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Tailoring AEDP Interventions to Attachment Style

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Abstract. Accelerated Experiential Dynamic Psychotherapy (AEDP) is an attachment-based, experiential and transformational treatment model whose theory, procedures and maps are ideally suited to address and treat relational trauma, which often underlies the motivation of patients to seek psychotherapy. AEDP's therapeutic stance is one that employs corrective emotional and relational experiences to help patients know they exist in the heart and mind of another. Yet, to enter this kind of explicit relationship can be daunting for patients with insecure attachment styles, whose adaptive strategies become defensive shields to protect them from further relational wounding. This can be challenging for the therapist and patient alike. This paper is part of a larger project on how to differentially apply AEDP's comprehensive model to treat attachment wounding, given the distinct formations of each attachment style. The paper starts with a brief summary of attachment theory and styles, and how AEDP applies and adapts the theory to therapeutic work. The grids I developed are then introduced to help match defenses and interventions to attachment style, to help orient and guide the therapist. The first grid shows detailed configurations of defense and affect regulation strategies for each attachment style. The second grid identifies the configuration of secure attachment as applied to the psychotherapy relationship. The third grid identifies specific interventions and targets specific goals to mobilize optimal transformations for each style. Here, transcripts illustrate how these AEDP interventions can be optimally attuned to patient attachment style.

Introduction

The first time I introduced attachment styles and working with attachment in an AEDP Essential Skills course, the question came, "But what do you do with the patients who have these different attachment styles?" That question and others like it launched me to undertake this project of tailoring treatment to meet the distinct presentations of each attachment style. Excited to inquire phenomenologically, I set out to explore what I was2 doing in the process of treatment with my patients. This paper is the net result of studying each attachment style's specific and contrasting elements. It remains a work in progress. AEDP's comprehensive theory is a profound match for the healing of the relational trauma that underlies insecure attachment. The AEDP therapist is theoretically poised and methodically trained to build a secure attachment in the therapeutic relationship, which provides an essential base for treatment (Bowlby, 1988; Fosha, 2000).

Sometimes, however, a patient's capacity for security does not easily come online and we find ourselves in the domain of insecure attachment patterns. This paper is designed to address these challenges by bringing greater precision to the understanding of the whole composition of each attachment style. In this paper I will first provide a brief summary of attachment theory and styles, and how AEDP adapts attachment theory and interpersonal neurobiology to psychotherapy practice. I will then discuss the challenges for therapists when insecure attachment shows up in the therapy room, and present the grids to help understand what's happening and provide a compare/contrast among attachment styles. Lastly, I will explicate interventions tailored to each attachment style, with transcripts of videotape illustrations.[1] My overall intention is to show that when the clinician addresses

[1] At this point, I want to share a frame that is important and arises from time to time when I present this material in training programs. Attachment style characterizes the relationship, not solely the person, because attachment status and states of mind change with relationship (Bowlby, 1988; Main, 2005). Yet, throughout this paper, for ease of expression, I may refer to avoidant patients or ambivalent patients, or I will speak of people who exhibit dismissive or preoccupied states of mind. What I mean by these labels is "a person who habitually, though not always, tends to manifest dismissive or preoccupied behaviors in relationship, and who is doing so now in the context of the patient/therapist dyad." To avoid that mouthful, I may speak more simply of dismissive patients or preoccupied patients.3

the particular needs of patients that are paramount to each attachment strategy, treatment can mobilize the specific transformations needed to bring about their "earned secure attachment" [2] (Siegel, 1999).

BOWLBY AND ATTACHMENT THEORY

Attachment theory has its roots in animal studies, i.e., ethology. When John Bowlby was seeking to understand the profound impact of maternal loss and deprivation on young children, he was introduced to and inspired by Konrad Lorentz's work on how ducks imprint (Bowlby, 1988; Parkes et al., 1991). His studies led him to see how the bond of attachment serves humans across their lifetime. He is known for saying, "Attachment operates from the cradle to the grave," meaning that human beings need relationships with others throughout our whole lives. We are social creatures and our nervous systems are designed to see and be seen, to care and be cared for, and to participate and belong to family and social groups with others (Adler, 2002; Cozolino, 2006).

Bowlby identified three behavioral systems of attachment: the attachment system, the caregiving system and the exploratory system. Young beings engage *the attachment behavioral system* when they are in pain, fatigued or frightened or if the mother appears to be inaccessible. This proximity brings protection and thus provides a "secure haven." *The caregiving behavioral system* (parenting) refers to that aspect of the attachment

[2] Earned secure attachment is a pattern noted in the Adult Attachment Inventory (Main, 2000) to describe a person who grew up with the background that led to insecure attachment, who has experienced a relationship with another person that enables them to rise above their insecurity to the point that they can express themselves with the coherence and cohesiveness that characterizes secure attachment. (Siegel, 1999, 2007, 2010)4

relationship in which the mother responds to the child's needs, providing comfort in

times of distress and reassurance in times of fear. With these in place, a child has a "secure base" from which they can explore the world, developing *"the exploratory behavioral system*" (Bowlby, 1982).

Bowlby also developed the construct of *the internal working model*, the way the relationship between child and caregiver is internally represented (Bowlby, 1969, 1973). In the achievement of a secure attachment bond, when one's caregivers are sensitive and responsive, the "Other," i.e., the caregiver, is represented as responsible and reliable, and the "Self" feels protected, worthy and secure (Ainsworth, 1978). Someone with a secure attachment has an internal template for relationship that represents others as capable and willing to respond, and one's own self as worthy of response. This brings about trusting and seeking proximity and help in times of need to be a natural experience. Bowlby (1988) has further postulated that psychotherapists can build both a *safe haven* and a *safe base* with patients, which allows them to feel safe in the relationship and to explore the necessary memories and experiences that need attention and healing in psychotherapy.

When she joined Bowlby at the Tavistock Clinic, Mary Ainsworth developed the "The Strange Situation" as a prototype for attachment research,[3] which led to the classification of attachment styles. Subsequently, her student Mary Main gathered data about those with inconsistent responses that did not fit into the existing classifications. Main and her colleagues identified this category that arises specifically in response to trauma as reflecting "disorganized attachment" and characterized its dilemma as being "fear without solution" (Main & Solomon, 1990). Main also developed the Adult Attachment Inventory (Main, 2000), and studied how the attachment styles and representations maintain across time and how the attachment style of each parent impacts the attachment style of the child in interaction with that parent (Main, Hesse, & Kaplan, 2005).

[3] The Strange Situation is a procedure in which the attachment behaviors of children and their caregivers between ages 12-24 months are observed. In abbreviated form, the mother, stranger and child are in a room. The mother leaves, and the child is left with the stranger for a short time. The observer notes how the child responds when the mother leaves and when the mother returns. The child who expresses distress when she leaves, resumes play and engages with her upon her return is classified as secure. The child who ignores her when she leaves, plays/explores little, and ignores her upon return is classified as avoidant. The child, who protests when she leaves, is distraught while she is gone, and unsoothable upon her return is classified as resistant or ambivalent.5

Role of Mentalization

Peter Fonagy has written extensively about the biological need to be understood and how we internalize others to build a sense of self. He has focused on the development of a reflective state of mind and identified this as *mentalization*: when a person has the capacity to think about their feelings and feel about their thoughts (Fonagy & Target, 1997). In describing how the reflective state of mind develops, Fonagy describes that when the internal world and the external world are equated, this is *psychic equivalence:* "how I think of myself matches what comes to me from outside of myself. "

When the internal and external world decouple, this is *the pretend mode*: how I think about myself has no relationship to what presents in the outside world. Mentalization is the integration between these two modes.

"In normal development, the child integrates these two modes to arrive at the stage of mentalization—or reflective mode—in which states can be experienced as[6] representations. Inner and outer reality can be seen as linked, yet they are accepted as differing in important ways and no longer have to be either equated or dissociated from each other" (Baron-Cohen, 1995; Gopnik, 1993; from Fonagy, 2005, p.57). In other words, with a developed reflective function, which is achieved in secure attachment, there is flexibility between how a person relates their internal world with external reality. Fonagy also has identified *the alien self,* a representation of unresolved trauma, akin to an introject. The child internalizes the mind of another, which can be very disturbing when it erupts later in life. When this happens, the person's felt experience is that this is "not me." This becomes relevant to know with traumatized patients who have not received adequate mirroring and care, and subsequently lack a developed reflective capacity. Fonagy says: "Attachment theory shows us how a person's sense of self emerges through their early bonds with caregivers, but that this is not an end in and of itself, but is part of how we develop a representational system that has evolved to aid human survival. That with secure attachment, we are able to know our own selves and are able to know and understand another" (Fonagy, 2005, p. 2). When a parent can hear and perceive the distress in their child's cry and reliably respond with the specific help that is needed for that child in that moment, most often the child settles and receives the comfort that is offered. When this expression of their internal state is met by their parent's response, the child can form a representation that *their needs can be soothed by another*. They are, in fact, soothable.

Interpersonal Neurobiology of Attachment[7]

Allan Schore has contributed immensely to our understanding of affect regulation and right brain development, and how caregivers' behavior with their children shapes how the children's brains will mature to appraise, as well as respond to human communications. He also speaks about state-sharing in psychotherapy which addresses how our right-brain to right-brain communications with our patients are essential to promote growth and development. He states, "At the most essential level, the intersubjective work of psychotherapy is not defined by what the therapist does for the patient or says to the patient (left brain focus). The key mechanism is how to be with the patient, especially during affectively stressful moments (right brain focus)" (Schore, 2012, p. 44). This right-brain-to-right-brain accompaniment is an essential ingredient to providing corrective emotional and relational experiences by offering the deep "being with" that was absent at crucial times in a patient's life.

Dan Siegel (2007, 2010) has integrated enormous amounts of interpersonal neurobiology as it applies to the practice of psychotherapy. His contributions articulate the development of the reflective mind and how mindfulness practice contributes to earned security. While Fonagy's work makes clear how being understood leads to the development of a reflective mind, Siegel studies the neuroscience of the brain's resonance circuits and explicates how the therapist's mindful presence and responsiveness can help clients develop the specific parts of the brain that yield this capacity for reflective function (Siegel, 2009).[8]

Fonagy established that it takes only one relationship with one understanding other for the impact of trauma to be transformed (Fonagy, 1995, from Fosha, 2000). Siegel's recent work discusses the mind as an organizing process that regulates the flow

of energy and information and expounds upon what happens in trauma and in health. In a state of trauma, there are many crossed wires, bundled circuits, where associative links trigger nervous system activation. Siegel emphasizes that when a person can identify their source of upset and can access their pre-frontal cortex to make understanding, they are creating linkages between different parts of the brain, which eases their disturbance (Siegel, 2007). This is ever so relevant to the healing of early attachment trauma and disorganization.

In gathering the essence of these contributors, it seems clear that what we psychotherapists have available to guide our interventions is paying close attention to our interactions with our patients and how they unfold. I want to remember that my patient was once a child who grew in the light and shadows of how his or her caregivers treated him or her. The way the caregiver attended the child's nervous system arousal and recognized and responded to their emotion, formed the basis for how our patients now regulate their affect. When a child's cues are heard and met with sensitive care, the child develops basic trust they can be met reliably and be understood. This helps the child to feel worthy and establishes a secure internal working model of self and other. Being seen, felt and understood forms the substructures of self- reflective capacity which matures into a deeper understanding of self and other that continues to evolve throughout the stages and seasons of life. However, when patients come into our psychotherapy offices for9 whom these early attachment needs have not been sufficiently met, our work begins, with all of this background in mind and heart.

PORTRAITS OF ATTACHMENT STYLES

Turn It Off: Avoidant/dismissive

With avoidant attachment style or dismissive states of mind, (Main, Hesse, & Kaplan, 2005), the distinguishing feature of the procedural learning is self-reliance, which has an insulated quality, which is residual of a profound lack of connection between self and other. Early on, protective walls have been erected to protect the self from rejection, intrusion, and/or vulnerability. Withdrawal and shutting down have been sure ways to survive the agony of being hurt by disappointment, humiliation, and rejection. Pursuing, doing and accomplishing are ways of realizing success in the world, while often disconnecting from the loneliness within. While anxiety is definitely part of the picture (Ainsworth, 1978, describing the avoidant child's behavior in the Strange Situation) it is often deeply held, concealed. So much is internalized, and so little is expressed. This way of living, one that diminishes experience by suppressing arousal, becomes a kind of disappearing oneself, making it hard to be seen, much less known by another, also hard to find oneself or acknowledge one's own needs. Facial expressions are masked, and words are withheld behind walls of silence. Energy conservation is the way and the how.10

So often these successful-in-the-world people enter psychotherapy when their partners complain and struggle with lack of intimacy and want more satisfying connection. The partners' approach behaviors and bids for deepening relationship have been met with hostility and dismissing words and gestures: the avoidants' hands motion "stop right there," their arms brush off contact, giving implicit and explicit messages that shout "leave me alone." While underneath there can be a yearning for contact, the avoidant attachment strategy is a defensive prohibition against needing others in order to prevent the risk of being hurt. Early longing was disrupted. Getting close to that again

must be avoided at all costs. Cassidy and Kobak (1988) identified secondary attachment strategies, *deactivating* and *hyper-activating*, to describe what happens in affect regulation when one's attachment figures are unavailable and seeking proximity is fraught. Avoidants are prone to use deactivating strategies, turning the attachment system off, to disconnect their need for others as a way to bear and cope with anticipated loss, frustration and rejection.

Turn It On, and On… : Ambivalent/preoccupied

With the ambivalent attachment style or preoccupied state of mind, (Main, Hesse, & Kaplan, 2005) the procedural learning revolves around clinging and protest, with an excessive focus on the other. These behaviors are actually strategies to counter the deeply ingrained fears of abandonment that arise in the wake of inconsistent caregiving. When caregivers are sometimes present, attentive and attuned, then at other times are not available, and are actually inaccessible or abandoning, their children suffer the insecurity of unpredictability. Uncertain whether mom will be available or absent, these children11 learn to keep a keen eye on her and often burst out with excessive displays of emotion to get her attention. Sadly, despite their clamor to be noticed and their longing for affection, they have a difficult time receiving soothing and calming, and letting it penetrate to their core. Even though the language of this attachment style appears to be one of attachment longing, this too is a defense. There is a high expenditure of energy and drama which actually obscures internal experience by externalizing discomfort, often with "walls of words" (Pando-Mars, 2013) that are tangential (Main, 2000) and ironically push others away in an effort to control the terror of abandonment. In this style, the secondary attachment system, *hyper-activating strategies*, (Cassidy & Kobak, 1988) keep the attachment system turned on high alert, in attempts to get the help, love and support they need.

Disorganized: Unresolved/Fearful

With disorganization, the state of mind is unresolved, not representative of a particular attachment strategy in and of itself, but rather, a state that occurs when early attachment needs have been wired with trauma. When emotions in relationship are touched, this can generate enormous amounts of anxiety and distress in anticipation of what Mary Main calls "fear without solution." There can be rapidly oscillating shifts between dismissive avoidance, fearful preoccupation and dissociation or fragmentation. The procedural learning is a response to longing and fear that co-arise; yet both of these neurological circuits cannot fire at the same time (Siegel, 2007). When the ones who are supposed to protect and care for you are frightening and terrorizing, or frightened themselves, it is quite the vicious circle when these loved ones are the ones who hurt you.12 Emotions are unsafe to feel and unsafe to express. Rather than feel emotions, someone in this state anticipates becoming overwhelmed, and dissociates to sever the connection. This both *dissipates* longing arising from inside, and *disconnects* fear about what is happening on the outside. Sometimes this dismantles the charge; other times it is acted out impulsively in threatening actions towards the self or others. When two contradictory circuits are activated at the same time, a fuse must blow out, and one of them gets extinguished. When this occurs, the therapist might notice a shift in posture, a clouding over or light gone from the patient's eyes.

When a parent who has been traumatized raises children, disorganization can also result, especially when these parents behaved in unpredictable, fear invoking ways. Their

children develop role reversal strategies where the caretaking and controlling extend inversely from child to adult (Main & Hesse, 1990). This too is protective, and such strategies enact "I can't need you and be scared of you at the same time, so I will leave, take control or caretake you in the meantime."

THE AEDP APPROACH

AEDP is an experiential, transformational treatment model whose theory, procedures and maps have deep foundations in attachment theory and interpersonal neurobiology, with a central focus on processing affective experience through to completion in close rapport with the psychotherapist. In AEDP, the heart of this transformational model is the relationship, as the therapist and patient foster the immense potential to become a healing partnership (Pando-Mars, 2011). The AEDP therapist is13 engaged, attentive, caring, and explicitly empathic (Fosha, 2000), with the intention to foster security between therapist and patient. This is the backbone of the therapist stance in AEDP. *Establishing safety* and *undoing aloneness* (Fosha, 2000) are the guiding principles of this model, to provide a safe haven and a secure base. Within the safe haven, we accompany our patients and facilitate their regulated affective experience, while we monitor their receptivity to our help and care. With this safe base, we support their exploration of their psychological issues, and we work experientially, moment-to-moment, to catalyze transformation in both their emotional and relational realms (Fosha, 2003; Lipton & Fosha, 2011; Prenn, 2011; Tunnell, 2011). Then, we process the change itself, i.e., we metaprocess the change that happens when people who have not been able to, indeed do so. This kind of metatherapeutic processing (described in more detail below) continues to deepen the self's capacity for reflection, integration, and action on behalf of the self (Fosha, 2009b; Russell, 2015).

What AEDP strives to do is bring a secure attachment relationship to the fore, so that patients can develop a secure base within themselves. AEDP has a *three*-factor theory of change: It involves affect, relatedness, *and transformation.*[4]

Empathy, attunement, and the establishment of security and safety are essential, but not sufficient. The bond that gets created as a result of dyadic processes, the adult therapeutic relationship equivalent of secure attachment, serves as a matrix, a holding environment in which deep emotional processes, the kind mediated by the limbic system and right brain, can be experientially accessed, processed, and worked through, so that they can eventually be integrated within the individual's autobiographical narrative (Fosha 2003, pp. 231-232)

[4] Diana Fosha added transformation to her original two-factor theory of affect and relatedness. (Personal communication, October 2015)14

The AEDP therapist focuses, first and foremost, on dyadic regulation of affect (helping the patient access, tolerate, and experience deeper feelings) to create a secure base for our patient's explorations. We want to help them to make use of our presence, and genuine interest and caring. The AEDP therapist inhabits the relationship authentically, allowing his or herself to be impacted by the client and is looking to impact the patient in ways that serve up new experience—new in the sense of being corrective of previous attachment lapses. Diana Fosha expands upon Fonagy with her assertion of the importance of existing in the mind *and heart* of another. This incorporates "feeling felt" (Siegel, 2007) as well as feeling understood, which offers a depth of meeting that can

profoundly impact the undoing of aloneness that besieges patients who were not seen and responded to reliably and with care. Most importantly, this establishes the container for the deep emotional processing that is needed to restore the patient's essential self.

The AEDP therapist also affirms signs of new relational and affective behavior in the patient, supports patients' attempts to change old patterns, and is on the lookout for signs of distress that need a responsive touch. Seeking to undo aloneness and promote adaptive affect regulation, the AEDP therapist offers a) expressions of delight and judicious self-disclosure to build rapport and connection; b) explicit empathy and willingness to help, which may include providing psycho-education; and c) dyadic affect regulation for the accessing and processing of heretofore unbearable emotions. The AEDP therapist tends to the coordination of the attunement, disruption and repair cycle,15 stepping in when patients become dysregulated by anxiety or shame and *lends a psychological hand* (Fosha, 2000) to help patients regulate their arousal and affects.

In so many ways, the AEDP therapist occupies the right-brain–to-right-brain state sharing that Shore emphasizes, responding with sensitivity to what may be needed at any given moment. And at a point, we methodically shift from a right-brain exploration and accompaniment to a process using left-brain reflection. The AEDP therapist punctuates moments of meaningful experience with periods of reflection, referred to as metatherapeutic processing, or metaprocessing for short (Fosha, 2000). This alternation between experience and reflection gives patients opportunities to bring awareness into places that emerge freshly during the therapeutic encounter. Such reflection serves many functions: a) it initiates a pause that makes space for a new experience to be noticed, b) allows for deepening the experience and its integration, c) gives time for meaning making and "clicks of recognition" to arise, and d) helps the brain to encode new experiences so that, as Rick Hansen (2013) says, "new states become new neural traits."

A specific intervention quintessential to AEDP is to check in with patient's receptive affective capacity to inquire about how the therapist, their interventions, disclosures or other offerings are being received. And I hope that you, dear reader, are seeing by now how important this is: We as therapists need to know how our patients are feeling in our presence and how our intentions to be helpful are actually landing inside of their experience. So we ask our patients directly: What is it like for you to hear me say that, when I self disclose something about myself, appreciate you, to have gone through such an emotional experience together? And more specifically, what happens in your16 body? When we can identify markers of arousal and activation and respond with what is needed relationally, we are offering qualitative accompaniment in the here and now. My intention in this paper is to provide inquiry as to what makes for just the precise relational dosing to be palatable and necessary for each patient to progress.

As patients feel met by their therapists, they are more likely and able to reveal unresolved traumas, losses, and disappointments and to show up in ways that allow themselves to be seen and to be known. Innate capacities and strengths begin to emerge naturally in such an environment, when what was sorely lacking is offered and now can soothe discomfort and ease pain. As the AEDP therapist encourages accessing and tolerating heretofore dreaded emotional experience and, with accompaniment, emotional processing to completion, this activates the specific adaptive actions that stimulate growth and well-being. Our assiduous systematic and consistent metaprocessing of each moment of growth and change serves our biological need to reflect on experience, to

build understanding which deepens integration, and the capacity to know both our own mind and the mind of another (Fonagy & Target, 1997). This helps our patients move towards greater wholeness into a self that is transformed: secure, flexible and capable of being able to be in relationship while adapting to current life situations.

Thus, the patient *transforms* how they relate to their past, and by doing so can now thrive in the present. Transformation, the third factor in AEDP's theory of change, is woven throughout the model of AEDP in multiple ways. First, AEDP is guided by the map of the phenomenology of transformation, which shows clear markers of affective17 change processes through the four states.

5 This includes transformance: the immense motivational force of growth and self-righting, the urge to actualize our intrinsic capacities, gifts and talents (Fosha, 2008). Transformation is enhanced by way of recognition processes: the "match" between something out there and something inside (Fosha, 2009a, 2013a). Recognition gives rise to realization affects that fuel discovery and understanding. In AEDP, the therapist is keen to recognize and foster such glimmers of health, self-awareness, and inner guidance. Noticing and reflecting these aspects of the patient's self taps a vital need to be seen and known, which further energizes the process of healing and growth (Fosha, 2009a, 2013b). We harness recognition and the sense of truth as motivation to guide necessary explorations. When *knowing* occurs and our patients begin to trust what springs from inside of their own experience, their "will" also comes online, as well as longing and intention.

This is the aim of AEDP, and we have ample evidence that despite histories of insecurity and disorganization, there are many patients who are able to move session after session along this transformance path, where their relationship with their therapist stays secure even as they explore difficult issues. Transformance allows the capacity for secure attachment to come to the fore in safety-inspiring relational environments and give rise to corrective emotional and relational experiences.

5 State One includes defense, distress and anxiety and also incorporates transformance glimmers of health and resilience. State Two refers to core affective experiences such as categorical emotions, coordinated relational experiences, ego state work, receptive affective capacity, authentic sharing, somatic "drop down" states. State Three refers to transformational affects of mastery pride and joy, the grief of mourning the self, healing affects: gratitude, feeling moved, the tremulous affects, clicks of recognition and the realizations affects associated with new understanding. State Four is core state, a state where calm and the sense of truth prevail and give rise to a coherent, cohesive narrative to stabilize change.18

Main and her colleagues discovered that a child's attachment style is most often tied into the parent's attachment style. This has enormous implications for treatment. Mario Mikulincer of Israel has done much research on secure priming, to show how people can intentionally evoke a sense of security (Mikulincer, 2015). As the field of attachment theory grows, and its application to clinical practice (Bowlby, 1988) it continues to reinforce the AEDP principle for therapists to foster secure attachment during treatment so we can best help our patients face and explore what troubles them with maximum openness, curiosity and compassion. One of the constructs that AEDP has found particularly of use is that of "self-at-best" and "self-at-worst" (Fosha, 2000). Self-at best is a state in which a person is able to access their emotions and be present with

their own experience while also able to accurately register the experience of others. They feel capable and effective in themselves and have a realistic view and understanding of others. Self-at-worst is a compromised state in which a person has difficulty accessing their emotions and staying present. They may be experiencing heightened anxiety, defense or dysregulated emotion which distorts their perception of others. In the way that self-at-best and self-at-worst are representations how the self perceives the self and other, attachment styles can be viewed as self-at-best and self-at-worst configurations.[6]

AEDP on Attachment Styles

[6] Diana Fosha first articulated this in a conversation among AEDP faculty in a meeting early 2013 when I presented my grids showing the constellations of insecure attachment styles.19

AEDP understands attachment styles as inner representations that depict how early relationships formed the neurological basis for how the self functions with emotions and relatedness in the context of relationships. Thus the contribution and terminology Diana Fosha introduced in her 2000 book, *The Transforming Power of Affect*, ties security of attachment with the capacity to regulate and experience all emotions, and insecurity of attachment with defenses that develop when the relationship is not able to hold the individual, and whereby the experience and expression of certain emotions cannot be tolerated.

Fosha (2000) thus describes attachment styles in the following ways:

Secure attachment: "*Feeling and dealing while relating"(p.42)*: The capacity to simultaneously be with self and to be with another, to be with and process emotion while engaged in relationship; it also speaks to the capacity to be with and process emotion on one's own without needing to heavily rely on defensive processes.

(Organized but) Insecure attachment: **Avoidant**: "*Not feeling but dealing" (p.43):* A defensive stance of favoring self-regulation over dyadic regulation, self-reliance above shared experience. Emotion is defended against; it is contained, denied, internalized, often below surface awareness. Avoidant defenses are powerful in keeping emotional and relational strivings offline, but functionality at any cost is privileged. Along with closeness, what is often sacrificed is vitality and energy for life.

(Organized but) Insecure attachment: Ambivalent*: "Feeling (but reeling) and not dealing" (p.43):* There is a defensive focus on the other and compromised contact with oneself. Emotionality is pronounced, rather than emotion, and is attention-seeking rather than relieving or informing the self. Here, emotionality, which often gets confused20 with emotion, is really the by-product of defenses against emotion. Relationship at all costs is privileged over autonomy and functionality, which is where the cost shows up. These patients often present as "reeling" in response to the pressures of daily life, and often come across as hanging on by their fingernails.

Disorganized attachment*: "Not feeling and not dealing"(p. 44):* Difficulty being with self, difficulty being with other and the inability to experience core emotion without being overwhelmed, which is why emotions are dissociated. This leads to fragmentation in self to deal in relationship, and emotion that is dysregulated, dissociated or somaticized. Functionality is either compromised and/or painfully achieved at the cost of feeling real or present.

Therapy: When the Way Seems Blocked

For some patients the relational stance of the AEDP therapist is welcomed and received as a parched plant absorbs water. For these patients, counter to what one might expect based on their relational attachment traumas, treatment flows along the transformational pathway through the four states that characterize the process of change (Fosha, 2009a). Yet, for other patients—and they are the focus of this paper—these behavioral attempts to establish self-at-best instead challenge or even threaten the patient, as their nervous system is activated at the level of the attachment wounding. They are baffled by the invitation to be seen and cared for, and with them, the work can lack a sense of flow and connection. These patients with more entrenched patterns of attachment insecurity are wary to give up their protective barriers to let such accompaniment permeate to their core.21

Defenses come into play for a child when their distress is not mitigated by caregiver's responsiveness to help and provide the care that is needed. From an early age, children will adapt to the absence of such response by doing what is needed to cope. By the time they arrive at our offices, those with insecure attachment will have become quite accustomed to living in their preferred defensive adaptations. Of course, defenses are an integral aspect of our functioning in the world. I am talking here about when defenses interfere and become an impediment to living life in a meaningful and engaged way. The more a patient rigidly relies on habituated, defensive pathways of interaction, the more likely the therapist will be challenged to be effective (Schoettle, 2009). This is what can make engaging patients with significant histories of relational trauma so difficult.

DEVELOPING THE ATTACHMENT STYLE GRIDS

As I began to explore how to intervene with sensitivity to each attachment style, common therapeutic obstacles and patterns related to attachment style began to emerge. I started by creating a visual grid to specify the behavioral markers under each attachment category (see section below and Figure 1). By studying the parts, I hoped to identify the whole configuration of each style's coping strategy. I recorded what I noticed with different patients, i.e., what happened in the different sub-groupings of experience. I saw distinct and specific relational attitudes, patterns of arousal, affect regulation, defenses, and how these behavioral responses initially were adaptations to the behaviors of significant others in their lives. Over time, I refined and clarified the key items and categories into a template through which I could study the different constellations of each attachment style, and see the ways they compare and contrast with each other. I also22 created a grid for client patterns when there is secure attachment (see section below and Figure 2).

As I worked on these grids, I began to integrate how they fit the AEDP frame of self-at-best and self-at-worst (see footnote 4). In the AEDP model, one major thru-line of treatment is to *work with the self-at-worst under the aegis of the self-at-best*. This is an AEDP phrase that emphasizes the importance of building a secure base first and foremost with our patients. This foundation provides the safety and accompaniment necessary for exploration and generating new corrective experiences that can treat and heal old patterns of insecurity and trauma that resulted in these—seemingly—fixed and invariant patterns of each attachment style (Fosha, 2000; Bowlby, 1988; Mikulincer & Shaver, 2007). Once I established the first set of grids, I observed how I responded and intervened differently with each style, and then created the grid of interventions, which specifies differential treatment approaches for each attachment style (see section below and Figure 3). The net

result of these grids is having a tiller with which to steer treatment.

Grid I: Self-at-Worst in Therapy Per Attachment Style

In this grid, I identified characteristics of each insecure attachment style: avoidant, ambivalent and disorganized, and grouped them into subcategories as mentioned above. This can serve to orient psychotherapists as to what is actually going on with patients when psychotherapy seems challenging or the way seems blocked. Having some understanding of how arousal and affect regulatory patterning, for example, fits in witthe bigger picture of each attachment style, can inform clinical decision making by steerig treatment towards what is actually needed for each patient given how they developed.23

Avoidant/Dismissive in Therapy

When the AEDP therapist draws explicit attention to the therapist-patient relationship, and this brings about dismissiveness, we are in the terrain of *avoidant* defenses. Specifically, distance and withdrawal are *defenses against relatedness,* which work to break the connection to the attachment figure in an adaptive move to preserve the integrity of the self (Fosha, 2000). If a person avoids interaction with the person who injures them, they prevent themselves from feeling hurt. This is what underlies the above avoidant response to attention on the therapeutic relationship. The task of revealing oneself to a therapist can tap painful memories of not being seen and known by a caring other from a young age. Some of the usual ways the AEDP therapist intervenes to establish safety and undo aloneness, offering the possibility of relational accompaniment, can actually escalate the discomfort (arousal) and *increase* the defensive strategies in avoidant patients. With patients who have been self sufficient, and relied on their own instincts to get by, they may misinterpret the therapist's affirmation as patronizing. Attempts to validate the patient can generate a reaction of irritation, confusion, or even blankness. The therapist's well-intentioned interventions can bring about deactivating strategies as the patient shuts down his or her access to relationship needs.

Rather than exposing vulnerability, avoidants use these *defenses against relatedness* to provide protection from the feared and expected rejection, humiliation, disappointments, losses, intrusions and/or shaming. When a person has become accustomed to a lack of being seen and known by a significant other from a young age,24 they derive a sense of control from not needing. Thus, deactivating when faced with potential vulnerability. *Defenses against emotion,* such as shutting down and disconnecting, helped the person to manage being overwhelmed, suffering the aloneness, and feeling intense affects by disengaging or distracting from his helplessness at a time of need. Defenses against emotion break the connection to self, which was an adaptive move to preserve the attachment bond for big picture survival.

With avoidant patients, therapists may feel challenged and have a difficult time maintaining their own self-at-best when their comments are dismissed, ignored, or rendered pointless. Avoidants may be verbal and explicit with their dismissing words. Or they may be less obvious but impactful by making gestures of brushing off or facial expressions of displeasure, disapproval or distain. Here it is important to notice how the dismissive actions effectively diminish the therapist's movement towards relational or shared experience. As the avoidant may rely on overfunctioning in an intellectualized way, therapists might feel frustrated and ineffective when their efforts to engage meet the fixed stance of self-reliance.

Ambivalent/Preoccupied in Therapy

With ambivalent patients, their thoughts usually instigate the onset of feelings, but thought-driven feeling does not move in waves that arc and complete. Rather, the intensity of oncoming thoughts drives the emotion with high levels of anxiety and no release, which is emotionality rather than emotion. More aptly, *defense against emotion*, as the deep-seeded fear of abandonment leads to run-on sentences full of tangential25 thinking and fragmented themes. Often overlooked by caregivers, this person's relationship to their own self has been untended, and now, stories of their own lack of deserving and unworthiness spin like a broken record. Only they do not notice the skip sound that repeats again and again, as their stories circulate building fears and anxieties in repetitive loops between their nervous system and tales predicting messages of doom. While ambivalent patients are preoccupied, and very other-focused, they also have *defenses against relatedness*. They manifest in how these patients can have difficulty picking up relational cues and seeing the therapist as a separate person from them. There is often a sense of pent-up energy, spewing information, building a case about self or other. Yet they don't seem to be really be listening to their selves, or expect to be heard. They are unable to process their own experiences, much less make use of their articulations. They have trouble making use of the therapist's presence for connection and soothing. When hyper-activating strategies loom, the patient's fear of abandonment and/or self-fragmentation may indeed ward off the kind of true engagement needed to quiet such desperation.

With ambivalent patients, facing preoccupied thinking and indirect expressions, therapists may feel overwhelmed and have a sense that control of the session has gotten away. When therapists attempt to deepen affect, agitation can worsen as emotions are bundled, mixed with anxiety, and filled with unrealistic views of others and self. Focus is difficult to establish when subject after subject are thrust on the table in the effort to "get it all out first." Here, notice how the preoccupied strategy functions as a defense against26 relatedness, as the constant digressing actually becomes a wall of words, with momentum that thwarts the therapist's attempt to engage. At the extreme, when the ambivalent displays their frantic need for attention and help, the therapist can feel pulled under by the flailing of unboundaried anxiety.

Disorganization/Unresolved in therapy

With disorganized patients, who have unresolved trauma, their narrative comes out in incomplete expression (Main, 2000) and may not hold together in a coherent way. Their presentation may be disoriented, confused, or stories may tumble out in succession. Affect may not match what is expressed verbally. Emotion and memory are often disconnected. Young parts of self are often abandoned without explicit memories, yet their implicit (unconscious) memories are often driving their reflexive behavior. Many times, these patients describe being in relationships where they are being mistreated or they are mistreating others. Emotions sometimes erupt without predictable provocation. People who generally display *organized* secure, insecure avoidant, or insecure ambivalent attachment styles can also become disorganized when unresolved trauma is triggered. In disorganized states, *defenses against emotion* appear with dissociation, displacement and numbness. Affective parts of self have been splintered off, locked up, stored in such images as a beaten-down dog or a forlorn child. Sometimes these parts of self are despised and hated. Utterings can be incomplete. During the therapy hour, approaching these dissociated parts can provoke cognitive disruption and loss of focus.

Defenses against relatedness show up in a patient's struggles with issues of power and control. Patients can appear, and even be, threatening to self or other. They may take on a pathetic voice of submission or a domineering voice of control. States of trusting the therapist can slip into states of pathogenic affects when the patient drops into deep shame, or unbearable aloneness. Patients can become immobilized, caught by attacks against self yet unable to reach or be reached by the therapist.

Sometimes, the disorganization can appear to move and settle into something more organized as one part of the person convincingly steps forward. Here, the therapist might inadvertently support the apparent *strength* (or whatever aspect appears) of one part without realizing that this may be a compensatory expression, and that a counterpart might be close behind. This can be quite disconcerting for the therapist when the following week an opposing part arrives to session in a reactive mode, with a whole new set of issues. The therapist can be daunted by the backlash, a seeming undoing, when a different part surfaces after a piece of work that had seemed to move the process in a "positive" direction.

With disorganization, therapists may find themselves confused about what is significant in these inchoate, fragmented ideas or actions that seem to be non-sequiturs. Sometimes metaprocessing questions are met with blank stares or dissociation, as the self-reflective capacity is underdeveloped.[7] The therapeutic relationship can also be dicey when working with clients whose role reversal was in response to parents with unresolved trauma. Therapists may find themselves challenged to stay clear in their perceived role as an older, wiser other to patients for whom the parent-child relationship has switched upside-down in early life.

When therapists are working to build secure attachment and their patient's self-at-worst behaviors fail to budge, it can be orienting to realize this is the realm of insecurity of attachment, disorganization, and the different styles they manifest in. Since these once adaptive, now defensive, strategies appear at the intersection of emotion and relatedness, it behooves psychotherapists to pay attention to how we intervene—and when—given that what can be helpful and regulating for one patient may actually be triggering and dysregulating for another.[29]

FIGURE 1: The Self-at Worst Configuration within Each Insecure Attachment Style[30]

THE SELF-AT-BEST CONFIGURATION WITH SECURE ATTACHMENT

As we look at the procedural learning that comprises insecure attachment, it is important to define what happens when secure attachment manifests (Figure 2). This can serve us in two ways. It will help us recognize the patterns of secure attachment when they appear in our patients, and it will help us to identify the specific ways in which we can be ourselves, and attune to each of our patients to evoke security and assist them to feel welcome and in the right place from the get-go and throughout.

The self-at-best is the sense of security that shows up when the therapist can access a reflective state of mind and a heart of good will, especially helpful when the

[7] Fonagy (1997) makes an interesting point about how maltreatment affects self-reflective function. More accurate to the picture than underdevelopment is fractionation – that reflective skill development does not happen along a singular progressive pathway – but evolves along varied pathways, influenced and molded by many dynamic interactions.

therapy is stuck. It is the capacity to provide help to our patients in the way they can receive, with respectful inquiry that engages a spirit of collaboration. With a flexible capacity to engage—by having a sense of one's own experience and the experience of the patient—the therapist can address obstacles as they appear in the therapy. Whether there is a disruption in the therapeutic relationship or an activation of the patient's nervous system from an earlier trauma, the characteristics that make up self-at-best serve the therapist to meet the patient in the most specific way possible for that patient in that moment with the sensitivity and responsiveness required. For example, if the patient feels doubt in me or suddenly a lack of safety arises, I do not have to insist that I am trustworthy. But rather, I can trust something important is emerging, despite the fact that this development seems to knock out the very trust in our relationship that we have been31 so meticulous to nurture. Even when the ground beneath us appears shaky, and shadows of the unbearable are lurking, I can strive to maintain a steady presence with my patient, with interest, faith and invitation to meet whatever is happening. My presence and willingness are important at the threshold of what grips my patient. With consistency and successful navigation, these fallouts become opportunities for building strength in the therapeutic alliance. In time this can help bring some of the patient's self-at-best back online, so that instead of further demoralization, together we can face the demons, process what is needed for the patient to find and reconnect with vital, essential forces that were severed at crucial moments of pivotal life experiences.

As previously discussed, AEDP's theoretical base provides theory, skill sets and interventions pathways designed to maximize the potential for self-at-best to come online for patient and therapist alike. Grid 2 summarizes this secure configuration to provide a compare /contrast with markers of insecure attachment styles as well.**Figure 2: The Self-at-Best Configuration within Secure Attachment**

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INTERVENTIONS TAILORED TO EACH ATTACHMENT STYLE

The obstacle is the lever.

from *The Mother* by Satprem (1982)

In the following sections, I will expand the points in Figure 3 and show the ways I intervene to meet the specific attachment-shaped needs of the patient in front of me. While the interventions in and of themselves may not *appear* so different, closely understood and unpacked, they are. The intention, manner and the sensitivity with which I seek to respond to their impact is an important part of tailoring treatment to the manifestations of the attachment style of that particular patient. After all, building security is the underlying need that is common to all. As Diana Fosha has said, *"the unit of intervention is not the therapist's comment, but the therapist's comment **and** the patient's response*" (Fosha 2000, p. 214). And, in turn, the patient's response is what determines the therapist's next intervention. Depending on the precise nature—verbal and non-verbal—of my patient's response to the intervention I just made, I consider what is the actual right next step for each patient. This involves attuning to their regulatory needs and capacity to work with me as an trustworthy ally, or accompanying other; or alternately, realizing that they are needing some space while questioning whether or not they dare take a risk.

As I begin the work of articulating interventions, I will continue to hold the AEDP three-stranded braid of relatedness, emotion and transformation. I am just as34

interested in leaning into emergent signs of health, as I am at transforming outdated strategies of protection. As we know, old patterns die hard. For this reason, I find AEDP's articulation of transformance strivings a brilliant gift to give our patients who are so threatened by what happened to them at a young age, and so determined to prevent it from happening again at any cost. When therapists can identify the resilient features of their patients' strategies and help them to augment these ways by affirming and leaning in, with just the right dose of attention and staying power, the going gets easier. My emphasis is that what to lean into changes depending on who is in front of me, so first, I want to attune, and second, I can aim to choose the pathway that I hope will be most helpful.**Figure 3: Interventions Tailored to each Attachment Style**

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If my heart could do my thinking
And my head begin to feel
I would look upon the world anew
And know what's truly real.
Van Morrison

Avoidant/dismissive

With avoidant patients, I have come to see that the focal goal of treatment is to harness relational action tendencies. These are a) being open to the giving and receiving of attention and empathy to another; b) feeling close, moved, and tender with another; and c) recognition of one's own needs and the needs of others (Fosha, 2000). This incorporates building connection to self, which ultimately can include allowing early memories, and recognition of unmet longings, to emerge. Herein develops the capacity to empathize with others, by first healing their own impoverishment in the realm of relationships. This begins in the therapeutic relationship as the therapist shows up as a reliable other on whom the patient can begin to lean and learn how to connect to his emotional life. While the avoidant has come to self-reliance as a primary modus operandi, what they rely on in themselves tends to be determined by thoughts. Their capacity to value somatic and emotional avenues of expression is relatively narrow. Questions about what is happening in their bodies are met with blank stares, a shrug of the shoulders, an eyebrow raised in confusion: What does that have to do with anything?

When the therapist approaches any expansion of the avoidant's repertoire, the likelihood of being met with a defensive response is predictable. It is important to understand how dismissiveness to the best intentions of the therapist operates reflexively37 and automatically. When the dismissiveness comes implicitly through a subtle wave of the hand or turn away of the head, this message can be a powerful derailer. Therapists may have to expand their own internal working models in order to perceive fully the impact, when encountering this defensive, implicit, non-verbal information.

The therapist can begin by initiating a respectful exploration with patients who have survived in life by pulling themselves up by their own bootstraps, so to speak, using these very strategies. Bringing a patient's attention to bear on their awkward discomfort, and explicitly noting that this is uncharted territory, can sometimes alleviate some of the distress by sharing information about what may be an unknown experience. Here, when the AEDP therapist can employ the classic *making the implicit explicit*, with curiosity and collaboration, treatment has more potential to gain traction.

With avoidant patients especially, I am struck anew with what a courageous act seeking therapy can be and how we need to be sensitized to the delicacy of reflecting this

transformance drive to an avoidant in a non-triggering way. The avoidant has often achieved significant accomplishments, without much acknowledgment and attention from significant others. The direction here is to notice what happens with contact, to find a window of tolerance, aiming for just enough activation to supply some energy to have a new experience (up-regulate), but not so much arousal as to bring about becoming overwhelmed, defensive shutting down, aggressive reactivity or rejection of the treatment.

Feel into Thoughts, Images, Affect-laden Words[38]

The best interventions are always those which are already trying to happen. (Mindell & Mindell, 1992)

If an avoidant has responded to a question by telling a story, I can notice whether or not they are answering the question, or I can stay with the patient and listen for the response in the narrative and then have them feel into a thought they just shared. I might focus on an affect-laden word or sensation or imagery. Sometimes with such patients, images come more easily than feelings. In fact, many alexithymics who are perplexed about emotion will share an image. When I notice my patient is spontaneously using an image, I will ask for focus on what they are seeing. In this way, I can highlight something that is already happening to help the avoidant pay attention to what is in the background (implicit) and bring it into the foreground (explicit) of their awareness. By receiving the story, noticing an image and reflecting back an affect-laden word, I accept what the patient shares. This counters anticipated rejection from another or worries about not being enough from the self. I help the patient to hear, see and notice their own emphasis, which is a way to build their connection to self and their capacity to register experience while in my presence.

With many avoidant patients, inquiring about what is happening inside, in their bodies, brings a disgruntled response. This can be a reaction to what is interpreted as a criticism. Or perhaps I am actually asking for something about which the patient has no awareness (and thus has no capacity to respond). The deflection from such inquiries serves to protect the person from the risk of vulnerability or being seen as inept.[39] Naming something I observe assists the patient locate where to focus, so that they can have a sense of ownership in the exploration. Mirroring what is already happening bridges the gap between making contact and finding words. In this way, the distance between that which is revealing itself, but is not yet known or realized, can be navigated with the therapist's caring attention to each stirring emergence. This kind of reflection builds a collaborative stance that amplifies the senses, and invites the self to take notice and become curious.

Amplify Glimmers of Core Affective Experience

When interactive mirroring and delight are absent, unreflected aspects of the self remain unformed areas of experience. (Fosha, 2013)

When I am therapist to an avoidant, for whom emotional vulnerability is sealed off, I am aware of searching for the young one who was neglected, rejected, given little or no attention. Lack of attention becomes a lack of knowing how to attend to the self, to the needs and emotions of everyday life. There is a profound stillness of being that resides in the quiet of loneliness, in the emptiness of hours spent without engaged, loving presence. This is what I reach for, as a therapist with my heart engaged. I am listening for the rustling of an adapted younger self who struggles with doubt in the midst of knowing "I can do", while the doing "on my own" has left such a void.

Approaching the experience of affect and emotion can be fraught as the entry requested taps the very void that was neglected. Here it is so important for the therapist to40 remember that someone with a dismissive strategy uses this defense for an adaptive reason. At best, emotional experience wasn't noticed, and at worst it was met with hostility, criticism or rejection. To approach this terrain is to venture into the circuitry of the nervous system that is hardwired to deactivate, to disengage from risk of being hurt. The challenge here is caught so aptly by RD Laing, who said, "We are unaware that there is anything of which we needed to be unaware, and then unaware that we needed to be unaware of needing to be unaware" (Laing, 1969, from Bromberg, 2011, p. 31). This is tricky indeed with an avoidant – to bring awareness to something where so many layers of disengagement cover the more vulnerable self.

For this reason, I find it very important to notice and accept the channel of experience (Mars, 2011) that opens. When early emotions have been disavowed, other channels have an easier time coming online. Some avoidants will shake their heads (movement channel) at the request to describe what they are feeling. And yet, they might identify an energetic flow with their marital partner when a back and forth exchange leads to satisfaction for both of them. To receive this communication as significant is so important. Here we are countering the sensitivity to rejection and shame, and making sure to receive the way the patient responds to our bid for affective communication.

Sometimes expression of experience comes through gestures. By asking our patient to repeat and/or amplify their movement, I can often help them notice and be with the gesture, which can facilitate connection to its underlying affect and potentially reveal a body-based affective memory. This brings connection to early life experience and the roots of relational experience; and to prove the cliché, actions speak louder than words. Contact in this way reaches below the thinking mind, and from here there is often an41 easier process of linking procedural learning to problems in relationship, and increases awareness of customary defensive and protective reactions.

For some, merely being seen is activating, as not being seen has been the refuge. I have one avoidant patient who cringes when I notice signals of his tapping fingers or jiggling feet. At this point when he sees me seeing him, he blushes, grits his teeth and makes a kinds of "shucks" sound. He tells me he feels unsuccessful, that my seeing him is evidence of the failure of his intention to be unreadable and thereby unflappable. While this may be his best option in his business negotiations (the "ole poker face") we are playing with the potential that visibility and transparency between him and his wife, while breaking all the rules, might possibly lead to some fun and affection. With him, humor has been my ally and a place we can meet.

Build Receptive Affective Capacity

When a therapist dares to tread into the territory of inquiring about how the patient is receiving the therapist's attention, help or care, the result can be mixed and relational interventions can be suspect. *Not needing anyone is the procedural learning that underlies these defenses*. When the therapist offers to help, the patient may have difficulty receiving the offer, as it would seem to undermine the defense structure as a whole. "If you are offering me help, you must see me as needing help – which is intolerable." Herein lies a catch 22. Or, "If I let you see me, for sure you will later reject me and I would attack myself for being a fool and bringing on that pain … In fact, I won't be vulnerable at all, for that is dangerous … Better to hide behind my wall and

suffer in silence." It takes the persistent, respecting inquiring attention of the therapist to42 draw out the protect-at-any-cost rules of the patient's internal working model. The therapist needs to help the client notice what is different in the here and now, which takes sensitivity on the part of the therapist to titrate the attention and give the avoidant the space from which to approach the therapist and see for themselves. The intention is for the present experience with the therapist to disconfirm the certainty of those expected responses (Ecker, 2012).

An Illustration

The following psychotherapy session begins with an established client with whom I have worked for over a year, with whom the above interventions were instrumental. At this time, our selves-at-best are online, which enables us to traverse self-at-worst conditioning while remaining in communication. Underlying her avoidant strategy are layers of protectiveness covering profound hurt. Despite the fact that we have established trust between us, when the attachment system is activated, doubt emerges. This session started with her acknowledgement of feeling safe. As the session unfolded, she encountered an early memory of being with her father that conveyed her longing as a little girl and yet how frightened she was of doing the wrong thing that would bring him to reject her. Sadness emerged, and she was baffled and confused. This session reveals the power of the internal working model and the force of the injunction against opening up. This section was chosen to illustrate the harsh messages that drive avoidant defenses and how the patient's perception of safety changes on a momentary basis.

PT: If I had had one person, one adult who had been kind, loving …? Or somebody to43 just ask me who I was or what I thought about… [**Her longing emerges – transformance**]

TH: Well that's kind of what I feel like I want to do right now… I'm really loving getting to know who you are and what you thought about – so important… what happens when I say that? What's it like for you to know that I want to know you, what you think about, feel about? [**I offer my interest in her and then I check for her experience of me as therapist – checking her receptive capacity.**]

PT: I think I'm not convinced anybody really wants to know who I am? It's hard for me to really believe that. [**Origins for the development of the avoidant strategy**]

TH; Yeah…

PT: (*nodding*)

TH: It's hard for you to believe that I want to know you? [**Amplifying by making it explicit in our relationship**]

PT: yeah

TH: What happens when you look at me? When I say I want to know you? [**Make the relational experiential.**] What do you see in my eyes?

PT: You're all blurry, I can't see without my glasses – that helps. (*Laughs*) [**Humor regulates anxiety.**]

TH: it does help… okay in this blurry state – [**staying with her**] what do you see through the blur? [**I join her with laughter and still keep the focus.**]

PT: I can.

TH: What do you see?44

PT: I don't doubt your sincerity. I just don't believe that anybody really wants to know me. [**Fixed invariant patterning**]

TH: You don't believe and that comes from way inside, right? And so when you see me, you don't doubt my sincerity, what does happen? [**I acknowledge her belief and encourage her to explore the here and now with me.**]
PT: Well I have a whole defense, "she doesn't really want to know, that she's, this is part of the therapy…"
TH: These are all the thoughts, but what happens with your eyes, when your eyes are seeing my eyes? [**Bypassing the defense**, **staying with the direct relational experience**]
PT: My eyes tell me that you are truly here; truly looking at me, really want to know… (*tense voice)*
TH: and how, what's that like to… [**I wish I had said yes, and affirmed first before metaprocessing.**]
PT: that's hard for me to trust
TH: It's hard for you to trust (*hand motioning inside*) How far in can that go? [**I go with the receptivity that emerges when she names her eyes so that I can tell I am truly here**]
PT: *(sigh*) I think it can go in, I think if I can just relax…
TH: Try out how that can go – [**Make it experiential.**] try out relaxing just see how much you can take in.
PT: yeah
TH: To take in that I care about you and I want to know you. [**This might have over amped the charge.]**45
TH: What happens, let's take it slow and see what happens this time.
PT: (*deep breath)*
TH: That's a deep breath [**Moment–to-moment tracking, always important to notice]**
PT: There's something that really is – it's like a block. It's like it doesn't just sink in. [**This is self-at-best talking about self-at worst.**]
TH: Do you know where that block comes from?
PT: um, umm
TH: see if you can see…where that block comes from. [**I want to know if she can she make the link.]**
PT: I think it just comes from being disappointed in the past – so just like "Don't do that again!" *(spoken in harsh tone)*
TH: right (*mirrors her hand gesture which shows a firm marking a boundary between self and other*)
PT: DON'T do that.
TH: DON'T. (*Echoes the harsh tone*)
PT: DON'T let that in again.
TH: DON'T. (*Repeats mirroring hand gesture – Pt. is nodding*) That's it… [**Affirming her and amplifying her expression of her internal working model]**
PT: Don't be stupid. Don't (*hand firmly presses her leg now*) you know? Don't believe that somebody is really interested in you. [**Procedural learning**]
TH: Ohhh, (*big sigh*) How painful, right, to believe and be disappointed… that makes good sense – that you wouldn't let in what's here – cuz of the past disappointments. [**Explicit empathy with the defense]**46
PT: yeah (*cries a bit*)
TH: Just let that through – see what that's like to recognize. Stay with me, what are you

getting? What's happening?
PT: (*sniffs, looking down and away*)
TH: How do you feel right now as you are noticing this? [**I am checking her window of tolerance.**]
PT: umm (*nodding*) I think a lot. It's so hard for me to go into my feelings cuz I think a lot….. [**Increased self awareness of her defense**]
TH: Stay with me – together we can help sort this out. [**And she just did go into her feelings.]**
PT: I've always been that self sufficient, didn't need anybody, developed my own thoughts. Even turned away a lot of relationships, you know, don't get too close…
[**Click of recognition… describes the cost of the avoidant strategy, which this work is asking her to notice, to reconsider and to try something different**]
[**Once we penetrate the defense, feelings emerge that register the pain and the loneliness – the disappointment is wired together with the defense, which appeared in full force**.]
With an avoidant patient, I want to heighten the relational action tendencies, whether it is relating to themselves or to others. Their ability to make use of the therapist, as another who can be an accompanying and a caring presence, is what is called for to develop receptive affective capacity, to truly undo the aloneness and impact of being rejected, dismissed, and objectified This has everything to do with connection. I believe47 that in order to be connected to another, I must be connected to myself. So, as I help this patient tune into her own internal world of thought, feeling and customary behaviors, this opens the patient's capacity to reflect on her own self, both the longing and the dread. This unfurling brings us to an adaptive action that translates into opening curiosity with more space for understanding rather than reactivity. In this moment the balance shifts to revealing herself in the presence of the therapist.
PT: I try to get myself to figure out what I'm feeling. [**Transformance glimmer**]
TH: Good!
PT: I always feel like "Don't set yourself up for disappointment, I just come back to that over and over.
TH: Right, so that's (*points to her head)* you learned that, that is hardwired in you, right?
PT: *(nodding)*
TH: That was your motto as a kid, and something today – what about if you put that right next [to each other] (*shows both hands*) "Don't set yourself up for disappointment and "what have we been working with today?" What do you get if you put them together?
[**Psycho–ed in a mood of conspiratorial exploration, then metaprocessing]**
PT: (*big Sigh*) That's a tough one. Because I want to believe that I can trust you, and other people, that they can give me what I need, but that's just not there (*chokes up*)
TH: you know what's there? There's feelings…(*gently noticing*) that still need to come out cause the thing is they're getting in the way…of your taking this in… [**I am staying with what is happening and lend my trust that if feelings are emerging, they deserve to be felt.]**48
PT: *(nodding)*
TH: Your feelings are really about all that hurt. [**It's as if I am introducing her to her feelings with my understanding and acceptanc**e.] What's happening right now?
PT: It's a grief that makes me sad that I can't get that in my life. It makes me sad, it

makes me…
TH: The grief is about you *couldn't get* that in your life, you didn't get that in your life…from the person that you wanted it with, so this is that little girl in you that just couldn't get what you needed… [**Psycho-ed about mourning the self, with empathy**]
PT: (*looking down and away*)
TH: Stay with me, what are you feeling? Stay with this.
PT: You know it's hard because when I was a kid to need my dad or my mom in my family was just considered horrible, what's wrong with you? [**The significant events of her early life experience now reveal her prevalent attitude in her current life.]**
TH: So come here for a second, I want to check in with you. How is it to be here with me? [**The deactivating strategy pulls at her. I see she is slipping out of the present with me, and sinking into shame.**]
PT: (*stays in eye contact*)
TH: Cause I feel like I so want to go with you to these places. [**Therapist's explicit use of self to undo aloneness and counter the old experience**]
PT: (*gaze averts and looks around*)
TH: Cause you don't have to feel alone.49
PT: I don't feel alone.
TH: really
PT: I really feel like you're right there with me… I really do. [**I have to admit this feels like a surprise and a relief.]**
Step-by-step, sometimes forwards and sometimes backwards, we forge ahead.
From here I am able to ask the patient if we can take this accompaniment back to the little girl in her. This opens a doorway into an imaginal world that she occupied alone as a little girl. Only now she takes me with her out into the fields she explored as a little girl, and imagines me taking her hand and walking alongside her.[8] We are constructing a more trusting relationship by ferreting out the stops of the internal working model and challenging the procedural learning with our present here and now experience.

Ambivalent/Preoccupied

With ambivalent patients the focal goal of treatment is to develop self-action tendencies, to strengthen the sense of self and self-efficacy. These are a) becoming aware of one's own needs, b) learning how to express them, and c) being willing to stand up for one's self (Fosha, 2000). To this I would add, that the preoccupied patient needs to learn what exactly belongs to them and falls under the responsibility of their own self-purview. In order to achieve this, much differentiation needs to take place, between self and other, thought and feeling, past and present. The therapist may need to take deliberate steps to

[8] Here, I am fascinated by the entry point that arrives through the imaginal channel, and in future works I want to explore the connection to the convergence of *pretend* as knowing play and the *pretend mode* of experience, en route to expanding the reflective capacity.50

slow down the ambivalent patient, to penetrate their wall of words, and to help them to identify how their emotions are driven by their anxiety-ridden thoughts (emotionality).

Differentiate between Self and Other

I want to help the ambivalent patient differentiate between self and other. With preoccupation, the boundary between self and other is often confused, leaving a poor sense of what belongs to whom. Boundary confusion is part of the composite of the

preoccupied state. An important aspect of treatment is to present opportunities for ambivalent patients to distinguish what's happening inside themselves from what is happening with another person. In the preoccupied state of mind, the tendency to predict and project what is to come in the future is mostly fear and anxiety driven, based on things that happened in the past. I want to help these patients become conscious of and able to discern their own visceral, body-based feelings from their perseverations about others' perceptions and intentions. I want to do so with compassion and understanding that hyper activating to get the attention of the other developed as a strategy to do the best to cope with their primary attachment relationship.51

Dyadic Regulation and Self-regulatory Skills

At the start I am often focused on anxiety regulation and looking for ways to help my patients redirect their attention to self-care. As therapist, I attempt to step in as an other who can slow the torrent of words with containment, summarization, or wondering, so I can make contact and let them know I hear them. I want to help my patient find calm as we shape their emphasis to respond to their own self-experience. Teaching grounding, self-regulation skills and breathing practices help patients learn ways to attend to their own activation and recognize signals of anxiety in themselves. The more anxiety is regulated, the closer patients can get to their own self, and tend to actual glimmers of core affect and self-knowledge.

To do this, therapists must be able to regulate their own anxiety, especially in the presence of someone with permeable boundaries and heightened anxiety. Like flying on an airplane with small children, the therapist must put the oxygen mask on their own self first. By noticing and regulating my own and the patient's anxiety, I model self–care and consideration.

Discern between Thought and Feeling, and Empathize with Core Affect

With more capacity to regulate anxiety, the more likely it is that one can access core affective experience. However, sometimes focusing on emotion leads to heightened arousal. It is so important to teach such patients to discern between thought and feeling. In preoccupied states, patients are sometimes overwrought and don't really know what52 happened that led to their current level of distress. Many patients believe they are sharing feelings when they say, "I feel that he… doesn't love me anymore, is going to fire me, is going to leave me." Therapists must check the accuracy of feeling words vs. thinking words and teach patients the difference. With some patients it can be very helpful to name the categorical emotions of sadness, anger, fear, joy, disgust and surprise. Some appreciate having a list that gives examples of mild, moderate and intense feeling words. The intention is to help these patients to notice such thought streams and to redirect their attention to their body-based experience. From here, we focus on the somatic edge of core affect and help the patient to stay with what crests and falls, surges and wanes, arises and dissipates. No matter how small or large the wave of affect, we want to help our patient learn to recognize how affect moves, so that then we can reflect on these emotional experiences. As we face these moments together in our present relationship, the relevant historical memories can come to mind in a clearer way and we can link the current trigger with its early life disturbance or trauma.

Build Receptive Affective Capacity

Although ambivalent patients tend to be externally focused and reliant on others, they actually need considerable help to take in soothing and care. Early experiences of

abandonment or lack of consistent attention by self-absorbed caregivers have left a significant dearth of trust that anyone would want to be there for them. In response to gestures of care, there can often be significant doubt in the sincerity of the motivating intention behind them. In more extreme cases, stubborn bouts of angry resistance deflect[53] such offers and exemplify defenses against relatedness and defenses against emotion, all in one.

When the therapist provides contact and care with stability and predictability, the hyper activating strategy can begin to ease, as the patient can begin to internalize that the therapist gets them. And yet, ambivalence may show up when the therapist checks for the receptive capacity. For example, when the therapist offers support and *withness* to undo aloneness and follows up with a relational intervention such as "Can you feel me with you?" The ambivalent's initial response may be a "maybe" or weak "yes." Possibly followed by an explanation, "But then I will *always* have to do this *entirely* by myself." Or "That's only here, can I take you home with me?"

The dual-prong goal is to have both. I want to help patients notice what they can receive, and to notice what happens when the patient can't take in anymore. This usually means that an early attachment strategy is activated, and something needs holding and to be known. When the therapist can meet such a place with interest and steady attention, we are overlaying a new experience of receptivity on an old experience of "something missing." When ambivalent patients receive this quality of care reliably, they can begin to saturate in the new experience and let it become part of how they realize they feel met and soothed. The mechanism is for this absorption to sink in so that they can begin to take seriously their need for connection from the inside. I am always delighted when patients tell me how they had a conversation with me in their head during the week, or how they thought of me when they knew they needed to calm down. This is clearly a transitional experience that leads to the capacity to self-regulate.[54][55]

Gain Access to the Self behind the Wall of Words

Here, the therapist needs to filter through the rapidly erected defensive screens: the wall of words, to select for momentary, emergent glimmers of self. The therapist must catch what is quickly batted away, before it is doubted and obscured with familiar thoughts—protective deflections woven to conceal what would threaten the status quo. I want to interrupt the patient's rapid movement past self-discovery by joining in, slowing them down and reflecting their own words. In this way, I insist that patients realize that I hear what they say and that they must listen to what they are saying. Often we can catch the spark of an emerging self. We focus and care for these embers of self, in present time and space, and see how fears of abandonment perpetuate when one ignores their own self. When they can turn this around by listening for inner movement and stirrings, they can find the parts of themselves that have been alone and untended. I was working with a woman who located such a young aspect of herself, and through our meeting she realized that she never knew soothing was possible. In giving up that possibility, she had left a part of herself behind. As we come into contact with this part, a whole new level of self-empowerment emerges, and with that arise realizations and important self-knowledge.

Amplify Glimmers of Transformance: Containment, Self-soothing, Self-knowing; Support Internal Guidance

When working with someone who relies on a hyper activating, preoccupied strategy, first, I want to make sure they know their call for attention is being received.

Then I am on the lookout for signals of self-direction. I want to highlight and emphasize56 this potent indicator of transformance-at-work to maximize the development of inner knowing and guidance.

An Illustration

We enter the following segment of a psychotherapy session at the point where the patient is discussing how she had reached out to me when I was out of town, as an alternative to calling her husband with whom she was having difficulty. Instead of calling him repeatedly and insistently, she drew upon self-care materials we had discussed. Even though I wasn't immediately available, she was able to make use of the call, a friend and self-compassion tapes.

PT: What I would've done, had I not received that and been able to take it in... is to bother S...to try and get regulated...I would've gone to him in irritation and frustration and wanting him to kind of soothe me...and it would've been just impossible. [**Other-reliant behavior**]

Th: Wow. So even though I texted you a few hours from the time you texted me, it was still soon enough? [**Reaching out to me was a new behavior, which she found stabilizing**]

PT: Yeah...cause I went out dinner and a movie with a friend and then I came home...

Th: Ohhh (*eyes wide, pitch rises*)

PT: And so I had that in my...[**She is starting to reflect.**] well I could kind of freak out and throw a fit and get passive aggressive and angry and all those things I do to get him to regulate [me]...or maybe I'll try listening...cause maybe it's not about what he can do for me but what can I do for myself [**She is discerning what is within her own boundary.]**57 in this moment of just feeling so undone (*eyes squint*). [**This anxiety is *hers* to care for.**]

Th: (*nods, eyes wide*) Wow!

PT: That was kind of cool! [**mastery – a marker of State Three**]

Th: Yeah...feel into what you just said and what you just organized.... oh my gosh! [**metaprocessing and deepening this new experience**]

PT: (*eyes closed*) I organized...I made use of something that I hadn't done before in a really conscious way...made a decision...a cross point [**a new self action behavior]** (*looks at Th*) ...There was a crossroad. I could've easily gone the way I usually go or...

Th: And...The way you articulated it to me...can I say it back to you?

PT: Ok.

Th: Cause you said...I could come undone and throw a fit to get S's attention and instead of doing that I thought maybe there was another way I could help myself. **[I want to reflect her own words back to her for integrating and deepening.**]

PT: Yup.

Th: So you went from trying to like (*hands gesture in swirling motion as chaos*) to do the preoccupied dance to get momma's attention...instead of doing that thing, you went into some self-soothing with a little help (*points to self*). [**Psycho-ed and reminding her I was involved in her getting what she needed**]

PT: Yeah...I was able to go to sleep a little later... [**That she was able to go to sleep suggests that her nervous system was in balance.**]

This next section shows a bit of the recursive nature of working with the preoccupied strategy. During this part of the session we are reviewing what happened and speaking to58 it from different angles, all the while sorting out the new from the old, deepening integration, and valuing this new direction of incorporating new choices into the patient's

repertoire.
Th: Well even that sounds like...given the choices you were giving yourself, you took the high road.
PT: Yeah...felt more embodied or something. More like an adult-to-adult self.
Th: Wow. Self-guiding?
PT: Self-guiding. I'm like, what is it gonna do to wake him up or whatever...so (*exhales*).
Th: Yeah...how are you feeling as you're saying this?
PT: Well I want to stay with the good feeling but then I just keep getting distracted by how irritated I was at him...so I don't want to do that because that kind of undoes my good thing.
Th: Maybe compartmentalize it a little bit? Like, you could tell me how irritated you are at him in a little while...we can make space for that (*hands make sweeping gesture to the side*) in time. [**bypass the defensive hyper-activating**] AND...There's something, a new way of listening to yourself, reaching out, asking for help, turning back towards yourself, giving yourself a new solution and taking it and then afterwards, still feeling some resentment and deciding to sleep on it instead of act that out...[**As we metaprocess, there is a need to sort out the new behavior from the old, and to affirm her decision and her choice to act on the new, despite feeling activated**.]
PT: (*gazing intently at Th*) Right...
Th: So making more healthy choices from a guiding adult place in yourself.
PT: Yeah...that's a big deal.59
Th: This feels worthy of really (*hands encompass a large imaginary ball)* acknowledging and holding (*CL mimics holding gesture*)...embrace.
PT: Yes...embrace...ok...
Th: And then yourself be with that. That you've done something so layered of a new way of getting yourself calm. [**affirming her capacity to self-regulate**]
PT: It did feel really good. Like I feel my heart kind of racing in thinking about it...it was exciting...something really empowering about it...like [**brings energizing vitality affects**]
Th: Cool!
PT: I'm gonna go and soothe myself...just putting the focus on myself and really getting that I can relax myself...can you relax yourself? [**Doubt emerges – did I just do what I did?**]
Th: It looks like it. [**affirming**]
PT: It felt like part soothe but also part calm down, soothing feels more for like when you're hurting or wounded...I wasn't in that place...I was more in the wound up, agitated place.
I can walk myself down the tree. That was cool to be able to do that. But now I also feel like...
Th: Walk yourself down the tree...that's really cool that you could do that. [**Emphasize the self adaptive action and positive choice.**]
PT: Yeah.
Th: Cause this is the direction...this is right. I don't want to be judgmental about it, but at the same time I want to say (*palms up in receiving gesture*) this is like...how do I say this without being judgmental (*brow furrows*) but I want to acknowledge this. [**I am realizing that the direction she is naming is self-righting– and yet at this moment I feel shy to be taking such a strong stand.**]60
PT: You say...this is powerful. [**Here – she affirms me… dyadic regulation works both ways!**]
Th: I feel proud of you...that's what it is... [**Now that I am more regulated, I know what**

I am feeling.] I feel proud of you and I hear you feeling empowered...and I feel proud of you for taking the high road...
PT: Yeah...thank you.
Th: For taking new chances.
PT: I just hope it doesn't mean that I have to that all by myself all the time. [**Here the old anxiety surges: "Does self-regulation mean I have to be solitary from here on out?"]**
Th: But I want to remind you that you didn't do it all by yourself cause you did it with me. [**I remind her that we have been working together towards this possibility**.]
PT: Oh yeah...I asked you.
Th: That's what's really cool.
PT: Oh yeah...I reached out to you and then you gave me this connection...and then I connected to that connection and then it connected back to me. Somehow, it's like you passed the ball to me and it's mine and then whatever I do next is I'm by myself. [**She recalls the pathway and how it worked between us, which helps her to receive my response to her more deeply. Although note the ending fear-thought, "I'm by myself."**]
Th: For that bit...and this is like a work in progress.
PT: Yeah...
Th: These are important building blocks...
PT: Yeah...it's step 1 of a multi-layered process. It's a beginning.
Th: We don't know what the end of the story is yet. [**We are co-creating a narrative.**]61
PT: Cause yeah...I really felt...I put the headphones on and I listened to it and I really did climb down the tree. I really settled down and I really got out of that (*hands make swirling gesture around head*)...you know, it's a frantic...I want to make him pay attention to me... make him make me feel better and make him...whatever it is that makes that go away...no going there (*hand stretches out to side*) and going somewhere else...I really feel like I was delaying...in DBT, they call that opposite action...it's a very cognitive approach...this feels more like an intra-relational thing with you but then with myself so it feels deeper than just....
Th: (*hands pressed together then sweep apart*) rather than delaying, that's like stalling out and in a way...it's like (*hands press together)* you bring something to me...I bring it back... There's a sharing and a giving and a taking... [**I reinforce our coordinated efforts together.**]
PT: Cause I wasn't coming to you...I'm trying to understand how might I do with you what I do with other people...you know? I have a feeling I am mostly self-reliant...more avoidant...but with Sean, I'm disorganized...
Th: With a pre-occupied edge...it's the anxious attachment.
PT: So I get really clingy and demanding or manipulative. I'll get inside of those places and I don't feel I do that with you. Like it's contained and clean... **[differentiating her self-at-best behavior with me]**
Th: Well, that makes sense because this is my job. What I mean to say is my job is to help you feel in a balanced way with me... [**building a secure base between us**]
PT: Right
Th: To feel safe enough to ask for help so you don't have to clamor for my attention...62
PT: (*eyes wide*) Right...
Th: Cause I want to give it to you. I'm here for you and you trust me enough now that even if I'm not responding in like (*clicks fingers*) immediately... [**making the implicit explicit**]

PT: Right...cause that could be a trigger for some people...if I were in that state...just say I wasn't in a relationship with him...and I texted you and didn't get a response back right away, I could see getting activated and then acting that out, like Hello? (*mimics anger*) Where are you? I could see myself doing that... [**She is comparing self-at worst behavior to this self-at best behavior.**]
Th: Totally...
PT: But I don't do that...
Th: So instead, maybe there's a little delay...go to dinner...go to a movie...and by the time you get back...oh, she's here...she's back like I'm back...
PT: Yeah...
Th: I'm online, she's online.
PT: So the hope is that maybe I can do THIS.... it's a both/and kind of thing...with myself and then in relationship with others, right? [**Core state, recognizing what she is doing with me and wanting that to extend that to others**.]
Th: I see what you're seeing as what I would hope for...what I actually feel very excited about.
PT: It's both not as scary as I thought it would be and terrifying. More terrifying than I thought it could be. (*smiles at Th, who returns her smile*) Cause it's a balance beam feeling...of learning something new and I'm all...AHHH! I spook myself out.
Th: But you're not spooking as much.63
PT: No
Th: You're not spooking like falling...it's the tremulous place.... [**State Three: The energy of the new experience…]**
PT: Yeah...it's tremulous.
Th: So it's enough new that you're doing something different but enough safety that you can bear it. [**window of tolerance**]
PT: I can bear it and kind of modulate...cause that's where I guess I'm at...a feel like really Ph.D. level attachment work (*smiles*).
Th: *(smiles*) Ph.D. attachment work...and then I was thinking Ph.D. level self-care?
PT: So true...and I've been making my food and grocery shopping and cooking my meals and I'm shocked at how much time and energy it takes…[**developing self-care]**

Undo Psychic Equivalence

When preoccupied patients begin to understand themselves, they often register how their inner critic and maladaptive self perceptions were actually formed by the offensive labels bestowed on them by others, which is what we can see in the following example. When Fonagy identifies psychic equivalence as the internal and the external world being equated, he states that the self-agent is submerged. In the preoccupied strategy, the sense of self has been forsaken by the lack of other reflection and understanding by the caregivers. I notice and help the patient learn to recognize that although bad things happened to him or her, these experiences do not have to define their identity. When the patient begins to get some separation between self and "bad experience," the self can start to realize the impact of such experiences and begin to64 process the emotion, and in this case the deep mourning for the self, with regard to that experience.

An Illustration

PT: What is true is that I am realizing that I am enough. The more I realize that I am

enough, I don't feel needy. [**huge shift towards self-efficacy**]
Th: So what's this when your hands go like this? (*mirroring the way she wraps her arms around herself*) [**unpacking the movement channel**]
PT: I feel me. I'm holding myself. I'm here for me. [**self-soothing, containment**]
PT: The more I understand myself and my story...and it's easy to see where they came from having the family that I had and actually being told that I wasn't enough and that I better get it together...I was made to feel like I was broken. [**procedural learning**]
Th: you always *got the message* you were broken. [**subtle distinction that this was a *message* of being broken**]
PT: As much as I didn't want to believe that, and didn't really feel like I did, it took over me...that message was drove into me and it was like I couldn't resist it. It took over [**She receives this message, an example of psychic equivalence.**]
Th: Such a thing that you got this message that you're this...you're broken and then you can't separate out your self from this message. [**boundary confusion**]
PT: Yeah, you believe it. I can clearly see how I became the way I did. (*voice filling with tears*) How I acted as if I was broken and needed someone to love me make me feel special.
Th: Right now what are you feeling, just let it through.65
PT: I feel sad for my little self that lived this way. [**We enter a big wave of grieving for self.]**
PT: I feel sad for my little self that lived this way. [**grieving for self]**
Th: Just let yourself feel this wave cause it's a deep one.
PT: Yeah...(*sobbing*)
Th; Breathe into that [**I wait for breath as signal of wave passing through.**]
PT: Yeah. (*tears, reaches for Kleenex… then sobs emerge…)*
Th: Just let it through…
PT: There's a sadness …. A grieving feeling… To have suffered so much in my life...so I'm really getting to understand myself and see my stories and know now where they came from. [**mourning the self**] They're not really me. [**self-righting online**]

Desirable Mobilization: Self-Action Tendencies

In contrast to helping someone with avoidant strategies to develop relational-action tendencies: the capacity to receive and feel with and for others, someone who is preoccupied and other-focused needs to develop self-action tendencies. Cultivating a sense of self is crucial. Connecting to the inner little one who felt abandoned is key. There is ambivalence to receiving comfort, for fear it will leave or not be available. In helping patients to both internalize my constancy and build a relationship with their younger aspects of self, this wheel-spinning drama to be cared for can begin to slow down with the presence of self-to-self connection. (Lamagna & Gleiser, 2007; Lamagna, 2011).66

DISORGANIZED/ UNRESOLVED

In beginning to discuss treating disorganization resulting from unresolved trauma, a few noteworthy topics and important considerations must be mentioned. Further descriptions of classification systems have grown out of adult romantic attachment research (Bartholomew & Horowitz, 1991; Bartholomew & Shaver, 1998; Shaver & Fraley, 2000). Bartholomew devised the following two-dimensional model that incorporates the categories of models of self and models of other. (See Figure 4).

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Figure 4 *The two-dimensional model of individual differences in adult attachment* Shaver & Fraley, 2000).67
This model emphasizes the poles of anxiety and avoidance, as they most closely resemble the manifest items used to measure the four attachment styles. (Shaver & Fraley, 2000) A fuller discussion here is beyond the scope of this paper, but I include this model for its significant contribution to the growing field of attachment research. In a nutshell, this system looks at how our attachment representations can move from one person to another across the dimensions of the above quadrant. It acknowledges how people have *many* different attachment schemas, which change according to anxiety and avoidance, which may be activated depending on the level of support or non-support in a given relationship (Mikulincer, 2015).
While I have written this paper with the stark classifications of each attachment style in mind, I also must say that in clinical practice when interventions land, and the defense structures loosen, the attachment strategy can change. This can happen with a patient who is using an avoidant strategy. What the above model shows is that as anxiety is heightened, the dismissing avoidant may move across the sphere to the place of fearful avoidant, which is analogous to disorganization.
In the transcript working with the avoidant patient, when I leaned into the here and now of our relationship, the patient's old schema of being disappointed and hurt came in strong. *An important part of clinical work is that therapists must be ready to navigate at a moment's notice.* A successful intervention can surprise a patient. When the structures that once held an underdeveloped self intact loosen their grip, previously warded-off affect, memory, realizations arrive and make their presence known and felt. This can be disquieting and even disorganizing for patients.68
In working with disorganization, the goal of treatment is to build the patient's capacity to be with self (and parts of self), at the same time as being with another and over time building safety and trust. Many times, when patients come into treatment with unresolved trauma, they don't have a clear picture of what really happened to them. While the need to survive was so strong, many times just what they were surviving is out of conscious awareness. Perhaps they have memories of mean or neglectful caregivers, but not the related emotional affects. Perhaps they have strong emotional triggers and upwellings that seem out of proportion to their current life experience, yet no clear understanding that makes sense to them. The patient needs help to locate evidence of what happened, and sometimes he or she can benefit when the trauma can be named. The work is to find and get to know it, and then to build connection between dissociated aspects of self and the core self, to feel genuine emotions and link them to specific memories, to release the adaptive action of categorical emotions, to resolve hauntings from the past, and, finally, to restore the capacity to engage and relate with self and other in present time and space.

Find and Engage Resources

Building resources can require constructing a safe place and/or person, for the patient to go to when the threat of overwhelm looms. When affective experience arrives, I welcome being with the patient and helping them to receive my attention and care so that we can build both tolerance of being seen and felt by another and tolerance of feeling and being one's own self. It is necessary to understand that individuals who have been

traumatized often have relegated parts of themselves into compartments, and stepped69 outside of these places to go on living. These ways create distinct ego states, which can be confusing and aggravating to loved ones, to whom such changes feel like whim or willful deception.

Regulate and Build Tolerance and Capacity for Emotions

I want to help the person to feel safe, to feel connected to self or to understand something more. These interventions with someone who is disorganized are really aimed towards building the capacity to experience what is happening in the present moment. Distinguishing what is happening here and now from feeling memories that intrude from past trauma and hurt, helps a person to realize what they need to care for themselves, while they learn to process unresolved emotional experiences. This empowers them to expand self-care as well as their relationships with others. This work is geared toward helping the patient regulate emotion and thus, we need to titrate this work within a window of tolerance. It is important here to notice and attend to the markers of dissociation and shame, the dorsal vagal slump of shutting down (Porges, 2009.) I want to help the patient become curious about these processes so that with caring we can build links between the parts that are disconnected and the triggers that set alarms in motion.

Empathize with Dilemmas

What can sometimes appear and be quite challenging for therapist occurs when patients arrive, often in an agitated state, and want help to make some kind of decision. I remember a female patient who would have a problem with her boyfriend and come into session in a dysregulated state, insisting that this is the end—that she no longer can stay70 in the relationship. The following week she would arrive and all memory of this "decision" seemed to have vanished. I began to see that when such agitation presented, while there was a desire to leave, there was also a longing to stay. I learned to empathize with the dilemma when she is up against such contradictions inside of herself, challenged by her own blind spots and activations.

Sometimes patients seem to be engaged in activities of both of doing and undoing, where on the one hand they are working with much creative effort, they simultaneously thwart themselves by acts of self-sabotage. There appears a back and forth inability to settle into a coherent strategy; to choose one direction may mean leaving behind another. It is important to find a way to hold both, to make room to find the logic beneath the surface. What makes sense may reveal the disorganizing challenges of an earlier life situation. In the simplest way, I am trying to shift from a focus of *either/or* to *both/and*. To consider that with disorganization two contradictory circuits are activated at the same time – our work is to develop compassion for such deep dilemmas and hold the possibility that the present day relationships don't have to operate at such a cost or that no one has to stay in ones that do.

Trauma Does Not Define the Person

In healing deep trauma, there needs to be a distinction between the self of the person and the events that happened to them. Ultimately, instead of needing to split off an unlovable, untrusting part of self, one can make sense of the fact that some mean and awful events took place that hurt. And now, the self doesn't have to dissociate to bear the unbearable, but rather their capacity to *feel and deal* can grow. The present–day self can71 get sturdy enough to withstand the storms of past trials and tribulations, to allow in the memories and associated feelings about what happened, in the presence of love and care,

from self-to-self and person-to-person. This to me is integration: that what had once disappeared from awareness can now be found, and even understood with care and tender holding. When someone has a young part of self that stores memories of being mistreated, it makes sense that they mistrust (and even mistreat) others out of reaction. Therefore, the focus of therapy is to heal the splits between trust and mistrust, moving towards an integrated self that can navigate their experiences in the context of a current relationship. The therapist can take interest and selectively inquire into these chasms of long lost, undeveloped, misaligned aspects of self. At times patients with deep hurt have turned against themselves and have very strong disgust, dislike, even hate towards their younger more vulnerable parts of self. Building interest and connection can take a long time, and the therapist in this situation needs to proceed with the dilemma of holding both, the part that is in reaction to younger self and the younger self who has been banished. Such forays, with an intention to stay regulated enough, can build trust in the value of becoming acquainted and curious about what can be discovered and learned from these dissociated parts and integrated into aspects of self. When this happens, there is a making sense that often has a calming impact and relieves the pressure of confusion and deep insecurity.72

Amplify Glimmers of Transformance: Safety, Links between Traumatic History, Current Experience and Dissociated Affects

In working with such disorganization, I want to create links between traumatic history, current experience and dissociated parts. When I am able to hold disparate pieces in mind and then reflect them back to my patient, I function as their pre-frontal cortex, serving the mentalizing function. I'm really trying to witness and make meaning and share meaning as it's coming to me as a way to build safety, and to help the patient make sense of their own experiences. In treatment, I have found the dilemma of contradictory emotions so helpful to identify—the window of tolerance so important to expand—links between what happened then and what is triggered now, so important to make.

An Illustration

The following transcript is from two significant sessions about eight months apart, with a woman with whom I have worked for three years. In the first session the patient is facing a troubling experience with a current boyfriend that clearly has roots in her early life experience. Very briefly, when she started in treatment, while there was a known history of a childhood that was riddled with abuse and neglect, the emotional experience and connection between her current choices in romantic relationships was somewhat abstract. The mere mention of a younger self was met with a sense of disdain. In working with patients for whom emotional memory is dissociated, I often hold an image of some particularly poignant moment that seems to crystalize a traumatic memory.[9] In this case,

[9] There is a description of such technique called *model scenes*, from Lichenberg & Lachman (1992).73

my patient had told me of an experience where she was caught between two very self-absorbed parents in quite a frightening situation, and yet there was no emotional access to what she might have actually experienced as the young girl at that time. We enter this session as she makes a statement that ties her current relationship experience into something from her history.

PT: …And it's not like that's a defect. That's a wound that somebody left on me. So now the whole world gets to see…

TH: wait? Hold on for a second. That's a wound that somebody left with you? [**She is identified with the wound and feels vulnerable about being seen.]**
PT: yeah
TH: right… that just brings compassion to me… [**I offer my compassion as antidote to shame.]**
PT: it's embarrassing to me.
TH: I understand… [**Staying with her**]
PT: how could you have compassion? It's so humiliating. [**She becomes curious about my response.**]
TH: Look at me, how can I have compassion for you, really? [**I want her to see me here with her.**]
PT: well you could just feel bad for me [**I hear this as speaking from shame… I mobilize to speak up on her behalf.**]
TH: No, I feel mad on your behalf and I also understand that you were raised in a very unprotected way and your little heart was torn between two parents who were very self-74 absorbed and locked away in their own crazy worlds: Him desperate in his way and your mom desperate in her way…and you caught between them. [**I bring awareness to a specific memory we have previously talked about – that epitomizes the very core of her struggle and relational trauma – a "model scene.**
"]
PT: yeah
TH: being asked to help, so getting the message from early on – "You have to be the one to save me, you have to be the one to get mom to help me… I'm gonna like drown if its not you." So I just have like a world of tender ache in my heart for how that little one was so unprotected and how that could get. …[**Empathic elaboration**]
PT: I feel like I'm really going away. It's too much. [**She recognizes she starts to dissociate. My explicitly drawing this scene forward to the extent that I did exceeded her window of tolerance.**]
TH: Can you come back? Well, thank you for telling me. [**Dyadic regulation: appreciating she was letting me know I had misattuned and went too far is also how I make repair.]**
PT: yeah I just started being like, I hear your words but I don't (*eyes looking up and away)*
TH: stay focused with me, what part could you hear, what part was too much. [**I want to help her to notice what she can, to identify the anxiety that surged before the dissociation.**]
PT: I hear your words in the beginning. Like that's my chorus – caught between two self absorbed people, and sometimes I hear you say it and it feels just like – I mean its real – but it's like numb. I know that happened. I know your seeing something … important. I75 know it's a theme. I know it's a template… but I don't have like a sad feeling for that person…like I… [**I am glad she can hold this much –the part where I bring in more affect on her behalf as I start to feel for her predicament was the part that evoked so much anxiety. Then she says she doesn't have a sad feeling for "that person."]**
TH: so if we stop there, can we be with the numb… and like notice your present self. [**Moment-to-moment, be in the moment with her and resource her in present time with present self.**]

PT: I'll watch you feeling sad and compassion for that – but it feels like I'm watching a show on TV
TH: Its like you're a little depersonalized… so that's where we need to stop. Like anything else I said after that (*waves hand as if to push away*) [**My feeling for her is the moment that triggers her.**]
PT: and I don't remember [**She goes away and starts to dissociate.**]
TH: it doesn't matter, right, cause that to me is – the place where there's a recognition that I'm naming something that you know happened. I have feelings for it – and you don't. **[I platform by naming the process I am seeing that led to her dissociating – I don't avoid it – I don't move past it – we stay here to explore what is happening.**]
PT: (*shaking head*) – yeah I just…
TH: I have feelings for you there… and you feel dissociated or disconnected. So that to me says – Okay… Can we somehow work together around helping you build a bridge into that part? [**Ask permission to build collaboration**]76
PT: and then I get this angry disgusted feeling toward myself… about Why is this taking so long? Why does this take such hard work (hand *scratching her hair – looks off to the side*) what is wrong with me that… [**She turns against herself.**]
TH: so what if you directed that energy towards either of those parents who were pulling at you… [**I want to redirect the energy outwards.**]
PT: it's the same feeling I have about getting mad at him right now – It feels pointless, I feel unimportant… it feels I don't really matter. It's just a bullshit pretend game. [**She refers to the current situation we had been talking about before dropping down to the underlying pattern with her parents.**]
TH: right, th… th…
PT: it's just a game [**Having her feelings is such a stretch.**]
TH: right that's the defensive place that you say 'It doesn't matter." The "I" that doesn't matter is stuck. Right cause they gave you so little recognition… that you can't see yourself here. [**I am reaching for her and wanting to make a link that she can't quite give herself what she wasn't given**.]
PT: right. I'm not even sure there's like an 'I' there.
In talking about a current relationship problem, she expressed that there is really no point to feel anger, there is just no way out, no way that her feelings matter. This is a classic situation in psychotherapy, how to convey to patients that indeed, feeling on your own behalf does matter, and is indeed a key to unlock being imprisoned in the past. What she began to notice was fascinating. She remembered how she felt love for her father, despite his rampant self-centeredness. She gave to him the love she craved. In a sadly77 ironic way, she is realizing that her focus on others is an adaptation to the lack of attention given to her. What was there for her was just plain empty. Herein lies another dilemma of working with someone who suffered from neglect: How to bring compassion for what was never received in the first place.
C: I sort of feel like I developed that part – may be being mean to myself – that that was a way to get him to love me. I saw that if I was ever going to get anything – I better feel for him and meet his needs [**The maltreated one looks to understand the mind of the other for her own survival.**]
TH: well then, how beautifully resilient of you. [**Affirmation of self**]
PT: right

TH: to get yourself some care where there was nothing.
PT: right
TH: SO how can we honor this little girl who gave of herself to protect herself? [**I sense this is our opportunity to make a connection with her younger self.]**
PT: Without completely merging and going under? [**She fears dissociation and disorientation.]**
TH: Right, can we do that? [**I am checking for willingness.**]
PT: Right, like have one foot in here and one foot there. [**She identifies the way, by keeping one foot in present time and one in the past.**]
TH; Right… Actually I love your question, how do I not merge with what – we still have a few minutes…78
PT: Just the despair… and the sadness and the eech disgust – such a fixed experience a fixed template – so that's one part of me – so not be overcome by that. [**She wants to find the window of tolerance.]**
TH: Right, what if we make an agreement that you don't go there alone, that you don't have to go there on your own. Can you do that? Can you contain that or compartmentalize that or put that in a loving – I see a loving padded box…[**Making agreements to contain for safety**]
PT: (*one side of lip is curled up*) right…
TH: those little fluffy cushioned boxes… [**I want to extend cushy comfort to her.**]
PT: like velvet inside
TH: I see like velvet…. [**At first, I think she is with me in this.**]
PT: okay put that like take that snapshot and put it in there – [**Containing**]
TH: and we can keep working with it cause the feelings that you're describing need to be felt, but not alone for goodness sake – [**Accompanied**]
PT: right
TH: and if anything to cultivate compassion… [**Creating an imaginary caring place**]
PT: yeah
TH: kindness, like how you feel towards P [**Resourcing with her feelings towards someone she knew at church**]
PT: ummhmm
TH: Like how you feel towards somebody that you care about… that you have an uncomplicated relationship with79
PT: I was going to say I have such complicated relationships – Actually I don't have one with P.
TH: what if you take that feeling *(towards P)* and surround that box with it – that little girl – even if you can't connect to her, love her anyway
PT: I think what I can do is just put her in like a crate, like a wine crate or something and just stuff her in there and put it to the side. I can't do all the surrounding and the velvet and the [**As she feels into the imaginal picture, she summons the brakes.**]
TH: oh you can't [**I inquire to be sure.**]
PT: I can't
TH: can I? [**If there is a way for me to hold when the patient can't yet, I want to try.]**
PT: I could lie to you…
TH: no, I want you not to lie to me. I love your straight talk. You gotta be straight with me… [**What is real and true matters more than compliance.**]

PT: and I think am I just being contrary, am I just being difficult? How do I even know what's real. I just know I was having trouble come up with an image… like velvet or fluffy or cute box, so that probably means that's not going to work…
TH: (*nodding*)
PT: So then the next thing that came is you know – just like a crate… just like a milk crate or something… And so that's better than nothing.
TH: it is, especially if she is contained… [**I accept that she is finding a way that works.**]
PT: yeah and there is like air holes… for her to breathe
TH: I'm going to throw her a blanket80
PT: (*laughs out loud*) you're going to throw her graham crackers
TH: I'm just going to stuff a blanket [**I am aiming now to provide some cushion.**]
PT: a juice box
TH: just a blanket…in and around the edges so that…she's got a little softness in there…
PT: she's all like cold
TH: She's cold okay so I give her a blanket [**Now for warmth**]
PT: that's very nice… she likes that? And she has her thumb…
TH: and a juice box?
PT: yeah a juice box and graham crackers,
TH: okay
PT: … she's set (*waves her hand off)* it's very comfortable [**Note the "it"]**
TH: Okay…we'll come back **[We have co-constructed a contained place and a specific way to hold this young part until we meet again.]**
PT: (*chuckles*) we'll see you next week
TH: we'll come back
PT: bye bye…(*laughing*) yeah we'll just do that.
Over the next 6-9 months, we had periodic visits and explorations with this young part still in a crate. In the session following this one, we happened to call it *the feral child*, which stuck. PT. recognized the tenacity of this part who has been so banished, yet PT. realized that she has taken over at significant times and influenced choices PT. made that were harmful to PT.'s overall well-being. This has been a huge connection. After the following session PT. grows in her appreciation of the strength and grit of this young part81 and was able to reflect on how she had come to disconnect from her instincts. She also identifies how she is internalizing the care and compassion with which I have been holding her and how this is changing her relationship with herself.

Eight Months Later

PT: I was having a conversation – I was having a wondering, an aside, I think I was getting something back. I think I was having an empathy… an empathic exchange – it's not like I remember the feral child "I'm hungry". It was more like I was curious, getting that was really hard. It was more like I was understanding somebody is locked up they haven't been taught anything. I don't know if it was after I left here or the next day (*sing song voice*) I know – its cause I was talking about how hard it was for me to have contact…in between sessions and I realize I was having contact – and I was like – I'm having contact! [**Vitality affects surge with the recognition that this is right action**!]
TH: (*Laughs delightedly*)
PT: I'm having contact and even if it was just a few minutes [**transformance glimmers]**

TH: that's fantastic
PT: it felt really alive, but it wasn't…
TH: That's what is important, that it felt really alive for you… [**Affirm and validate**]
PT: It was like I was mimicking what I see you do [**She is internalizing our secure haven.**]
TH*: (nodding*)
PT: but it felt me – doing it but more like practicing or something. [**Imitating me but feeling as herself. Wow!]**82
TH: And you wanted to tell me in person. That's so sweet. [**Authentic sharing in person]**
PT: I know…I said that's, be… no… it's not urgent…and I'm starting to have a trust that I'll remember things. Isn't that a big deal? [**Trusting herself to contain and remember**]
Th: Yes, it is.
PT: even if I don't have to remember it. But in the coming in, and the sharing, and the relating… that it will come out. [**Trusting our process**]
TH: it will be remembered…
PT: it will be remembered (*stated affirmatively*)
TH; WOW
PT: maybe I can on my own…remember it… but that's not really the point I don't think…
TH: there's a context that we're containing…and bringing this into…
PT: and I knew not to stare at the sun for too long…like I knew okay that's it… moving on. So…
TH: (*nodding and smiling)* hmmm
PT: that was just very sweet.
TH: very much, much, much
PT: yea… very cool…
TH: So how do you feel, right now?
PT: yeah some pride – maybe I can do more than I think even. **[Transformance glimmer]**. Maybe I get down on myself, and feel insecure – and you have faith in things and you have trust in the process… and I'm relying a lot on that I think… [**She's**83 **borrowed my faith and trust as she gathers experience from our work together to fill in what was missing.**]
TH: and I have trust in tangible things… which is so much why I am trying to share with you what I am seeing – so that you can grab hold, not just of castles in the sky.
PT: Yes… wasn't that a movie?
TH: (Smiles) I don't know
PT: not castles in the sky, I like that. Tangible, concrete…and its so interesting cause you'll say those things to me. And yet, my mom was home this time and she won't say those things to me
TH: no one will say how they see you growing or changing?
PT: No, I'm trying to think. They don't. [**But I do, and she is sharing that her receptive capacity is serving her growth.**]
Desirable Mobilization: Categorical Emotion Adaptive Action Tendencies
The desirable action tendency here is courage: the courage to face what has been lost, disconnected or cast off. Feeling into affective glimmers and the fractals of self

experiences (Fosha, 2013a) that arise in small bits and allowing them into awareness and to move through is how to build capacity. It is this willingness to engage and bring back online dissociated affects and memories that can give rise to understanding and making sense and lead to developing the capacity for reflective functioning. I also want to support any action tendency that strengthens the patient's capacity to relate to another, as in the disorganized state the patient can vacillate between seeking the other to feel safe84 and then rejecting the other's response of contact and care. The most important handhold here is to remember the adage of *both/and* as opposed to *either/or*. The definition of disorganization is that two contradictory circuits cannot come online at the same time. Treatment needs to proceed slowly and with care to enable splintered selves to coexist, while building a large enough window of tolerance so that eventually it becomes a window of opportunity for corrective emotional and relational experiences.

CONCLUSION

In summary, I hope this presentation of my grids with detailed discussion and transcripts illustrate how to both conceptualize interventions as well as to apply them in practice. My intention is to emphasize that first, the way we care for ourselves, and our patients, is strengthened by our own capacity to operate from self-at-best, and second, self-at-best is strengthened by our understanding as clearly as possible, the mechanisms behind the challenges of our patients as well as ourselves. The more we can decipher what is going on in our patients, the closer we can attune to what they actually need from us and with us. The grids can be considered in combination as well as alone. Instead of being caught by blind spots when faced with the insecure attachment styles, they can help us to prepare for how to address our patients who have deeply entrenched attachment strategies and how we might respond when facing particular difficulties. Our presence can be an antidote to expectations based on earlier schemas. Interventions are offered to help with typical challenges of each attachment style, but also with a direction in mind of what is important to develop.85

Ideally by cross-referencing the grids, we can build a bidirectional concentration. With an eye on the past, while stepping more fully into the present, we can help our patients to heal and grow into the most fully human beings possible, more capable of enjoying secure functioning within themselves and in relationships with others.

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References86

Adler, J. (2002). *Offering from the conscious body: The discipline of authentic*

movement. Rochester, VT: Inner Traditions.
Ainsworth, M., Blehar, M., Waters, E., et al. *(*1978*)*. *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum.
Ainsworth, M. (1990). 'Epilogue' in *Attachment in the preschool Years*, ed. M.T. Greenberg, D. Ciccheti, & E.M. Cummings (pp. 463-488). Chicago: Chicago University Press.
Ainsworth, M. *(*1991*).* Attachments and other affectional bonds across the life cycle. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 33-51). London: Routledge.
Bartholomew, K., & Horowitz, L. (1991). Attachment styles among young adults. A test of a four-category model. *Journal of Personality and Social Psychology, 61,* 226–244.
Bartholomew, K., & Shaver, P. (1998). Measures of assessing adult attachment: Do they converge? In J. A. Simpson & W. S. Rholes (Eds), *Attachment theory and close relationships* (pp. 25-45). New York: Guilford Press.
Beebe, B., & Lachman, F.M. (1998). Co-constructing inner and relational processes: Self and mutual regulation in infant research and adult treatment. *Psychoanalytic Psychology, 15 (4)*, 480-516.
Bowlby, J. (1969, 1982). *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books and Tavistock Institute of Human Relations.
Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: Anxiety and anger*. New York: Basic Books.
Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. New York: Basic Books.
Bowlby, J. (1988). *A secure base.* New York: Basic Books.
Bromberg, P. (2011) *The shadow of the tsunami and the growth of the relational mind.* New York: Routledge.
Cassidy, J., & Kobak, R. R. (1988). Avoidance and its relationship with other defensive processes. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 300-323). Hillsdale, NJ: Erlbaum.
Cassidy, J., & Shaver, P., (Eds). (1999) *Handbook of attachment: Theory, research, and clinical applications*. New York: Guilford Press.87
Cozolino, L. (2006). *The neuroscience of human relationships: Attachment and the developing social brain.* New York: Norton.
Dozier, M., Stovall, K., & Albus, K. (1999). Attachment and psychopathology in adulthood. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 718-744). New York: Guilford.
Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, *9*, 679-700.
Fonagy, P., Gergely, G., & Target, M. (1999). Psychoanalytic constructs and attachment theory and research. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical* application (pp. 783-810). New York: Guilford.
Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Maltoon, G., Target, M., & Gerber, A.(1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*. *64 (1*), 22-31.
Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2005). *Affect regulation, mentalization, and the development of the self.* New York: Other Press.

Fosha. D. (2000). *The transformational power of affect.* New York: Basic Books.
Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disordered attachment. In M. F. Solomon & D. J. Siegel (Eds.). *Healing trauma: Attachment, mind, body, and brain* (pp. 221-281). New York: Norton.
Fosha, D. (2007). Transformance, recognition of self by self, and effective action. In K. J. Schneider, (Ed.), *Existential-integrative psychotherapy: Guideposts to the core of practice* (pp. 290-320). New York: Routledge.
Fosha D. (2009a). Emotion and recognition at work: Energy, vitality, pleasure, truth, desire & the emergent phenomenology of transformational experience. In D. Fosha, D. J. Siegel & M. F. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development, clinical practic*e (pp. 172-203). New York: Norton.
Fosha, D. (2009b). Positive affects and the transformation of suffering into flourishing. In W.C. Bushell et al.,(Eds.), *Longevity, regeneration and optimal health: Integrating Eastern and Western perspectives* (pp. 252-261). New York: Annals of the New York Academy of Sciences.
Fosha, D. (2013a). A heaven in a wild flower: Self, dissociation, and treatment in the context of the neurobiological core self. *Psychoanalytic Inquiry*, *33*, 496-523.88
Fosha, D. (2013b). Turbocharging the affects of healing and redressing the evolutionary tilt. In D. J. Siegel & Marion F. Solomon (*Eds*), *Healing moments in psychotherapy* (pp. 129-168). New York: Norton.
.
Holmes, J. (1993). *John Bowlby and attachment theory*. New York: Routledge.
Holmes, J. (2001). *The search for the secure base: Attachment theory and psychotherapy*. London: Brunner-Routledge.
Hanson, R. (2013). *Hardwiring happiness.* New York: Harmony Books.
Holmes. J. (2015). Attachment theory in clinical practice: A personal account. *British Journal of Psychotherapy 31***,** 208–228.
Karen, R. (1998). *Becoming attached: First relationships and how they shape our capacity to love*. Oxford: Oxford University Press.
Lamagna, J**.** (2011). Of the self, by the self, and for the self: An intra-relational perspective on intra-psychic Attunement and psychological change. *Journal of Psychotherapy Integration*. 21 (3), 280–307.
Lamagna, J., & Gleiser, K. (2007). Building a secure internal attachment: An intra-relational approach to ego strengthening and emotional processing with chronically traumatized clients. *Journal of Trauma and Dissociation*, *8 (1)*, 25-52.
Lichenberg, J. D., & Lachman, F.M. (1992). Model scenes: Implications for psychoanalytic treatment. *Journal of American Psychoanalytic Association, 40,* 117-138.
Lichenberg, J. D., & Lachman, F.M. (2015). Model scenes and the search for clinical truth. In J.D. Lichenberg, F.M. Lachman, & J. L. Fossage (Eds). *Self and motivational systems: Towards a theory of psychoanalytic practice* (pp. 21-24). New York: Psychology Press.
Lipton, B., & Fosha, D. (2011). Attachment as a transformative process in AEDP: Operationalizing the intersection of attachment theory and affective neuroscience. *Journal of Psychotherapy Integration, 21 (3)*, 253-279.
Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Genetic factors, Parenting contexts, and developmental transformation from infancy to adulthood. In J.

Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 666-697). New York: Guilford.89
Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status. In M. T. Greenberg, D. Ciccehetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161-184). Chicago: University of Chicago Press.
Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. In M. T. Greenberg, D. Cicchetti, & M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 121-160). Chicago: University of Chicago Press.
Main, M. (2000). The adult attachment interview: Fear, attention, safety and discourse processes. Also titled, The organized categories of infant, child, and adult attachment: Flexible vs. inflexible attention under attachment-related stress. *Journal of American Psychoanalytic Association, 48*, 1055-1095.
Main, M, with Hesse, E., & Kaplan, N. (2005). Predictability of attachment behavior and representational processes at 1, 6, and 19 years of age. The Berkeley longitudinal study. In K E. Grossmann, K. Grossmann, & E. Waters (Eds.), *Attachment from infancy to adulthood: The major longitudinal studies* (pp. 245-304). New York: Guilford Press.
Manfield, P. (2010). Dyadic resourcing: Creating a foundation for processing trauma. USA: CreateSpace, a DBA of On-Demand Publishing, LLC
Mars, D. (2011). From stuckness and reactivity to the felt experience of love. *Transformance: The AEDP Journal, 1 (2).*
Mikulincer, M., Shaver, P.R., Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion, 27*, 77–102.
Mikulincer, M., & Shaver, P.R. (2007). *Attachment in adulthood: Structure, dynamics, and change.* New York: Guilford Press.
Mikulincer, M. (September 2015). Adult attachment research: Intrapsychic and social relational aspects. European Association for Cognitive and Behavioral Therapies, Jerusalem.
Pando-Mars, K. (2011). Building attachment bonds in AEDP in the wake of neglect and abandonment: Through the lens and practice of AEDP, attachment and polyvagal theory. *Transformance: The AEDP Journal, 1 (2)*.
Parkes, C.M., Stevenson-Hinde, J., & Marris, P. (Eds.) (1991). *Attachment across the life cycle.* New York: Routledge.90
Piliero, S. (2004). *Patients reflect upon their affect-focused, experiential psychotherapy: A retrospective study* (Doctoral dissertation). New York: Adelphi University.
Porges, S. (2009). Reciprocal influences between body and brain in the perception and expression of affect: A polyvagal perspective. In D. Fosha, D. Siegel, & M. Solomon, (Eds.), *The healing power of emotion: Affective neuroscience, development, and clinical practice* (pp. 27-54). New York: Norton.
Porges, S. (2010). Polyvagal theory: Demystifying clinical features of trauma, autism and early development. California Institute for Integral Studies, Professional Conference, San Francisco.
Prenn, N. (2011). Mind the gap: AEDP Interventions translating attachment theory into

clinical practice. *Journal of Psychotherapy Integration, 21(3)*, 308-329.
Russell, E. (2015). *Restoring resilience: Discovering your client's capacity for healing.* New York: Norton Books.
Satprem. (1982). *The mind of the cells.* Mt. Vernon, WA: The Institute for Evolutionary Research.
Schoettle, E. (2009). *A qualitative study of the therapist's experience practicing Accelerated experiential dynamic psychotherapy (AEDP): An exploration of the dyadic process from the clinician's perspective* (Doctoral dissertation). Berkeley, CA: Wright Institute.
Schore, A.N. (2012). *The science and the art of psychotherapy.* New York: Norton.
Shaver, P.R. & Fraley, R.C. (2000). Self-report measures of adult attachment. Retrieved from http://internal.psychology.illinois.edu/-refraley/measures/measures.html.
Siegel, D. J. (1999). *The developing mind: How relationships and the brain interact to shape who we are.* New York: Guilford Press.
Siegel, D. (2007). *The mindful brain*. New York: Norton.
Siegel, D. J. (2010). *The mindful therapist*. New York: Norton.
Siegel, D., & Hartzell, M. (2003). *Parenting from the inside out*. New York: Tarcher/Penguin.
Tunnell, G. (2011). An attachment perspective on the first interview. In C. Silverstein (Ed.), *The initial psychotherapy interview: A gay man seeks treatment* (pp. 137-155). New York: Elsevier Insight Books.Wallin, D. J. (2007). *Attachment in psychotherapy.* New York: Guilford Press.