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To Make the Implicit Explicit and the Explicit a New Experience:

My Discovery of AEDP in a Swedish Context

Anna Christina Sundgren

I will introduce an article that was written in Swedish as an introduction to AEDP for Swedish therapists and published in the periodical *Psykoterapi,* February 2014. I have then revised, translated and added one more vignette, some clarifications with reference to the international readers, and I have added a preface, discussing AEDP in a Swedish context. I have written this article during my own AEDP-journey, a senior psychotherapist discovering a therapy model that represents what I had longed for, for many years, without knowing it.

Without really knowing, we divine;
our life has as sister ship, following quite another route.
While the sun blazes behind the islands.

Tomas Tranströmer, (1983). The Blue House

Preface

Do cultural differences matter when applying a therapy model in a new cultural context?

I will share some thoughts and experiences that could resonate with the application of this experiential model into the Swedish cultural context. Although the Swedish population is among the most trusting in Europe (Trägårdh, 2009), I believe the phrase "dealing but not feeling" (Fosha, 2000) best captures how many of us are raised. In social research, Swedish trust is also mentioned as "cool" (Trägårdh et al. 2013), which may refer to a common consensus about security. This can also have contributed to a cultural norm that discourages the open expression of emotions—particularly those that risk eliciting shame in oneself or, perhaps even more

Anna Christina Sundgren, MA, Licensed Psychotherapist, is a Certified AEDP therapist and supervisor, and an Adjunct Faculty member at the AEDP Institute. She is a member of the AEDP International Development Committee and Ambassador and Co-founder of the Swedish AEDP- community. Direct correspondence to Anna Christina Sundgren at animare@animare.nu.

distressingly, exposing one to the shameful reactions of others. When it comes to positive emotions, the Law of Jante[1] is worth mentioning. It is the idea that there is a pattern of group behavior towards individuals within Scandinavian communities that negatively portrays and criticizes individual success and achievement as unworthy and inappropriate. First commandment of the law is: "you are not to think that you are anything special." Swedes still often quote the Law of Jante, and I hear it rather frequently from my patients when they describe the atmosphere in their family of origin and how they were brought up. It also happens when a patient feels shame coming up, they suddenly notice the need for protection themselves and say: "you know, it's Jante again." The Law of Jante is often set in contrast to "the American Dream"[2] and the American stereotype of the self-made man who can reach success regardless his background.

I learned of the Law of Jante from one of my patients, whose mother warned her not to stand out or take risks for fear that others would think she believed herself better than them. As a teenager, my patient wanted to go abroad as an au pair to learn new languages and explore the world. However, her natural curiosity and longing for growth were curtailed by her mother's fear of shame. This woman, now in her 50s, has taught me a lot concerning the many layers of shame. In the beginning of our contact, I noticed her pleasing smile and her avoidance of expressing an opinion of her own. That shame was unbearable, and she had learned from her mother how to avoid being someone. It took a long time before she felt safe enough to share her fear of being rejected simply for expressing something personal—because doing so would evoke shame for being someone like her: a person too frightened to hold or voice an opinion of her own. And if she did dare to speak, she was terrified of what might come next—the fear that her impersonality would be exposed, and that the other person might confront her with the devastating implication that she was not "someone" at all. Through the therapy, my patient mourned this "frozen" part of her life. Shame was replaced by a lot of humor and self-compassion, the deep experience of having a unique personality, and feeling proud - being in her self at best.

Foreign visitors often comment on the Swedish stereotype as quiet, reserved and stiff. However, I think individual differences are larger than cultural. When Diana Fosha and Ron Frederick visited Sweden for seminars in October 2014, they were warned: Maybe there wouldn't be so many questions and comments from the 150-headed audience. But the truth is that people were unexpectedly open and shared their questions and emotions to the point that some more reserved participants had reactions like "Gosh, is this a religion?" or "I like the lecturers but can't stand

[1] The concept is taken from a novel by Dano-Norwegian author Axel Sandemose (1934)
[2] Originally from James Truslow, The Epic of America (1931).

this positive "hallelujah mood" from the audience."[3] Sweden is the most secularized country in the world, and there is a lot of suspicion toward the full
expression of emotions and of giving oneself up, especially in big groups. In school we learn to first listen to our sense, think critically and be rational as individuals. Being too emotional outside the most

After Diana's and Ron's presentations at the 2014 AEDP seminar, which was the first encounter with AEDP for most participants, I heard many comments in the audience like "this is so American" and "it's non-Swedish." This probably referred to the videos demonstrating therapists' self-disclosure in being explicit in acknowledging patient's accomplishments, affirmations, and positive phrases. Swedish therapists consider such self-disclosure as lack of integrity and boundlessness. To be somewhat withdrawn and thoughtful is often interpreted as genuineness and seriousness rather than defensive.[4]
provided by the cultural code here. Such interventions could be experienced as too intimate or not seriously meant, ingratiating, or even false. When my patient Lisa, a therapist herself, had a reaction on my explicit empathy, she said: ''this is something you all say in this method, not genuine, it feels strange.'' Swedish psychologist Viola-Argus Zivaljic writes in her book introducing dynamic short-term therapies, that "Fosha's method is very relational and personally involving, why the author of this book considers it the most difficult method … to learn and work with … (as) the therapist shares their affective experience with the patient" (Argus Zivaljic, 2018).[5]

I believe that cultural differences matter in our first contact with a model such as AEDP. It´s not only about individual defenses. There are collective barriers to overcome as well to create safety. Cultural norms are learned and internalized to keep us safe in our community and society. As therapists we need to be extra sensitive. Kent, a quiet man in his 40's, told me that he was "allergic to affectation," when my soft attunement in the session contrasted to his upbringing in the North of Sweden, at a place where people are well known for their chaste sincerity and connection to nature and the unspoken.

"Working with AEDP is much more than a stance; it´s a way of being" (Fosha, personal communication.). When this stance gets deeply integrated in the therapist, it overcomes cultural differences, as core emotions are universal. When it comes to clinical work, the cultural differences, as well as everything else that emerges between the therapist and the patient, can be

[3] Comments from personal contacts with participants
[4] I think this his description applies in the first place to middle-aged people and older who haven´t grown up with social media.
[5] My translation. The other short term methods presented in the book are ISTDP, PFPP, APT.

dealt with and meta-processed. Cultural differences are generally “State one stuff,” but that means we need to be aware of them and deal with them if they interfere with safety for our patients. Attunement and moment-to-moment tracking are helpful tools for us to discern cultural differences from individual defenses, tools that informs us how to proceed in our work towards transformation.

Cultural differences require our attention as AEDP spreads and grows all over the world. For example, adaptation to Swedish language sometimes means toning down the emotional language of the therapist a bit. A culinary parable would be that different cultures prefer different varieties of spices, and different strengths of them. When tasting small portions, we soon get used to what first tasted odd or too strong, if we like it we want more of that taste, and we slowly integrate something new into our own cultural repertoire. What sounds natural in English can initially sound pathetic in Swedish.[6] The phrase “I love you” expresses a different quality of very deep emotion, used in family and in romantic contexts. It´s considered too valuable to say too often: “Something you say to everyone loses its value”[7] But also non-verbal expressions, as too long and evocative hummings: “uhummm”, “ooohhh”, that are emphatic and meant to stimulate right brain connection and foster secure attachment are more sensitive and need to be well-balanced to be received as genuine in our culture.
Allowing a bodily experience in the moment to reach the kind of poetry that, I believe, flows deep within us and is rooted in the attachment to our first language, our *mother tongue*—is a profound challenge for both parts. But when core feelings are emerging, also authentic words can emerge from a non-verbal level, from the Core self. Amazingly, those poetic expressions often seem to be as universal, as the transformational affects.[8]

Swedish poet Tomas Tranströmer (1974) offers a beautiful image of a jellyfish to evoke that wordless, unformulated level of experience—an image that can also illustrate a kind of protection against dyadic exploration.

> *...they drift like flowers after a sea burial, if you take them out of the water their entire form vanishes, as when an indescribable truth is lifted out of silence and formulated into an inert mass, but they are untranslatable, they must stay in their own element.*

This beautiful quotation may also mirror the choice to be quiet together in a deep emotional

[6] An example is the use of the word love. When the therapist wants to share their affection and says ”I love you” to a patient I´d rather say "I feel so much affection for you," "I care for you a lot" ...
[7] Comment on this subject in the blog ”Life in the suburb” discussing differences in Swedish and American use of the word.
[8] ”as universal and fundamentally encoded as our categorical affects.” (Diana Fosha, seminar, 2020)

moment of truth - or the well-known Swedish silence which is often portrayed in literature as an inherent unwillingness to put words to everything - often linked to our love for nature and silent lonely walks in the forests as a part of our collective spirit. When speaking about spirituality and transcendent experiences, Swedes often mention that their silent relationship with nature and natural scenery give such experiences. One patient of mine said while we were metaprocessing in the end of a session: “I feel great, let´s not say more, let me keep it as it is.”

What I have written here could be cultural attitudes or just different individual or common attitudes. How do we know, and does it matter in the long run? I know one thing – Swedes are generally, a little more reserved and quieter from the start in a relationship than many other people, and many of us welcome a model like AEDP to heighten the temperature.
AEDP was introduced in Sweden by The Stockholm Academy for Psychotherapy Training (SAPU) in 2003.

When I began writing the article presented below, I pioneered as a therapist who was in AEDP-training and supervision while also lecturing on AEDP in Sweden. I wanted to convey not only the transformative model, but also the notion that AEDP represents a paradigm shift—offering both a theory of transformation and a new role for the therapist. Doing that felt a bit scary, as I didn’t want therapists to feel too overwhelmed or defensive. I wanted to give them a new good experience of feeling curious and seen. The ‘Law of Jante’ -part in me said that I should tone down my enthusiasm and prepare myself for criticism. That didn´t happen. Since then, many Swedish therapists have connected to AEDP, and our community is growing - we now see a second generation of AEDP therapists joining us here.

Before writing this article in 2013, I have had a couple of workshops where I introduced Diana Fosha’s first APA-video. Most students were deeply moved and curious to watch more while some reacted with strong resistance and even aversion to Diana’s starting from “the get-go”. Students commented “this is intrusive”, or reacted defensively to her evocative style, speaking slowly and with a soft voice. I was very mindful of those reactions and in my article, I wanted to present AEDP in both an emotionally engaged and explanatory manner, using my own clinical vignettes to demonstrate that by being present and explicitly emphatic we can help our patients to feel safe enough to drop down and explore the glimmers of change together with a therapist who is genuine and authentic, who is using language and cultural codes that feel familiar enough, facilitating for the patient to dare take risks. I had a vision that presenting AEDP would open up for dynamic psychotherapists here to discover a transformational model that can heal attachment trauma in a way no therapy training before had offered. One of the fundamental keys was the concept of “undoing aloneness” and as so many other colleagues have experienced, it undid my aloneness as a therapist as well. I still remember the first time I heard Diana say: “AEDP is more

than a method, it´s a relational stance"[9], and how I felt the shift in my body. Since my basic psychotherapy training, I felt something had been missing. In supervision we were told not to self-disclose our genuine love, care and give spontaneous positive feedback to patients, as that would "stop transference to develop". Even if I was used to break those psychoanalytic rules since many years, no one had been explicit about how to do therapy from an intersubjective and attachment-based bottom-up stance, where our own emotions as well as the patient's, could be a vehicle in the process. So many AEDP'ers have expressed this feeling of "coming home", and having that experience, I wrote with my fellow colleagues in heart and mind: look here what we can learn to practice! What follows here below is my introduction to AEDP directed to Swedish therapists, translated into English.

AEDP - Offering our patients a corrective emotional and relational experience

Anna Christina Sundgren

Introducing AEDP

The patient needs to have an experience, a new experience. And that experience should be to be good. From the first moment of the first contact, and throughout the treatment thereafter, the aim and method of AEDP is the provision and facilitation of such experiences. (Fosha, 2002).

In this article I will introduce AEDP, Accelerated Experiential Dynamic Psychotherapy, an experience-based, affect focused, relational psychotherapy, which has been received with growing interest outside the U.S. the recent years. We find the theoretical roots in psychodynamic theory (inspired by Winnicott among others), attachment theory (Bowlby 1994), affect theory (Tomkins, 1962), neurobiology (Damasio, 1999), affective neuroscience (Panksepp, 2009; Schore, 2009) and body-oriented psychotherapeutic theories such as focusing (Gendlin, 1978; 1998).

AEDP has been described as a healing-oriented phenomenologic, body-based "bottom-up therapy", informed by clinical observations of what really works, that has then been verified in theories. Not least the latest neuroscientific research is supporting the clinical experiences of the model. AEDP is founded and developed by Diana Fosha. She is the founder of the AEDP Institute and author of *The Transforming Power of Affect,* (2000), editor of *The Healing Power of Emotion* (2009), in which a number of well-known clinicians and researchers in

[9] Immersion Course, 2013

neuroscience, affect theory and infant observation have published their articles, and many articles that can be found on the AEDP Institute web-site (aedpinstitute.org).

I will present some central concepts and clinical examples to give an insight into the phenomenology behind AEDP and its practice, with a short link to theories. The interested reader is recommended *The Transforming Power of Affect* to get the complete overview of the model.

A Transforming Experience

There is no better way to capture the ethos of AEDP than to say this: we try to help our patients – and ourselves – become stronger at the broken places. (Fosha, 2002)

My first discovery of AEDP was in the early 2000s when I read the newly released *The Transforming Power of Affect (my copy has been read several times since then).* The book was an almost revolutionary experience for me and started lively discussions in my study group at SAPU (The Stockholm Academy for Psychotherapy Training). There were excited comments like, "So non-Swedish and unashamed!" and "Isn´t this too provocative for the patient?" Even though the SAPU institute had a relational psychodynamic approach, self-disclosure was an almost non-existent phenomenon, as in psychodynamic therapy training in Sweden, and probably in general by that time. At least it was not mentioned as a psychotherapeutic tool, more as a mistake in our clinical work. We were also discussing the AEDP- therapist's warm and attuned approach from a cultural perspective – a general comment was that it seemed very "American," and difficult to adapt to Swedish therapeutic dyads. In spite of all the objections there was something irresistible in AEDP that resonated with some of us.[10] To me, the focus on the healthy and healing resources inside us all was, by that time, the first attractive reason for learning more. Then there was more to discover: attachment theory was integrated into the model, which described the transformation that emerges from healing resources—resources harnessed through a genuine attachment relationship and attuned emotional exploration; the respectful, moment-to-moment process of exploring with the patient how nonverbal experiences manifest viscerally as bodily sensations—and then following up with metaprocessing.

All this filled me with admiration for those (imagined) therapists who had the courage to work like this. Watching Diana Fosha's first APA-video together with my colleagues brought up a lot of feelings. I remember my own feeling of resistance - having to protect what I already had learned and practiced. Yet, at the same time, I was thrilled and exited to explore something new

[10] From my study group, I and Annika Medbo, who is now an AEDP faculty, started an AEDP-inspired peer supervision group.

and take the risk to re-evaluate what I had already learned and practiced (Sundgren, 2006). The patient should be helped to both new experience and to describe how his change is perceived and what it is like to experience an emphatic and self-disclosing therapist and process the relational experience to completion. This emphatic, relational work is big challenge to any therapist, and the last part of that sentence is the hardest, "… to completion." I will return to this expression as well as other terms I have mentioned, later on.

Transformance and Transformation

AEDP is clearly based in a relational matrix - the idea that the phenomena that emerge when expressing oneself and when communicating with an openminded and emphatic other to its completion, can lead to transformation of the self and to an integrative experience (Fosha, 2000).

Two recurrent key concepts are *transformance* and *transformation* (Fosha 2008, 2009, 2013). Transformance is the term for the overarching motivation for change - the life-force - that is biologically laid down in us from the beginning of life. Transformance is an ongoing process in which the maladaptive emotion gives to openness, hope, and vitality - fostering a (longed for) change toward growth, authenticity and coherence.

The opposite of transformance is resistance, which consumes and drains energy. Transformance can be observed as glimmers of resilience (Fosha 2013) revealed in the patient's narrative, and non-verbal expression. The therapist will notice these glimmers in parallel with the recognition of defenses, and explicitly name them, thereby helping the patient identify indicators of her emerging transformation. Transformation is a broader concept of what awakening of transformance drive can lead to inside us.

From the Get-Go

The attachment-promoting stance of the AEDP therapist—marked by attunement and accurate responsiveness to nonverbal communication and somatic markers—is informed by research on the dynamics of infant-parent secure attachment relationships, whose co-constructed, moment-to-moment interactions serve as a model for therapeutic engagement (Fosha, 2000). Positive outcomes of attachment security-enhancing interactions in psychotherapy have scientific support in infant research (Beebe & Lachmann, 2002; Trevarthen, 2004). One of the characteristic features of AEDP - also supported in infant research (Beebe & Lachmann, 2002; Trevarthen, 2009) and neuroscience (Panksepp, 2009; Schore, 2009) – is the operating assumption that our capacities for adaptive strivings, resilience, recovery and healing are biologically wired-in. The conditions for these self-organizing processes are also there from the first moment of the first

meeting with the patient; it is simply a matter of seizing the opportunity to notice and engage them. Healing and transformation are seen not just as a result of therapy, but also as a process that can constantly be activated to widen the patient's own abilities.

The AEDP psychotherapist tracks the adaptive strivings that already exist, from the first moment of the first session - "from the get-go" (Fosha, 2000, 2009). The therapist mirrors and raises awareness for what already works for the patient, and meets defenses with empathy, stressing their necessary value at the time they arose. This is the preparatory supportive and resourcing step before

starting to work with traumatic and emotionally painful experiences. This attachment-securing work to facilitate a patient's safety to process painful experiences may result in activating a patient's complex feelings regarding intimacy and closeness. However, it also serves to accelerate a process of developing a secure attachment experience.

Once defenses have melted and the dyad is able to process core affect (Fosha, 2000), followed by the experience of reflecting on what just occurred—known as metatherapeutic processing—the therapeutic process moves toward completion. In this state[11], patients often describe experiencing themselves as a more 'authentic' and 'true' (in their own words). From this core experience of Self, a new, coherent autobiographical narrative can emerge.[12]

From the get-go, the therapist and the patient create together their own unique relational patterns, via right-brain to right-brain communication (Schore, 2009). From the very first moment, the therapist conveys their intention to be present, to be mindful with the patient, and to engage relationally by directing their focus toward the patient's emotional experience—beginning with their first question: 'What brings you here today?' The therapist continuously monitors the patient's sense of safety by attuning to their moment-to-moment nonverbal affective fluctuations (Hanakawa, 2021)[13]. meeting them with presence and respect. In doing so, the therapist becomes a model of attunement, mindfully tracking the process and inviting the patient to articulate what they feel—especially as they observe the therapist mirroring their state and becoming emotionally engaged themself. Through this collaborative process, therapist and patient co-create a sense of intimacy. While the therapist is recognized as an expert in psychological processes, the patient remains the expert on his own life (Fosha, 2000).

[11] My omitting of the three states transformation and the four states (as well as the triangles was deliberate in this introduction.)
[12] When presenting this work, a common question from psychodynamic trained therapists is: "What about the story, the biography of the patient? When do you ask about that? Isn't this important in AEDP?
[13] This note was added when editing the article 2025

Below I offer some short examples of phrases from my own videotaped practice:
~"I hear that it took plenty of courage for you to get here today. You told me how long you have hesitated ... you have struggled so much ...been carrying so much... Imagine that you came here anyway! You tell me you're not able to achieve anything, but you came – you're actually here now! "
~And a little later: " What happens to you when I notice how you're struggling - and I put words to it? "
~And: " Do you notice that I am touched by what you tell me? How tough this is for you? Is it possible to say something about how you experience it right now?"
A patient who feels safe when invited to collaborate by an empathic, mindful, and attuned therapist will most often drop down emotionally and hence becomes willing to explore both his feelings and the ongoing interaction. During metatherapeutic processing, patients often describe the therapist's attention as having a widening and liberating effect. They may express this with statements such as, 'It's easier to relax, to be touched, and to feel my emotions.'

Until this happens, the patient is not yet secure, and the therapist must continue doing safety work: marking, tuning in, and not challenging defenses. The therapist must not proceed without attunement to what is happening in the moment. Instead, she asks the patient for help in exploring the defenses that are activated and respectfully inquires how the patient experiences them, also viscerally, here and now. If the response is that nothing is felt, the therapist gently asks, "How's that for you? What do you notice now when you don't feel anything?" The important thing is not to abandon the patient here, but to stay attuned to where the patient is, explicitly welcoming the patient's experience—even the experience of not experiencing or not sharing.

The therapist thus helps the patient regulate feelings of anxiety—not by challenging defenses, but by supporting the patient in finding a safe place. This helps avoid repeating attachment trauma, where the patient was left alone with unbearable, overwhelming emotions. When safety is established, defenses soften, creating space for the work to deepen and for adaptive feelings to emerge.

Recognition

Recognition is one of the phenomena that the therapist draws attention to, makes explicit, and experiences together with the patient. It occurs when the patient recognizes something transformational - like an "aha moment" in which the patient's emotional memory encounters an outer experience or a glimpse or of something of similar quality, serving as a kind of confirmation or "glimmer" of something meaningful.

This recognition creates something new—a "click," experienced as a small burst of positive affect, vitality, and energy occurring between the Self and the stimulus (Fosha, 2009), confirming that there is a match between them. On a visceral level, it may register as a feeling of "yes," often accompanied by deeper breathing and a mild sensation of warmth (reflecting increased blood circulation).

These emotional threads can contain both painful and pleasant feelings. Their emergence requires openness and receptivity in the dyad—a willingness to stay with and expand the experience. When this occurs, it enables the processing of old traumatic emotions while also allowing the discovery of new transformational ones (Gleiser, 2013).

Recognition is clearly illustrated in a poem quoted by the Swedish poet Tomas Transtromer (1970):

Two truths approach each other.
One comes from inside,
one from outside
and where they meet
there is a chance to see oneself

Such meetings probably occur in all types of therapies, but they are not recognized and reinforced as a transforming phenomenon.

Here is an example from a vignette where the patient[14] is imagining that she is talking to a younger version of the self:

T: What would you say to yourself?

P: I would say to myself – "can you give this girl a pause and some rest from your criticism."

T: Uhmm, so there is a caring part of you talking... yeah…

P: Yes, exactly, and now it says something like "just calm down for God´s sake!" (*Smiling)*
T: So good for you that you recognize this part as well, and that it wakes up now when we are sitting here and you have some space and time for both sides **[affirmation of the recognized younger part of the patient, trying to give more space for both sides in order to explore.]**

[14] When necessary for the confidentiality of my patients, clinical vignettes are adjusted.

P: Yes! It´s a funny feeling! Like something that has always been there but like buried for a long time, overrun by my hard and ambitious side that drives me on with its criticism, like hearing my father's voice, and now when you asked me, so weird, I like talked from another place inside me! Without any effort! (*Silence*) And then I get sad about what I´m doing to myself… **[P's own recognition of her father´s internalized critical voice in her child part and the affect that comes up with the recognition of it which "clicks" with her true Self experience - marked by no "effort" and self-compassion.]**

The phenomenon described above depicts the patient's experience of the "True Self" and also of the therapist as a "True Other" (Fosha, 2000). True Other, means a relational counterpart to True Self and describes the subjective experience when one individual responds to the other in a way that feels "right," and then, through the other, experiences himself as "true". In the co-created therapeutic interaction, the patient can emotionally 'check' if his own version of the experience feels authentic. We cannot try to be a True Other no more than we can try to be a True Self. It is an experience that springs from the authentic encounter. On a more general level, relational experiences of this kind, as a recurrent phenomenon in therapy, can gradually reconstruct the patient's life history.

Undoing Aloneness

One cornerstone in AEDP is clearly its relational strategies. The collaborativedevelopment of closeness and intimacy in the therapeutic relationship is central and does not consist solely of holding or therapeutic humming in the background (Fosha, 2006). The therapeutic process takes advantage of and is promoted by focus on the relationship.

I have already suggested an important foundational concept in AEDP: the notion that psychopathology arises from the child´s "unbearable state of aloneness" (Fosha, 2002) - a state in which the child is overwhelmed by strong emotions and is emotionally abandoned, left without mirroring or regulation by the caregiver. Later trauma shows a similar phenomenology. The therapist's task is to "undo the patient's aloneness," by being a safe and wise guide, and companion, who consistently present with the patient - mirroring, marking, giving back, regulating, and when the patient feels safe - exploring, deepening, and metaprocessing what is happening inside the patient and within the interaction. Example: This patient has been neglected by her parents and unseen as a child. She suffers shame and self-criticism, which has interfered with her career and her relationships with men. In this dialogue I don´t go into her conflict with her parents that is lurking in the corners, I first try to make her safe enough with me by undoing aloneness and de-shaming her.

T: And now when we actually are sitting here and I would say to you, what you're saying doesn't

sound ridiculous, and I wouldn't judge, would you believe me?
P: *(Laughing*) Sorry I get so full of laughter because I feel that I… I don't know exactly, no.

T: Tell me more, you "don't know exactly?"

P: I don´t know, it´s like my conviction is so strong when it comes to this kind of situation, I really feel like I'm a small child coming in and telling something that I experience as very hard…

T: And?
P: And (*silence*) aaah, then aah, like I, in a way, think how the other person will receive it and then

T: uhmm

P: And then it´s like I… (*tearing more and more*) Oh shit! Now it gets complicated, (*waving her arms*) I can't hold things apart…

T: Just see if you can stay with it, I'm here with you… **[explicitly staying with P, not to let P feel alone in the room]**

P: *(Calming down*) And then it's like (sigh), I don't know...like I see myself through somebody else and… (*silence*) …expect that other people will just wave it off?

P: (Sigh)

T: So that is what you are afraid of… *(soft voice*) **[validating P's experience, making it explicit]**

P: yeah

T: that I wouldn't take you seriously….

P: uhmmm

T: Uhmm
(Silence)

T: Which sounds horrible, to me, a horrible feeling for you… [**amplifying affect; self-disclosure of T's subjective experience]**

P: uhumm… *(silence, P looking down)*

T: Shame?
P: Yes, shame
(silence)

P: really…
(silence)

T: I want to say something to you now, from my point of view,
if that's ok for you? **[Asking for permission]**

P: Uhmm

T: That I believe that those times you and I have been sitting here and you
have told me about how you feel, I really, really feel very, very strongly that…
I experience that your efforts to be open, and your openness, and also my experiencing what it does to me, makes me feel so sincerely… that I take you seriously, because I see how you try to be so honest… It moves my heart to see how you really try to tell me what is painful to you and what you want me to help you with… **[Self-disclosure, regulation of anxiety and shame, affirming of P's efforts to be open, honest and confront her issue]**
(Long silence)

P: *(Nodding, looking at the therapist, tearing up)*

T: Uhumm… *(Nodding, looking back)* **[affirming the patient in dropping down]**

T: How is it for you when I say this?

P: *(Crying)* I cry but I was so happy to hear it! **[Affective break-through; healing tears]**

T: Uhum

P: uuhuh, that you said you are taking me seriously…

T: Uhmm

(Silence, P blowing her nose, crying)

P: It was so relieving to hear that from you… [**Post-breakthrough relief]**

T: How is that to be taken seriously by me and feel relieved?

P: It´s in here *(laying her hand at her breast*) and my breath, something feels lighter. **[Post-breakthrough affect]**
T: Lighter?

P: Something is gone. I can rest. *(Sigh)*
(Silence)

T: Can you feel me here with you now? **[Making the implicit experience explicit and making sure that aloneness is undone]**

P: Yes. I´m not alone now. And I feel safe here. *(Big smile through tears)* **[P gives a clear confirmation that aloneness is indeed undone]**

Metaprocessing and Core Affects

Metaprocessing is another corner stone in AEDP and is probably the part of this model that is most unique to AEDP (Elly, 2013). Metatherapeutic processing involves “dyadic mindfulness,” while the therapist is noting her own and the patient´s reactions and feelings in their interaction, she is also constantly reflecting, and sharing her reflection, of each new relational experience with her patient. This reciprocal communication ultimately becomes the origin of the next new relational experience, and so forth, in an upward spiral. Of central importance is the transformational power of core affects, provided they are “processed to completion,” (Fosha, 2000, 2009). The term, "processed to completion" is important because it refers to a specific emotional experience that could be described in Snyder’s poetic form: “in this moment nothing is missing.”(2013). One purpose of metaprocessing is to help the patient be fully aware of his own transformational experience while being safely connected within the co-creating dyad. This enables affective openness for further transformative experiences.

Metaprocessing can be done after every minor or major piece of conversation in a session and at the end of the session to process the experience of the session as a whole. The benefit of metaprocessing is supported by neuroscientific research on brain plasticity and how positive affective experience can alter maladaptive internal working models from the patient´s early attachment relationships (Panksepp, 2009; Schore, 2009).

During a session the interaction is often moving back and forth in waves of experience and reflection through metaprocessing. AEDP interventions - creating safety, tracking bodily cues moment to moment, identifying and bypassing defenses, exploring and deepening core affects and new relational experiences, discovering and seizing upon glimmers of resilience and recognition - are followed by metaprocessing.

The "waves" of experience and reflection through metaprocessing are illustrated in the example here below. This is a vignette from the middle of a therapy session where shame is the current theme:

P: I haven't always been shy. I remember when I sang in graduation at school, and I received applause from the audience and a lot of confirmation, how I thanked them and on my way home I was proud and very happy. Today I would never….

T: I can see a little smile on your face when you tell me this, and it´s like a glimpse in your eyes, is that correct? **[T. recognizes a glimmer of resilience by noticing non verbal cues]**

P: Uhum... (*smiling larger*)

T: … something happens right now…?

P: Yeah, I feel happy when I remember how cool that feeling was…

T: Is it possible to stay a little with that, what you are aware of inside right now?

P: Happy

T: …Where inside your body can you experience this happy feeling? **[T is trying to help the patient deepen her feeling through bodily awareness]**

P: (*Lays her hand over her chest*) Here!

T: And what do you find there? *(Lays her own hand over her own chest)* **[Mirroring]**
(*A short silence follows. The eyes of the patient fill with tears)*

T: What goes on inside you right now? *(Soft voice)*

P: I feel sad.

T: Uhum, sad….

P: Yes, because I had forgotten that feeling and now half of my life has passed without it, it's been like this ... Shit, so fucking horrible ... [**empathy for her own loss, mourning of the self emerges, seems like a mix of sadness here and now, and sadness for what has been]**

T: See if you can stay with what happens for a while, see if there is more… *(Speaking slowly with a low voice)* **[Attuned to the feeling, trying to make space for emerging feelings]**

P: I´m angry as well, angry at my mother who was so scared that anyone would look at me, that people should see me, that I would stand out, she could be ashamed of anything … and… (*weeping*) …Aaaah… **[Feelings that have been held back by defenses are now coming up, and given space]**

T: Uhum, a lot of feelings inside that you need to make space for now, so much that you held back for so long, trying to adapt yourself … **[affirming patient's feelings and recognizing her need for defense in the past]**

P: *(A deep sigh of relief)* Yeah, and for what use… (*takes a deep breath and wipes her tears, then gazes in the therapist's eyes for a long moment. Nods.)* [**Nodding marks physically that the patient is in contact with core affect and remain connected to the therapist.]**

T: (*Nods and feels her eyes are filled with tears. A moment of silence follows. Both are looking at each other.)* You can see that I am moved by what goes on in here as well? **[Self disclosure**]

P: Yeah…

T: How is that for you, watching my tears when you tell me? **[Metaprocessing]**

P: It feels good, and a little strange, as something warm in here, as if someone had poured smooth, warm milk over me. *(Moves her hand to her chest. Silence. Smiling through her tears.)*

T: (*smiles back and says silently:*) How is it for you when I ask you about this, that you are watching me being moved and I'm tearing up? [**More metaprocessing**]

P: It feels a little strange, but it's like you see me as I am, and as it opens up even more in me, I'm crying but that's ok, I do not hold back… it's nice and ... well ... strange and a bit scary as well ...

T: Yes, scary or shaky!

P: *(Laughs*) **[Tremulous affect] [safe vulnerability]**

After metaprocessing, P has an experience that it's ok to feel good and scared while at the same time, showing an emerging capacity to feel and be more open with core affects in the context of safe relationship and to allow a True Other to see her for who she is, to see her true Self emerging.

Metatherapeutic processing benefits from therapist self-disclosure and involves following each 'wave' of exploration with a conversation about what it was like to explore vulnerability together and what felt therapeutic about the experience. This deepens and accelerates the patient's healing by integrating emotions and helping them process to completion. Such a 'wave' can be short or long. The next 'wave' can deepen the unfolding experience of the patient's pain and sorrow—grief over what she has not received or has been missing in terms of relationship or attachment. The good feelings that emerge within the safety of the therapeutic relationship evoke a contrast, reminding her of what was absent. This, in turn, gives rise to mourning for what she hasn't had—what Fosha (2000) calls "mourning of the self." This kind of grief is adaptive and healing and is often, in its own time, followed by gratitude and a sense of peace.

Arriving at the end of a session, a more comprehensive Metaprocessing (this time with a capital "M") of the session can take place. Then yet a new wave of emotions can emerge, which are not categorical affects as defined by Tomkins (1962; 1963), but are core affects in the purest form, that are experienced in body and mind – among them are gratitude, grief, pride, compassion, love, deep connection with others. The experience of these aspects that follow from the metaprocessing a completion of therapeutic work within a session is transforming for both patient and therapist. The patient is given access to wider and deeper sense of self, experiencing authenticity and often feeling, in the words of patients, "more real" and "true." The exchange below illustrates this point:

T: ...so how is your feeling right now?

P: It´s fantastic.

T: If you go to your bodily experience? When you are as you say "prepared to meet life?"

P: Except from having to blow my nose, I feel calm inside and secure in a way, that I can be very mindful and present, though having to handle difficult questions, the unexpected, feel the safety

to handle the situations that will come, and that's good enough, breathing freely and prepared to meet life!

Although it is associated with vulnerability, pain, grief and fear, it is quite bearable and liberating when experienced in a safe environment. The patient dares to be "on the edge of experience," as if the self here created a "self-holding function" (Fosha, 2000). This is what is called ''core state''. If the patient instead is still in need of some defenses, it will appear when the therapist tries to metaprocess, then they will stay attuned to what comes up and take

another round of tracking what´s rubbing, always attentive to the micro-movements in the dyad.

Core affects are the emotions that make change and core state is the state experienced that one can rest in. Core state is sometimes described in terms of *surrendering* or *transcendence*, to *let go*, and is often an intersubjective experience associated with the feeling of being part of something greater than oneself, of coherence.[15]

The Therapist's Role and Self-Disclosure

One of the most challenging moments for the AEDP therapist during metatherapeutic processing is when the patient offers explicit expressions of positive feelings for the therapist. Many of us are trained in, and comfortable with, the processing of negative reactions against us in the transference, we find it much harder to receive positive expressions. Those reactions can be experienced as a rejection and be deeply hurtful to the patient. Fosha emphasizes that it is crucial to take advantage of the emotions, respond to them and use them intersubjectively. This means that the therapist becomes a model for the patient in their attempts to remain in adaptive emotions so that they can develop into completion. The therapist should try not to let such false modesty serve as a defense and reduces her experience. Gratitude from the patient needs a genuine reception. The therapist too needs to get in touch with core affect and core state.[16] This means that the therapist becomes a model for the patient in his attempts to remain in adaptive emotions so that they can develop into completion. The therapist should try not to let such false modesty serve as a defense and reduce her experience. Gratitude from the patient needs a genuine reception, therapists also need to get in touch with Core affect and Core state to develop and grow as professionals and as human beings. Simply practicing what we preach.

[15] More about these phenomena is found in a new Swedish book, Intersubjectivity - The interpersonal in health care and every day life" (Martenson, Blom & Wrangsjo , 2013).
[16] Today, a decade later, I would have written that most of us therapists need to work on expanding our receptive affective capacity.

Another difficulty we encounter when learning to be relationally present within the AEDP therapeutic modality, is to overcome our training to acquire a removed professionalism. We are trained to quietly keep counter-transferential feelings within us. Therapist self-disclosures and the direct metatherapeutic processing of the interaction no longer makes it meaningful to talk about transference in a traditional psychodynamic sense. AEDP considers the occurrence of transferential relating as a sign that the dyad has not processed inter-relational affects to completion. Thus, the therapist needs to develop tolerance for the anxiety that may arise when they are the focus of the other's attention and positive emotions.
This stance may feel strange within the traditional psychotherapeutic role, yet when embraced, we facilitate a transformational process within ourselves as well as our patient. Moreover, we are better resourced to facilitate the patient's transformation.

The following is an example of my own struggles and shortcomings to stay emotionally with my patient when he offers me positive feedback in response to my having validated his strivings:

P: … I have achieved something that I can both be proud of and satisfied with…

T: Yeah, you really, really have!
(*Short silence when P is tearing up deeply touched looking at T)*

P: But it's so much of you, it's so much you…! (*voice bursts)*

T: We've done … (*T. interrupting herself recognizing her own avoidance and embarrassment of being in focus of patient's strong feelings towards her*) I'm glad you say that, and that you can receive it when I say it to you, you can stay with it…and we can stay with it together and actually there are so strong feelings in here now… (*T is moved and embarrassed, trying to restore the "we"-ness here)*

[Some seconds later, metaprocessing. T. is trying to repair and restore being a safe model for her patient through self-disclosure]:

T: And I think that here you also teach me something about what we are doing together, that's when you tell me that I have helped you so much and I get the feeling that I want to do the same thing as you did before, saying "no, no, no, it's you, you did it on your own,", instead of meeting you in your appreciation, like you say you have learned from me. Now I say: Ok, that's true - Thank you for saying that!

P: This is cool!! **[P expresses appreciation for T's taking in his gratitude**] My basic assumption is that everyone is telling you how fantastic you are; it can't be just me that is doing that! [**Next challenge for the embarrassed therapist!]**

As I have already mentioned, AEDP sets special demands on the psychotherapist's own affective awareness, mindfulness, and insight into her own attachment traumas. Self-disclosure (Prenn, 2009) is an intervention that is widely used to the benefit of the patient.[17] It should be noted that self-disclosure is not a technique, but an expression of the therapist's authentic and deep feelings. When the therapist shares her genuine affective reactions to what the patient says or feels, the process often takes a leap forward. Self-disclosures concerning how the therapist perceives the patient's suffering, how concerned the therapist becomes, how happy the therapist becomes, how the therapist has thought of her patient etc., are examples of ''existing in the heart and mind of the other'' This expression coined by Diana Fosha, was adapted from Peter Fonagy's description of mentalizing. Fosha has added ''heart,'' and says that when patients feel they are thought of, affirmed and seen, not only in the therapist's mind but also in the therapist's heart, safety can grow and change is possible (Fosha, 2000).

The patient expands his experience of the other, and as this happens, over and over again, internal working-models of attachment change (Panksepp, 2009, Fredrickson, 2013). The therapist becomes a new model, an alternative experience of attachment. In this process, the therapist's own subjective presence is crucial. It is all about showing you are there, "real,'' loving, caring, and active.

A loving parent (therapist) is not only following but also responsible for leading and structuring in the encounter. It is important to note that the therapist's intention to be empathic is not sufficient for a secure relationship to develop, (Fosha, 2000), because if we don't know how we are perceived by the patient we don't know if they are sufficiently secure and experiencing our empathy. The therapist needs ask the patient how they perceive the interaction emotionally, and how they experience the showed empathy. Metaprocessing the patient's experience of the therapist's offerings and the dyadic relating teaches both the patient and therapist about each one's unique experience, and common experience. We do not make assumptions but inquire – an experience which contributes to the security that is required for daring to be ''on the edge of experience'' (Fosha, 2000).

Being "on the edge of experience" - open to emergence and curiosity, is a fundamental attitude for the AEDP therapist, and one which the patient learns to comfortably acquire. 'On the edge,' we always follow the patient, never knowing where we will end up. The therapist should be

[17] Self disclosures should be judicius, in service of the patient and the therapeutic process.

brave, and the patient safe. Fosha states, (Elly, 2013) ‘‘What you think is impossible, you are already doing.’’ She suggests that therapists are sometimes ahead of the patient and worry about what will happen, instead of being with the patient, in the here and now.

As usual -What sounds so simple, is the hardest part! Discovering and making explicit the glimmers of transformation in therapy, and metaprocessing the visceral experiences of connection and healing, enabling loving kindness to develop mutually and simultaneously towards the Self are not simply interventions but in these acts are also possibilities for the transformational growth of the therapist and their self-compassion.

In supervision, corresponding processes take place - as supervisors we can look for glimmers of resilience and resources in the supervisee and make them explicit and mutually experienced. This often leads to transformational experiences and development for both the therapist and the supervisor. Training and education to become an AEDP therapist has an obvious and essential base in video recording the therapy sessions, not only for supervision purposes, but also as a source of experience and knowledge for each therapist to repeatedly see the interaction and those micro-moments that shape it.

Conclusion

The purpose of AEDP is to facilitate the experiences of transformation, accelerate change for the better, while undoing the patient’s aloneness, increasing their relational mindfulness and deepening affective experience. The patient gets help to grow and to develop into a more grounded and confident person with more access to core affects and curiosity about life.

Concerning similar psychotherapeutic methods – Fosha emphasizes the importance of taking advantage of what others share with us, focusing on what we ourselves are doing that works, not on what the others don’t do. ‘‘However - and this is a big however - AEDP does not claim that its path is the one and only path.’’ (Fosha, seminar "State of the Union" October 18th, 2013). The AEDP community is growing over the world. The discussions taking place on the internet based AEDP list serve is flourishing with a spirit of openness and generosity. Therapists from different schools and geographic locations have ongoing conversations about big and small issues, most of them sprinkled with curiosity and eagerness to learn more of this game changing therapy model!

Thanks to Yuko Hanakawa

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