play here (Fonagy & Target, 1997).

Transformational Affects

A clinical focus on processing *core affect*, particularly categorical affects, involves work on emotions *of* the self toward others — anger, sadness, hurt, or joy, whose full assimilation and expression was somehow hindered at a crucial time in the past. Here, in shifting to affective states

associated with *transformational affects* (Fosha, in press), we enter a different realm where the emotions being experienced and processed primarily involve feelings *for* and *about* the self. Exploring and integrating these self-referential emotions serves to both link *and* differentiate the patient's conscious awareness of their own mental states and the subjective experience at the somatic and emotional level (Fonagy et al., 2002). The tears shed at this stage of treatment are generally not the tears the patient was unable to shed at the time of a particular painful event but rather tears evoked by recognizing, acknowledging, and assimilating the meaningfulness of these previously dissociated states in relation to self. In connecting with such emotional information (not available when punitive, phobic or dissociative responses were in force), there is an emergent understanding that the self's suffering is not deserved and that self is valid, valuable, and worthy of protection. Additional waves of emotional work are undertaken with the focus on mourning what the self needed and didn't receive, on newfound pride in one's inner resources and capabilities, and on mastery in recognizing the healing these affective change processes have wrought.

Healing affects constitute a second category of positive emotions that emerge from the exploration of the patient's experience of change (Fosha, 2000b, 2002, 2004). Brought about through the deep recognition and integration of some previously disowned feelings, thoughts, and impulses, this affective phenomenon is marked by feelings of gratitude, love, tenderness, and appreciation for self, the therapist, and the work. With such feelings comes the sense that something important and meaningful has taken place in the session. Indeed, the action tendencies gleaned from healing affects and self-referential mourning, pride, joy, and affirmation provide the fuel for the self system's movement toward greater openness, harmony, engagement, receptivity, and empathy (i.e., well-being) (Siegel, 2007). Continued rounds of processing culminate in the fourth and final state shift, to the calmness, ease, and clarity associated with *core state* (Fosha, 2000a, 2002).

Taken together, the practice of evoking and processing positive affective experiences associated with self-relatedness provides a mechanism for broadening thought—action repertoires, enhancing the assimilation of new information, augmenting resiliency, developing enduring psychological resources, and increasing creative capacities. In addition, over time, such work serves to undo the lasting effects of fixated, negative-toned, affective states (Fredrickson, 2001) that often become the norm in pervasively maltreated individuals. Whether involving the felt sense of connection, resonance, and expansion, a new openness to one's inner experience, empathy, care, and acceptance of self, or gratitude, love, tenderness, or appreciation, these positive experiential phenomena set an "upward spiral" in motion that facilitates emotional wellbeing (Fitzpatrick & Stalikas, 2008; Russell & Fosha, 2008).

Metacognitive Self-Reflection: Metaprocessing

Up to this point, much of the discussion about I-R clinical work has focused on the centrality of experiential processing. Indeed, research has demonstrated that exposure to intense emotions is the strongest predictor of outcome in many types of treatment (Iwakabe, Rogan, & Stalikas, 2000). However, catharsis is insufficient in and of itself (Fitzpatrick & Stalikas, 2008). The personal meanings embedded in emotional experience also need to be integrated for therapeutic change to take place (Fonagy et al., 2002; McCullough, 1997). This point is particularly salient for pervasively maltreated patients, who often become consumed by their emotions, without the ability to reflect on them (Allen, 2005; Van der Kolk & Van der Hart, 1991). This pattern of affective flooding has a disintegrating effect on mental functioning, compromising a patient's ability to attend to, recognize, regulate, interpret, and comprehend (i.e., mentalize) the contents of their mind (Fonagy et al., 2002; Janet, 1887; Van der Hart et al., 2006).

The I-R/AEDP intervention known as metaprocessing (Fosha, 2000b) addresses impaired reflective function by helping to bring the patient's mind "to mind" (Allen, 2005; Holmes, 2001). Described as alternating waves of experience and reflection on the patient's felt sense of transformation, it is used to help patients integrate and reinforce positive changes gleaned during a given session (Fosha, 2000a, 2000b). Initiated within a relational context, metaprocessing questions like "What is it like for you to feel sad for that hurt part of you?", "Ask the "angry monster" inside: What is it like to have us acknowledge this part's rage at your father?", "What is it like being with that feeling of energy in your arms?", and "What is it like for you and I to have done this piece of work together?" perform many therapeutic functions. First, as stated earlier, they evoke additional, deeper rounds of processing focused on the experience of change itself (Fosha, 2000b). Second, they privilege the action tendency of recognition (Fosha, 2008) by having the patient reflect on such moments with an actively engaged, emotionally attuned, empathic therapist. Here, the "reality," validity, self-ownership, meaning, and importance of these change events can be more fully recognized and assimilated. Third, they allow for the development and integration of linguistic/symbolic representations of the patient's emotional states, thus creating an adaptive buffer to previously overwhelming "raw" affect (Allen, 2005; Fonagy et al., 2002; Main et al., 1985). Fourth, oscillating between experience and reflection on experience provides an efficient way for integrating previously dissociated emotional information into the patient's autobiographical narrative.

CLINICAL ILLUSTRATION

The following vignette illustrates the clinical use of intra-relational techniques involving emotional attunement, the processing of relatedness-based positive affects and the metaprocessing of transformational experience (Fosha, 2000b). In many ways I-R appears quite similar to Internal Family Systems therapy (Schwartz, 1995) (particularly because I incorporated Schwartz's differentiation technique in mid-2008). The general similarity is fascinating given their separate development from disparate models of origin (short-term dynamic psychotherapy for I-R and family systems therapy for IFS) and their very different metapsychologies (Fosha, 2005). I propose that the sometimes subtle differences between the two models involve *the ways in which (and the extent to which)* the therapeutic relationship, emotion, and the experience of change are addressed clinically.

Looking at the therapeutic relationship, both IFS and I-R emphasize the importance of establishing a collaborative relationship with patients, guiding and supporting them in cultivating an open, caring stance toward various parts and in accessing and integrating unmetabolized, pathogenic experience. However, IFS operates from a stance that reflects its roots in structural family therapy. That is, the clinician's role is to guide members of the patient's internal system to communicate *with each other* and once "Self leadership" is established, to intervene only when this process is interfered with by elements of the system. The ideal intrapsychic system is seen as being whole in the sense that it has all the resources it needs to function optimally. I-R sees the individual as having innate self-righting capacities as well but in viewing the patient through a dyadic, psychodynamic/attachment lens, interpersonal attachment is seen as a need that exists "from cradle to grave" (Bowlby, 1982). Therefore, an I-R informed clinician unabashedly "enters" the patient's internal system in an experience-near manner, explicitly regulating intense affects dyadically. The therapist is encouraged to disclose his or her empathic emotional responses to the patient's expressions and to explicitly explore and undo blocks to the patient's fully receiving the therapist's attunement, compassion, and care. Metaprocessing is used to initiate rounds of processing that explore this via questions like "What is it like for you to see tears in my eyes?" and "What is it like for you to feel me here with you?" (Fosha, 2000b).

Another area for comparison is the focus on body-centered emotional experience. IFS uses body awareness at various points in the clinical work—bringing the patient's attention to sensations associated with "self energy" and finding where a part's unresolved experience is stored in the body. It, however, is "not primarily a somatic psycho-therapeutic model"

(McConnell, 1998).² I-R, on the other hand, is first and foremost focused on experientially tracking visceral aspects of affective experience and undoing defensive blocks to its activation and integration. One axiom among AEDP therapists is “Slow down the affect, speed up the process” (Osiason, 2006), which speaks to AEDP’s belief that staying with visceral experience linked to emotions catalyzes and accelerates change. This process is in force at every stage in the therapeutic process.

A third area involves the issue of change and positive emotion. Most psychotherapy approaches, including IFS, take some time to assess changes that occur for patients after a piece of healing work. However, I-R and AEDP are the only treatment approaches that formally and comprehensively “metaprocess” positive shifts in the patient’s sense of self and other. More than a debriefing that follows a change event, this exploration invites additional rounds of work regarding the different layers of affect and personal meaning evoked by change-for-the-better (Fosha, 2005). Change isn’t just about undoing negative affects but also about helping patients “tolerate” positive ones. This is particularly true with pervasively maltreated people (Leeds, 1999; Schore, 2003).

The case illustration presented here represents an edited and compressed composite of several treatment sessions with two similar patients, both of whom are middle-aged women with long histories of emotional neglect and abuse. Diagnostically, both meet the criteria for Dissociative Disorder NOS, in that they experience periodic disintegration of functions underlying consciousness, memory, identity, or perception but lack the amnesia for important personal events or the sense of losing executive control to distinct alter personalities seen in Dissociative identity disorder.

The excerpt begins with the patient criticizing herself over the emergence of dependency needs during contact with her family. Initial interventions are focused intently on regulating her emotion dyadically and helping the patient attune to the emergent flow of sensations, emotions, thoughts, and images as they enter consciousness.

Pt: I am just so pathetic! Every time I visit my parents it’s like I’m a kid all over again. I start needing their approval so badly that I just let them crawl under my skin! I was doing so much better with them and now
[Patient expresses loathing toward a self state whose unmet dependency needs create vulnerability to parental intrusiveness.]

Th: Yea, exactly. It’s really hard to see this coming up again—especially as you were starting to feel more empowered and hopeful. I understand that you’re frustrated with that, but I was wondering if we could just take a moment and focus on the part of you that felt hungry for

² Since the writing of this paper, I have learned that Susan McConnell has developed a variation on IFS called “Somatic IFS” which is primarily body-centered.

your parent's approval. Just pay attention to what's going on in your body or what may be coming up as thoughts or pictures in your mind. (pause). [*Therapist acknowledges anger, redirects to attune to core affect.*]

Pt: I have a sense of myself being very little—terrified that my parents were leaving me again. It's very intense . . . scary. [*Pt. shows some signs of agitation/anxiety*]. It's like there is a wound in the middle of my chest—a deep pain—an emptiness. (pause). I feel myself wanting to go away. [*She verbalizes an impulse to dissociate*].

Th: Okay. Check in with me for a moment. (Makes eye contact for a few moments.) [*Therapist works to ground the patient by fostering present sensory awareness.*]

Look around the room. Notice the color of the lampshade . . . (pause). [*After the client gets more grounded*]. So you, the *adult* you and I are here and you are feeling something that you say feels “young.” Can you check inside and see if you can get a sense of this young part of you? (pause) [*Therapist encourages contact with core affect linked to contact with “young” self state.*]

Pt: (With tears) The pain in my chest is getting stronger again.

Th: Um hum. Let's see if we can attend to the sensation together. Just breathe into it. [*Emphasizing “we” aspect of the exploration; dyadically regulating patient's anxiety.*]

Pt: (long pause) (Eyes moving as if thinking or visualizing)

Th: What are you noticing inside?

Pt: When I focused on the pain and went inside I got an image of a crying baby, but it was weird. The baby had no skin (pause). It's kinda like when you acknowledge me or look at me with kindness. It hurts. It hurts to feel your caring about me. It's like staring into the sun. [*Pain in chest is elaborated through symbolic images/metaphors; meaning becomes clarified.*]

Th: (softly) I see. So even though you want to find a way to end the loneliness, being with the baby—or having me be with you in a compassionate way, it is so painful that you move away from it. I'm wondering if the more compassion you take in, the more you realize how little you got and how much you needed it. [*Reflecting on possible intentions linked to approach/avoidance.*]

Pt: Yeah. I think that may be it. (pause)

Th: So, as you look at the baby there wanting care but somehow being unable to receive it, what do you notice inside? [*Facilitating attunement, engagement; possibly empathy.*]

Pt: (pause) (With tears coming to her eyes) I feel sad. She wants me to cuddle her but without her skin, it hurts too much to be held. (pause)

Th: [*Looking to sidestep resistance by titrating contact*] Well, one important way that mothers communicate is through gaze. I wonder if you and I could express our compassion for her through our eyes. [*Facilitating*

deeper attunement and coordination of affective states between the patient and part.]

Can you just look in her eyes and let her know that we're feeling sad about the pain and loneliness she carries? Can she look through your eyes and see my face? (pause) See if she can see us seeing her with our sad eyes.

Pt: (Patient looks at my face, tears up and looks away). She can see us but it's hard.

Th: What's hard for her? [*Exploring the source of receptive impairment.*]

Pt: Well it feels good at first, like a calming . . . but it's hard to trust it. (pause)

Now I'm hearing thoughts that "This is stupid!" and "Nothing is going to change the way things are" [*Reflective self state attempts to auto-regulate uncomfortable feelings linked to self-compassion by devaluing/sabotaging contact.*]

Th: I wonder if this is really scary to be with—scary to take it in? [*Empathic response to underlying emotion of reflective self state.*]

Pt: Absolutely!

Th: [*Using differentiation technique borrowed from IFS (Schwartz, 1995).*] See if you can ask the part of you that thinks this is stupid to just step back and not interfere with what we're doing right now. I get that this is unfamiliar territory, but let's see if it could just back off for now (pause). Is it willing to do that?

Pt: Yeah, I think it is.

Th: Okay. I really appreciate it being willing to do that (pause). [*Affirms part for cooperating.*]

Let's come back to being with the baby and her pain. What do you notice now?

Pt: The baby's still crying but it's different. [*Getting reflective part to "step back" allows other feelings to emerge.*] Before she was crying because she was left (tearing up). Now she's crying because I found her.

Th: [*Encouraging patient to stay with feelings expressed via the part.*] See if you can just stay with that as you notice her crying in this way.

(Minutes later)

Th: What do you notice?

Pt: (pause) The pain is subsiding and I feel calmer.

Th: Okay. [*Invites the patient to track shift in soma.*] Just notice the calmer. (long pause)

Pt: I just had the thought that "I want more of this."

Th: You want to be more compassionate and welcoming to these parts of you?

Pt: Right (Cries). It feels like wanting that comes from some deep place inside, and almost like I had to let the baby part of me know that I would

continue to try to do that—and that I know they need that. [*This highlights the patient's shift from avoidance and self-reproach to approach and recognition of need.*]

Th: That you need that. [*Emphasizing that part is a part of her.*]

Pt: Yes, well and sort of like acknowledging that I'm on their page.

Th: That is the opposite of compartmentalization right there.

Pt: It feels really good.

Th: [*Reflecting back.*] Being on the same page with yourself

Pt: Um Hmm.

Th: See if you can tune into what it feels like to be on the same page with yourself.

(Long pause)

Th: What's coming up for you?

Pt: I think it's interesting—that things come up and I begin to judge them (with tears). I see how closed off I've been from myself. [*Pt. sees defenses with clarity; experiences grief.*]

Th: (Softly) You have some feelings about that.

Pt: It's just sad. (cries)

Th: (Gently) It's okay. Just be with the feelings.

(Minutes later)

Th: What do you notice?

Pt: I don't know. I'm getting the same picture over and over.

Th: What is the picture?

Pt: It's me holding the baby. She's grown skin and we're together. She is relaxing into my arms. [*Intra-relational engagement deepens.*]

Th: Um hmm. [*Metaprocess*] And what is it like for you to have that baby part do that?

Pt.: It's warm. The word that comes to my mind is "truth"—that this is the way it's supposed to be.

Th: [*Metaprocess*] And what is it like being with the truth in this connection with the baby?

Pt: What is it like? Empowering.

Th: [*Guides patient to process positive experience.*] Just notice what "empowered" feels like in your body.

(A few minutes later)

Th: I am really touched by how you and this baby part of you are beginning to find each other. You're letting yourself see the pain that part of you carries and you are willing to bear witness to it. She doesn't have to be alone with it anymore. [*Self disclosure of feeling; Reflects observed shift back to the patient.*]

Pt: (Tears up) Before, the pain was unacceptable (pause). Actually, it was sublimated to the point that I didn't even know it existed. [*Recognition of prior defense.*]

Th: Right.

Pt: Like everything else, I avoided stuff and went numb: I just made it go away.

Th: Not today. [*Brings focus back to powerful shift experienced in session.*]

Pt: No, not anymore.

Th: (In a whisper) Wowwww. [*Aware of the monumental change in patient's stance toward self.*] I just don't know what else to say to that (pause). Just be with comes up.

(The patient associates to a recent memory of a friend lovingly responding to her self-deprecation with support and care.)

Th: [*Encourages reflection and meaning-making.*] What does that memory say to you?

Pt: "Stop judging yourself. You are okay." (Tears up).

Th: Can you be with that?

Pt: I'm trying. (Long pause) I don't exactly know how to describe it. It's like me and the baby facing the pain together. It's different. I don't have to hate myself for having the pain.

Th: [*Metaprocessing*] What is it like to say that—to feel that?

Pt: I feel warm (pause) and more connected to myself. It feels good. I don't feel the pain right now. It's strange. [*The felt sense of coherence still feels new and foreign.*]

Th: Let yourself stay with the feeling of connection. [Long pause] What's it like being with that? [*Metaprocess*] It's not a feeling you've described to me before.

Pt: I feel strong—like I know somehow that I'll be all right no matter what. It's different. I used to go away in my mind when the pain came. I just didn't allow myself to see the baby.

Th: You are now. [*Redirecting patient to "now" moment of change for the better.*]

Pt.: Right (tearing up). Allowed and acknowledged and praised. (pause)

That's appropriate to praise her?

Th: [*Affirming the patient for her hard work.*] Absolutely—to praise both of you, because as you see, it takes two to tango . . . She exists in your mind and heart . . .

Pt: (Tears up)

Th: And you in hers.

This segment illustrates ways in which IR seeks to foster emotional attunement, empathy, and resonance between the patient, therapist, and dis-integrated aspects of the patient's mind. A key assumption of the approach is that by fostering attunement and recognition and processing the experience of positive affect that such experiences engender, the pa-

tient becomes better able to address feared-to-be overwhelming emotions pertaining to the self. This, in turn, fosters increased coherence within the mind and ultimately greater emotional wellbeing.

CONCLUSION

In this article I have elaborated on a conceptual framework for understanding the mind that integrates contemporary views on attachment theory, affect, and relatedness (Beebe & Lachmann, 2002; Bowlby, 1979; Main et al., 1985; Izard et al., 2000; Stern, 1985; Trevarthen, 1993; Tronick, 2007), with a multiplicity model of self (Lamagna & Gleiser, 2007). Central to this parts-oriented heuristic view is the proposed existence of an internal attachment system comprising representations of past and present subjective experiences (subjective self states) and the reflective appraisal of those experiences (reflective self states) (James, 1890; Pascual-Leone, 1990; Lamagna & Gleiser, 2007; Spitz, 1957; Grotstein, 1999). Animating one's internal working models of self and other, the various parts of the mind occupying these two existential frames of reference interact intrapsychically to organize and regulate the individual's affects, thoughts, perceptions, and behavior. The implicit memories associated with these various states also govern our perceptions of the world and our ways of being in it.

Varying levels of emotional wellbeing are achieved when the qualitative character of relatedness between subjective and reflective self-states includes some measure of connection, openness, harmony, engagement, receptivity, emergence, understanding, compassion, and empathy (Siegel, 2007). These qualities engender greater coherence and complexity within the self system allowing for the construction of reasonably precise maps of the external world (Epstein, 1991; Adolphs, 2004), a general felt sense of safety, adaptive meaning making (Janoff-Bulman, 1985), receptivity to others (Cassidy, 2001; Siegel, 1999), the assimilation of emotional memory (Van der Kolk & Van der Hart, 1991), and appropriately flexible responses to life challenges (Siegel, 1999; Ornstein, 1991). Conversely, attachment environments characterized by persistent negativity, defensiveness, intrusiveness, inconsistency, neglect, and/or abuse create pathogenic patterns of self relatedness that are to varying degrees conflictual, insensitive, punitive, inhibitory, inflexible, and dismissive of personal feelings, thoughts, impulses, and needs (Allen, 2005. Lamagna & Gleiser, 2007).

Intra-relational AEDP, a variant of Accelerated Experiential Dynamic Psychotherapy (Fosha, 2000a, 2000b, 2002, 2004, 2008), is a clinical approach that blends AEDP's focus on interpersonal connection, dyadic affect regulation, experiential tracking of somatic experience, and process-

ing positive affects associated with transformation (Fosha) together with inner dialogue, imagery, and other techniques gleaned from parts-oriented psychotherapies (Moreno, 1946; Perls, 1951; Assagioli, 1971; Berne, 1975; Schwartz, 1995; Stone & Winkleman, 1989; Elliot & Greenberg, 1997; Watkins & Watkins, 1997). Interventions seek to help the patient and their internal subjective-reflective dyads develop the capacity for reciprocal attunement, resonance, responsiveness, and cooperation. Facilitating receptivity and engagement in this manner provides an opening through which long dissociated memories and associated emotions, thoughts, and impulses can be processed and integrated into one's autobiographical narrative (Siegel, 1999), maladaptive forms of internal relatedness can give way to self acceptance and compassion (Lamagna & Gleiser, 2007), and increasingly coherent and complex forms of self-organization can be achieved (Sander, 2002; Siegel, 1999).

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