

Emergent Imagery: Unconscious Processes, Play & the Co-Construction of Healing

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“When the Soul wants to experience something, she throws out an image in front of her and then steps into it.” (attributed to Meister Eckhart)

“Psychotherapy is done in the overlap of the two play areas, that of the patient and that of the therapist” (Winnicott, 2005, p. 72)

Abstract: Since its inception AEDP has relied on the use of imagery, particularly through portrayals, in order to help process emotional experience to completion. This article explores the therapeutic potential of imagery through a more organic and less structured approach we call *emergent imagery*, promoting a broader exploration of imaginal experience in clinical practice. A rich history surrounds the philosophical consideration of imagery and its use in healing, and recent research has started to expand our understanding of its scientific basis as well as its ability to facilitate therapeutic change. Current neurobiological findings suggest that imagery can access multiple brain networks and serves an important role in cognitive and affective functioning. The exploration of imagery utilizes right brain mediated processes and often accelerates access to previously unformulated experience. In the context of relational safety, this therapeutic approach taps into the power of play and enables a rich dimension of intersubjectivity. The use of metatherapeutic processing, an essential AEDP tool, facilitates further reflection and integration of therapeutic experience. Case material, with transcribed excerpts from a videotaped psychotherapy session, illustrates the concepts discussed in this article.

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Imagery in Philosophy and in Healing Across the Ages

Philosophers have long considered the role of imagery in the functioning of the mind. Aristotle viewed images produced by the imagination as essential to thought: “the soul never thinks without a phantasma” (Aristotle, 1984; as cited in MacKisack, Aldworth, Macpherson, Onians, Winlove & Zeman, 2016, p1). The Aristotelian belief that mental images were “the principal vehicles of mental content” persisted through later antiquity, the Middle Ages and into the era of modern philosophy (Thomas, 2008). Descartes and subsequent Western philosophers debated the relationship between ideas, mental imagery and consciousness (Thomas, 2008; MacKisack et al, 2016). Into the late 19th century, mental imagery remained central in philosophical explanations of cognition (Nanay, 2021). In the early 20th century, work done by a group of German psychologists sparked the “imageless thought debate” (Nanay, 2021) followed by a general diminished focus on the role of mental imagery in psychology and philosophy as behaviorism became dominant (Nanay, 2021; Thomas, 2008; MacKisack et al, 2016). In the 1960s and 1970s, there was renewed interest in the study of mental imagery as part of the cognitive psychology movement (Thomas, 2008; Pearson & Kosslyn, 2015). The “imagery debate” at that time revolved around whether imagined visual content could only be generated in a symbolic or language-like way, and this debate was settled in the early 1990s when neuroimaging demonstrated that visual mental imagery could be represented in a similar way to perception (Pearson & Kosslyn, 2015).

Achterberg has described imagery’s key role in all healing traditions, from shamanism to modern medicine, with practices that “alter the *images* or the expectancy that the persons hold regarding the state of their health... those who were skilled at wielding the powers of the image were awarded the greatest stature in the healing hierarchy” (Achterberg, 2002, p. 4). One of the first descriptions of imagery in psychological therapies was Janet’s use of “imagery substitution”

in his treatments in the late 19th century (Ellenberger, 1970). Freud initially encouraged patients to concentrate on images (Breuer & Freud, 1895), then moved to free association and later began

to value verbal processes more (Suler, 1989). Jung explored “active imagination,” a technique in which patients were encouraged to allow inner pictures to flow so that “our unconscious will produce a series of images which make a complete story” (Jung, 1916, p. 172). Fritz Perls developed Gestalt therapy which employed imagery and moment-to-moment awareness (Perls, 1973). Singer (2006) made imagery an important focus of his therapeutic work and viewed it as a precursor and central component of narrative thought. The use of mental imagery has been developed by many others and has increasingly been integrated into many different psychotherapy modalities (see Blackwell, 2018, for an excellent review).

Imagery, the Brain & Clinical Processes

Neuroscientific research of mental imagery has largely focused on visual mental imagery, which is internal representations of visual experience without external sensory input and is sometimes described as “seeing with the mind’s eye” (Kosslyn, Gannis & Thompson, 2001; Pearson, 2019). Approximately 27% of the human cerebral cortex is predominantly visual in function while about 8% of the cortex is predominantly auditory, 7% somatosensory and 7% motor (Van Essen, 2004). Visual imagery involves multiple brain areas including the frontal cortex, hippocampus and visual cortex, overlapping with the default mode network, and can function much like a weak version of our perception of external objects (Kosslyn, Gannis & Thompson, 2001; Pearson, 2019). Models of visual imagery generation indicate extensive involvement of areas implicated in visual, attentional and executive functions, including occipital, parietal, frontal and temporal cortices (Dijkstra, Bosch & van Gerven, 2019; Liu, Spagna & Bartolomeo, 2022).

Evidence suggests that visual mental imagery plays an important role in episodic memory and visual working memory (Keogh & Pearson, 2014) as well as in tasks related to autobiographical memory (Aydin, 2018). In the clinical example below, a long held image of a barren landscape with storm clouds on the horizon powerfully captured the patient’s autobiographical narrative of loneliness and emotional deprivation. Individuals differ significantly in their ability to utilize

visual imagery and this has been linked to the excitability of different brain regions (Keogh, Bergmann & Pearson, 2020). Abnormally strong visual imagery has been correlated with some psychiatric and neurological conditions in which individuals have difficulty differentiating internally generated images with exterior reality, such as schizophrenia (Marothi 2018), and Parkinson's disease (Shine et al, 2015).

Damasio (2018) has discussed the crucial role of imagery in the evolution of minds and elaborates on the mind's increased complexity emerging with language. He goes as far as stating "images are the universal token of mind" (pp. 89-90). While Damasio's conception of images here extends beyond visual representations to include other sensory experiences and the realm of feelings, his assertion is critically important—images permeate all of our mental functions. This would suggest that therapeutic efforts to access and work with imagery and other sensory experiences can accelerate connection with, and integration of, multiple cognitive and affective processes.

Fosha describes the *neurobiological core self* (Fosha, 2013; Fosha, 2021c; Panksepp, 1998; Panksepp & Northoff, 2008; Winnicott, 1960; Damasio, 2010), comprised of intrinsically integrative subcortical midline structures (including the periaqueductal gray) which coordinate with cortical structures (medial regions of the frontal and prefrontal cortices). This coordination manifests as "integrated affective/cognitive processes that give rise to identity, agency, ownership of experience, and behavioral coherence" (Fosha, 2013). Therapeutic efforts to explore "tags" of coherence, seeking/vitality, and recognition processes help increase access to the neurobiological core self (Fosha, 2013). In our experience, exploration of imagery can help to organize, and thereby give coherence to, internal experience.

Faranda (2009; 2014) has described *embodied images* as "image-based felt experiences found in the body/mind space" and further states "this experience of the mind represents a system of self-restorative potential constantly bubbling just beneath the surface of awareness... discovered as a playful flow of images or as an unformulated bodily experience" (Faranda 2014, p. 66). Drawing

on the work of Damasio, Panksepp and others, Faranda has described the central role of midbrain networks, involving the superior colliculus and the periaqueductal gray, in self-formation, emotion and image formation: "...we have an area of the brain that has all the equipment to generate, maintain, and I would suggest further, repair the very fabric of self. Accessing this system then, in a therapeutic context, is availing oneself of the functional and architectural capacity to reestablish, reintegrate, and remobilize dissociated, fragmented, and frozen parts of the self" (Faranda, 2014, p. 72).

Schore (2012) has suggested that the therapist's expertise depends largely on an expanded capacity for right, and not left, brain processing, and that psychotherapy's change mechanism primarily occurs through affect regulation and emerges in the connections between the patient's prefrontal, cortical, and subcortical areas of the right brain. "Clinical intuition, used in the context of psychotherapy, could be understood as a direct and immediate embodied knowing mediated by right brain receptiveness, relatedness and responsiveness to non-verbal affect" (Yeung, Fosha, Ye Perman & Xu, 2019). One way in which a clinician's right brain receptiveness manifests may be through imagery. At times, a spontaneous image may emerge in the therapist's mind as a form of developing knowledge about the patient's experience (Welling, 2005; see Russell & Fosha, 2008 for an example).

Evidence suggests that visual mental imagery relies on large-scale brain networks involving both left and right hemispheres, particularly bilateral high-level visual regions in the temporal lobes (Liu, Spagna & Bartolomeo, 2022). Yet there are profound differences in the *ways* each hemisphere attends to experience and interprets reality (McGilchrist, 2009 & 2021). "The LH [left hemisphere] aims to narrow things down to a certainty, while the RH [right hemisphere] opens them up to possibility" (McGilchrist, 2021, p. 28). The left hemisphere preferentially focuses on the explicit, the local and discrete, the familiar and fixed, the decontextualized, the literal and the analytic; in contrast, the right hemisphere is the domain of the implicit, the global, the novel and evolving, the embodied and the metaphoric (McGilchrist, 2009, 2021). Thus, the

open-ended exploration of the unknown, through imagery and other embodied phenomena, would appear to rely heavily on right hemispheric activity.

McGilchrist (2009) has described how the right hemisphere takes precedence since it “underwrites the knowledge the other [the left hemisphere] comes to have, and is alone able to synthesize what both know into a usable whole” (p. 176). McGilchrist has argued that our brains optimally function in a “reverberative” process, with left-right hemisphere interactions that are mutually, but not symmetrically, receptive and generative, and this process allows for the emergence of “something new, that was not present before, (and) comes into being through the process, not negating the earlier stages, but transforming them” (McGilchrist, 2009, pp. 216-217).

AEDP: An Integrative Therapeutic Modality and Theory of Transformation

Resonant with McGilchrist’s assertion that our brains optimally function in a “reverberative” process, from its inception AEDP has utilized the back and forth processing of implicit and explicit ways of knowing through the quintessential AEDP intervention called metatherapeutic processing (or “metaprocessing”) (Fosha, 2000a, 2000b) and what we also refer to as cycles of experience followed by reflection on that experience. Exploration of emergent imagery can amplify the back and forth rhythm between implicit/imagistic/feeling based ways of knowing and explicit/language-mediated ways of knowing. The case example to follow demonstrates the use of emergent imagery and metaprocessing in this interweaving of right and left brain processes.

Time and space do not allow for a full explication of AEDP. An excellent review can be found in Fosha (2021b), reflecting on the theory and technique first articulated by Fosha (2000b) and the two decades of its development since then. AEDP’s experiential focus guides “moment-to-moment” tracking and processing of affect, experience, and the therapeutic relationship. At the same time, AEDP adheres to psychodynamic thinking in that it sees much of psychopathology as

resulting from unprocessed, often overwhelming experiences from the past and people's adaptations to these experiences. It also recognizes the influence of unconscious processes, incorporates strategies for working with defenses and anxiety, and leverages the power of the therapeutic relationship. AEDP draws on research, theory, and interventions in affective neuroscience, attachment theory, caregiver-child interactions, emotion theory, and studies of processes of change, among others (Fosha, 2000b, 2021b).

AEDP has developed a roadmap for deep affective processing: the Four States Transformational Process of AEDP (see Fosha, 2021). These states will be referred to in the transcripts that follow for the benefit of readers who are familiar with AEDP. The work is also generally marked by alternating waves of experience and reflection, so that experiential work is complemented by a focus on meaning making. AEDP refers often to "privileging the positive" (Russell & Fosha, 2008; Russell, 2015; Russell, 2021) by which we mean focusing on and helping to elaborate that which is different from habitual modes of functioning; AEDP believes that accessing the self-at-best (open, connected to self and other, minimal defenses and anxiety) is the most powerful way to be able to work with aspects of self that are compromised, closed off or dominated by anxiety and defenses (self-at-worst) (Fosha, 2000b). The *resilience potential* of each individual is always there to be tapped (Russell, 2015) and *transformance*, the human tendency toward growth, authenticity, development and connection (Fosha, 2008) mitigates forces of resistance and points the dyad in the direction of healing.

The Intersection of Imagery, Social Engagement and Play

Dyadic engagement with emergent imagery can be seen as a form of play between therapist and patient. Something novel enters the space that is recognized by each as evocative and meaningful. But for play to be activated and engaged, sufficient safety must exist. Porges' work on the Polyvagal Theory of Emotion has relevance for therapeutic efforts to regulate affect and promote optimal autonomic arousal, with the goal of activating the "social engagement system" (Porges, 2011). This system, which requires conditions of safety, operates via ventral vagal

pathways and utilizes right brain-to-right brain communication (Porges, 2011; Schore, 2012). The Polyvagal Theory proposes that human beings' highest and most evolved way of responding to threat is social. We are wired to seek and use the proximity and care of other human beings to respond to internal and external experiences of stress and threat. When unable to use this social engagement system, people revert to less social adaptations like fight, flight, or freeze. Often, the co-creation of safety is a main focus of therapeutic work, especially early on in the work (Fosha, 2001) as in the first vignette of the clinical example below.

Helping to create sufficient safety in the subjective experience of the patient is rarely an end in itself. Rather, the purpose of facilitating a "safe enough" experience (Russell, 2021) is for the patient to feel sufficiently resourced to do the sometimes hard work of therapy and to overcome defenses against feeling, knowing, and being (Fosha, 2021a). As well as appearing as an exploratory outgrowth of the *safe enough* experience, at times play can itself facilitate safety. Creating safety through play, as when the therapist says or does something light and playful, or even funny, can help downregulate a patient from a state of hyperarousal and into the window of affect tolerance (Schore, 2012), shifting from mobilization with fear to mobilization without fear (Porges, 2011; Pando-Mars, 2011).

Research by Panksepp and colleagues (Siviy & Panksepp, 1987; Panksepp, Normansell, Cox & Siviy, 1994) has identified PLAY as an innate mammalian primary-process affective state which is based in subcortical brain regions and operates, in conditions of safety, during physical play. While less is known about the neurobiology of mature adult playfulness, "persistent verbal repartee that often characterizes friendly teasing has apparent parallels to... rough-and-tumble play" and "even human laughter is rooted in the ancient PLAY systems that generate joyful social engagement in other mammals" (Panksepp & Biven, 2012, pp. 366-367). Engaging the brain's PLAY circuitry involves endogenous opioid (Panksepp & Bishop, 1981) and endogenous cannabinoid pathways (Trezza & Vanderschuren, 2008, 2009). It also activates SEEKING circuitry, another primary-process affective state (Panksepp, 1998; Panksepp & Biven, 2012).

Play of a less pronounced nature that involves more general exploration likely engages the SEEKING system, as well (Panksepp & Biven, 2012). This system utilizes dopamine reward pathways (Panksepp, 1998) and “creates the conditions that are necessary for many forms of learning” (Panksepp & Biven, 2012, p143). Integrating imagery into therapeutic work often facilitates engagement, a sense of open exploration and play (Fosha, 2009; Russell, 2015). It would also appear to activate the “tag” of vitality (Fosha, 2013). According to Faranda, “It [play] is the space where one’s known felt experience is used to understand something unknown, something other. And it is the space where a simple image—that out-of-awareness conspiracy of affect, body, and brain—is formed and felt” (Faranda, 2014, p. 70).

Winnicott spoke about the necessity of play in psychotherapy: “psychotherapy is done in the overlap of the two play areas, that of the patient and that of the therapist” (Winnicott, 2005 p. 72). The Boston Change Process Study Group (Stern, 1998; Tronick, 1998) observed how transformational points in therapy were often marked by what they call “now moments”, in which heretofore predictable ways in which the relationship has progressed are suddenly disrupted. Whether positive or negative in their initial affective valence, they are opportunities for the expansion of the dyad’s capacity (Fosha, 2017; Tronick, 1998; Russell, 2015). If they are to be growthful, they need to be recognized and responded to in a spontaneous, courageous and unscripted way by each member of the dyad. The elaboration and expansion on the small moment of sheer possibility becomes what the BPSCG calls a “moment of meeting;” (Stern, 1998) a sustained interaction in which each person shows up with authenticity and a willingness to co-create something new together (Stern, 1998; Russell, 2015). This kind of exploratory, boundary-pushing, dyadic expansions of consciousness (Tronick, 1998) can feel playful, even if also challenging. And, importantly, it can be mediated through shared, co-created imagery that we think of as a kind of transitional *third space* (see below) between patient and therapist.

AEDP’s “Making the Implicit Explicit”: Bringing Imagery into the Foreground

Since its inception, AEDP has relied on the use of imagery as a main tool in accessing right brain mediated information in order to help process emotional experience to completion (Fosha,

2000b). It has primarily worked with imagery through the use of *portrayals*, first introduced by Davanloo (1990) as a way of accessing and deepening affective experience. Medley (2021) has written an excellent review of the many forms and uses of portrayal in AEDP. Briefly, AEDP therapists are familiar with and regularly use imaginal portrayals from the different perspectives of observer (e.g., Self looking at a younger part of the self) or what Blackwell (2019) calls a *field perspective*, meaning from within the self (of the present or the past). Portrayals tend to differ by scenario and the use of them depends on the clinical need of the moment. The most common are: *emotion to completion*, which helps a patient access and process emotions that had not been allowed to be expressed or even felt in the past; *reparative*, which are used to access longed for and blocked emotional, relational or developmental experiences; *reunion*, which are primarily focused on bringing the present day self into compassionate contact with younger parts of the self; and *rescue*, in cases in which imagining removing or protecting a younger part from a neglectful or abusive environment of the past is called for in order to undo traumatic aloneness (Fosha, 2000b, Medley, 2021).

In this paper we want to explore the use of imagery more broadly, less proscriptively, as a right brain communication that requires the therapist's third eye, third ear (Reik, 1948) and third space. By *third space*, we mean the creative, co-constructed space between therapist and patient in which the conscious/intentional and unconscious/exploratory processes of each are invited in to make something new. Panksepp's (1998) research and conceptualization of the importance of play in mammalian development is apt here. Tronick's (1998) idea of the *dyadic expansion of consciousness* is also relevant. This is more dance than exercise, more poetry than prose. We put this forth because of the ordinary, informal and spontaneous ways in which imagery emerges all the time in psychotherapy, and the rich potential it has for guiding the work if the therapist is attuned to it and willing to *play* with the "unthought known" (Bollas, 1987). It is also a wonderful example of what AEDP calls *relational transformance* (Russell, 2015), namely, the simultaneous, interdependent, self-reinforcing tendency for each individual to move toward growth, connection and development with one another (or within a larger group). Something

bigger than each of them is happening, but only because each shows up with an openness to the process, to each other, and to what might emerge from that connection (Fosha, 2005).

An image is something that hangs in the interpersonal space and can be manipulated, played with, associated to, and unpacked by both participants in a way that cannot be done with one person's bodily felt emotion. Without an agenda of facilitating a particular experience (as in formal portrayals), the improvisational use of emergent imagery allows for more open-ended unfolding of emotional and relational experience and may obviate defenses. The explicit and experiential exploration of this experience helps to undo a patient's aloneness and can facilitate the healing of past traumas, including attachment trauma (Fosha, 2017). By entering and actively co-creating an unfolding imagistic experience, the therapist demonstrates her desire to deeply connect with the patient's imagination and to offer herself in the service of the patient's healing. In making the experience explicitly relational, there is a dyadic expansion of consciousness (Tronick, 1998). Fosha writes, "The roots of resilience and the capacity to withstand aversive situations without resorting to defensive exclusion are to be found in the sense of being understood by and existing in the mind and heart of a loving, attuned and self-possessed other." (Fosha, 2000b, p60). The use of emergent imagery can also be a way of titrating and dyadically regulating shame, dissociated self-states, and attachment longings, and slowly facilitating new and reparative experience (Gleiser, 2013, Lamagma, 2021; Bromberg, 2003; Russell, 2015).

Knowing that one can have an impact as an agent on another leads to a more coherent sense of self and enhanced functioning (Pollock & Slavin, 1998; Russell, 2021). The fact that one feels "felt" or "seen," can mean something about the self, and not just something about the sensitivity, warmth or openness of the other, no matter how much of a true other they may be (Fosha, 2005). It means that "I" exist and have substance, importance and impact. AEDP explicitly encourages the therapist use of self in just this way (Russell, 2015, 2021; Lipton & Fosha, 2011; Prenn, 2009; Pando-Mars, 2011), and we believe that the active, creative, and sometimes playful use of emergent imagery is a powerful process for providing patients with tangible and undeniable

proof of their existence in the heart and mind of the therapist (Fosha, 2000b), and therefore, in their existential mattering per se (Russell, 2021).

Clinical Example:

The excerpted vignettes come from the third session with a 40-year-old cis-gender married woman whose developmental history is significant for her parents' separation when she was five, at which time her father dramatically abandoned the family. Both of her parents remarried. Her mother was emotionally unavailable, her stepfather was critical and neglectful, and she and her sister felt "replaced" by her paternal half-siblings. She developed a very cheerful, outgoing persona which felt false to her. At the second appointment several weeks before the current session, she spoke of her longstanding struggles with self-critical thinking and she reflected on how she always felt judged as well as alone in her family. For years she had an image of herself as a lost child, alone in a barren landscape with no road signs, storm clouds on the horizon. In that session she and the therapist worked with that imagery, leading to a powerful shift with the sky clearing, signs beginning to emerge, and a felt sense of more energy and hope. The patient agreed to meet for a follow-up psychotherapy session several weeks later, after her return from a trip to her mother and stepfather. In this session she tells the therapist how she felt she had regressed during her trip, and work done in the previous session is referenced. Gestures and nonverbal communications are italicized; reflections on process are in bold type.

Vignette One: Co-Creating Safety

Pt: ...it must just be the image, you know...there hasn't been any improvement in that..
(*gesturing*)...just still stuck...just still kind of, you know, wanting to move forward but just so afraid of what's already happened that... you know, just not having those skills and not having that way to push myself (*gesturing forward*) **(State 1, notably less access to the energy and hope she experienced at end of prior session.)**

Th: So what does that feel like?

Pt: *(sigh)* Well, it feels frustrating.

Th: So if we just check in in the moment and how you're feeling in your body? What is, what do you notice? **(somatic focus with aim of regulating anxiety.)**

Pt: *(looking out window)* I...I feel...uh, I want to say, *(turning to look at therapist)* I sort of feel defensive... [Th: OK] ...I guess if, if that's sort of a feeling, *(hand to chest)* I'm not always used to...but I feel like sort of defending myself. I sort of feel like...shielding... *(hands fan out)* [Th: mm, hmm...mm, hmm] ...you know... I'm hoping that that's the feeling that I need to move forward, is guarded but shielded, does that make... **(brief glimmer of readiness in midst of defensiveness)** ...I'm trying to describe it, I feel like... *(pulling back, hunching into herself, face scrunched)* **(vivid embodiment of fear)**

Th: You're kind of showing me, this feeling of skittishness...

Pt: Yeah...kind of skittish. Just kind of nervous and kind of like, ok, I know what has to happen, but my body is having like a... *(sucking in through her clenched teeth)*...you know, I'm shaking because I'm still kind of cold, but, um *(looking down)*.

Th: Is any of that about, you know, our meeting and apprehension... **(exploring sense of safety with Th, also the new presence of camera)**

Pt: *(shakes head)* No, no, not at all. Well, apprehension in that I know what we're going to be talking about, not like the video or anything like that, you know... I know what we have to process through so whether I acknowledge it or not is maybe...after you said it, I'm like, "No, yeah, no"...*(mild grimace, gesturing back and forth)*...this little fight with myself *(laughing)* Yeah, well, I don't know... *(more relaxed)* **(increased awareness of defenses leading to some softening of defenses)**

A few moments later:

Th: ... so I think what is really important is that, you know, we talk about how can this feel safe for you, you know, so that if you do open these parts, these raw parts, it feels like it's safe **(explicitly addressing need for safety, use of “we” language to help undo aloneness.)**

Pt: Right... right... (*exhales*)

Th: (*Th sighs*) and we take care of these feelings...and... (*exhaling*) ...um, so it doesn't feel overwhelming or scary **(dyadic affect regulation.)**

A few moments later, after further regulation of patient's anxiety:

Pt: ...so I sort of feel like, this is the wall I keep ...and I have to leap over it, and either heal from it or manage it or grieve about it or whatever...

Th: Right...you know, that fear makes a lot of sense to me given what I know about your family...**(validation of the defenses)**

Pt: right (*nodding*).

The therapist has been focused on providing safety through empathic attunement, regulating the patient's distress through right brain to right brain communication (gaze, gestures, eye contact, tone of voice, etc) (Fosha, 2001) and actively working to entrain her “social engagement system” (Porges, 2011) with the goal of bringing the patient into her window of affect tolerance (Schoore, 2012). Validating her defenses, such as naming them or framing them as adaptive in the context in which they developed, often paradoxically helps to soften these defenses (Fosha, 2000b). The

image of “the wall” emerges, offering an entry point which will be explored a little later in the session.

Vignette Two: Undoing Aloneness

The patient expresses worry about the therapeutic work potentially overwhelming her.

Th: So is there then worry that you're gonna have to deal with this alone?

Pt: *(exhales, drops arms, looking out window)* I, I, I think it's just the unknown... **(shift in response to having fear of aloneness named.)** [Th: OK] ...I guess...*(pausing, looking up, then at Th, more calm)*...the unknown has always frightened me...but at the same token, I know that's where the healing is... **(heralding affect; another glimmer of readiness.)**

A few moments later:

Th: I think it's important that it not feel like you have to let go of everything...you know, like, you can let go of things...in a manner and a timeline that makes sense for you...and that you're not going to drop everything... **(empowering Pt to move at her own pace, validating her caution/defense)**

Pt: Right *(nodding)*.

Th: ...and not be able to rely on anything **(naming defense of self-sufficiency)**...and to try to counter that all or nothing thinking *(calm tone and slightly slower pace)* **(dyadic regulation of anxiety)**

Pt: Yes, which is something... (*slow inhalation*)...I've been told that many times...I'll take a piece of it.

Th: Yeah, you'll take a piece of it and...

Pt: ...we can manage that... **(defense of self-sufficiency is softened)**

Th: ...we can manage that, exactly....and do it in a way that is helpful and not, it doesn't feel like too much.

AEDP views undoing aloneness as a central therapeutic task. Explicitly exploring the patient's sense of aloneness often paradoxically helps to undo that aloneness. The therapist has continued to co-create safety, regulate anxiety and work with defenses with the goal of helping the patient access her "social engagement system" (Porges, 2011) and transition to exploration of core affective phenomena; that is, to move from State 1 to State 2 on AEDP's clinical map (Fosha, 2021b).

Vignette Three: Exploration of Emergent Imagery

The patient has just described a tarot card reading, recently done on a whim with a friend. She was struck by the resonance of this experience with her last therapy session, particularly the first card which showed a blind-folded woman holding two swords with storm clouds behind her. In the prior session, storm clouds loomed on the horizon of a barren landscape in which her child self was lost. Another card indicated that a guide would help her on her journey, and the patient indicated that the therapist is this guide. As this segment starts, she is articulating her desire to move forward. The patient and therapist play with emergent imagery, supported by the patient's strong access to this right brain mediated process. The patient starts with an image of a hurdle, the meaning of which is unknown to the dyad.

Pt: And I sort of feel that...it's, it's that confusion right before I take that step forward. That's what I'm feeling right now.

Th: That's what you're feeling right now, that hesitation.

Pt: You know, at first it was kind of fear and now it's sort of like, ok, h-h-how? (*shaking head in confusion*) (**embodies self-in-transition; yellow signal affects** [Russell, 2015].)

Th: OK, so what does that feel like? (**attempt to focus on somatic experience.**)

Pt: Well, I mean, I guess the eyes are open and the, and the will is there, but it's... Even though it's open, there's a...(gestures a barrier)...it's the hurdle. (**more access to imagery than to**

somatic experience at this moment)

Th: So you visualize yourself... (**choice point: Th follows Pt's orientation to the imaginal rather than somatic experience**) [Pt: Yeah (*exhales*)...mm, hmm] ...and then you see a hurdle, and the view, what is it like around you? (**invites further elaboration of imagistic experience**)

Pt: Well it's, the swords are still there. I still have that visual and the storm is still behind me. But there is light and it's not too high that I can't jump over it, it's like I have to remember how to do a hurdle. I used to be on the track team...so for me it's a ...ok, I have to get a little running start ...or do I have to kind of just walk around it? (*motions sideways with hands*)...maybe not make it such a big, I can still see through it. It's not like a brick wall...which it was probably there before... (**softening of anxiety/ defense; her unconscious offered a more resilient image, a shift from wall to hurdle, with which she has a successful relationship**) ...what's the little piece that I can work on...so I can start the process forward?

Th: So can you let me be in that visual? **(critical choice point—Th respects Pt’s autonomy while explicitly offering her presence and another form of dyadic regulation)**

Pt: ...*(pause, looks around)*...Yes. *(decisive)*

The therapist makes an important choice here in requesting permission to enter the scene. The therapist is motivated by a sense that she can be helpful, perhaps emboldened by the acknowledgement a little earlier that the patient views her as a guide. The patient’s decisive “yes” is an important moment of receptivity. The emergent imagery which follows reveals important information about the patient’s relational patterns. Having received permission to enter the imagistic experience, the therapist has an opportunity to expand the patient’s relational capacities and perhaps bring an element of play into the unfolding scene.

Pt: ...yet...um...you're kind of far away, though. I mean you're off in the, in the light *(finger to mouth)* **(note positive association of Th with “the light”)**. And it's almost like you're *(raises hand, waving)* “I'm over here at the starting line, I'm way up here...I don't know why you're still back there, looking at the...” and I feel silly, like why don't I just walk over it...like knock it over *(motions hand forward)* **(brief emergence of pathogenic shame.)**

Th: Well, would it be helpful for me to move...or would you want me to? **(making explicit the Pt’s control over the scene)**

Pt: *(deep inhalation)* I kind of like that you're *(arm out)* **(emergence of agency; Pt asserts control of Th presence and unfolding imagery.)**

Th: OK **(Th honors and validates Pt’s agency and will.)**

Pt: I can hear you...and I can see you...but it's almost like I feel a little bit of stubbornness. And in my visual I feel like, OK...you need to do this, this is, this is where you need to...(Pt articulates need for mastery.)

Th: So there is the sense that you need to do it...

Pt: ...just do it, I mean...you're still there and you're jumping up and down (*arms flung out and cheering, head down, laughing*) (play spontaneously emerges from work with the image)

Th: (*laughing*) So I'm cheering, I'm cheering you. (experience of intersubjective delight)

Alongside the co-creation of safety and the cultivation of an “earned secure attachment” (Pearson et al., 1994; Roisman, et al., 2003), AEDP therapists also aim to cultivate experiences of intersubjective delight (Fosha 2017, 2021a). In the emergent imagery above, the therapist moves from being mildly critical and “ahead” of the patient to being enthusiastically supportive. The therapist explicitly affirms this updated and more accurate perception and expresses delight in the patient’s playful use of her presence. In the next few minutes, the patient describes seeing her husband and friends also at the finish line, suggesting some expansion of her capacity to receive support. The use of the therapist as a “transformational other” (Russell, 2015), allows for the recollection of others in her life who have facilitated positive growth, supports that are not accessible when relying on old defenses (Russell & Fosha, 2008). A few minutes later:

Th: You've got this whole cheering section but you kind of want to keep everyone at arm's distance (explicitly names defense as captured in image)

Pt: Yeah...and I feel like it's something that I...have to do...that, that's where my pride will come in. That's where my energy to move where you guys are, is that I need to collect myself before I get to that point, I guess.

Th: So what, what would it mean for you to let me come closer? Maybe on a radio, or you know? **(Th honors the need for some autonomy while playfully inviting a little more closeness; co-creative use of imagery.)** Or to let me...

Pt: *(looking up)* I think, it's almost like, this sounds silly but your brain, it just goes and you don't have control over it, but you know, if you would bring me some water...or something...and still not try to talk me out of going past that but just maybe, do you need this too? Before you...I can tell that I...there's want, there's need, there's ... I know it's going to happen, I guess that's the good news. **(beautiful example of State 2 experience of agency, will & desire [Russell, 2021] and simultaneously an expanded capacity for receptive affective experience)**

The therapist has been “pressuring with empathy” (Russell, 2015) in her gentle yet persistent offers of support and presence. The patient is accustomed to acting on her own, as if she experiences relationships as getting in the way of forward movement. Indeed, she may correctly intuit that she needs to express her agency as an antidote to her shame. While the therapist supports the patient in acting on her own behalf, she is asking the patient to also relate, that is, to “feel and deal while relating” (Fosha, 2000b). One powerful feature of emergent imagery is its capacity to bypass defenses, which happens here as she allows the therapist to be with her in her exploration and doing for herself. The patient is able to receive support without sacrificing the clear dictates of the self to act on her own behalf. This is a new experience.

Th: OK, OK...good

Pt: Even with you far away or moving close, those feelings don't necessarily change ...um...I think I'm just used to arm's length... *(gesturing arms far from herself)* ...like that...**[yellow signal affects.]**

Th: But you're letting me come closer to bring water... **(draws attention to Pt's transformance strivings in allowing more closeness; privileging the positive)** ...and some...checking in.

Pt: Yeah...I'm just like, eh, you know, *(smiling, shaking head, tone of voice changes)* “what, are you going to do this?”

Th: What does that feel like? **(regulating anxiety with somatic focus)**

Pt: Well, I feel a little *(motions arms, short and quick)* ...I still feel a little panicked...OK, I'm almost there...

Th: So just notice that, just notice that panic *(pt nodding)*...what does that feel like in your body?
(Th slows pace to do some more anxiety regulation.)

Pt: ...*(closes eyes, takes a breath)*...it's just...*(exhales)*...oh, god, do I want to do this, do I want to do this...and I know I do. It's just a lot. **(self-in-transition)**

Th: Yeah...so there's fear... *(therapist voice calm)*

Pt: mm, hmm *(puts arms on chest)*.

Th: ...and, and you...where...I'm putting my hand on my chest *(therapist mirrors patient's movement)* **(undoing aloneness with dyadic coordination)**

Pt: Yes, no, it's sort of in my...*(drawing arms in further)*...it sort of feels like... *(exhales)*...what is the word, like I need you to bring me a blanket *(hugs self)*

Some fear arises as the patient makes herself more vulnerable, this fear is dyadically regulated, and then she signals further openness to the therapist's presence. In more boldly articulating her attachment needs, she surprises the therapist. A “now moment” (Stern, 1998) emerges, a present

moment that “pops up and is highly charged with immediately impending consequences” (Stern, 2004, p151).

Th: OK, OK (*encouraging tone*).

Pt: ...and I feel like, oh, OK...maybe I need a blanket, maybe I need something to...warm me, something to comfort me (*gesturing, pulling toward self*)

Th: OK (*softer, slower*)

Pt: Whether it's the food, or you know, that's what it's been. Like something to... **(articulates insight into use of food and other addictive behaviors to address her attachment longings.)**

Th: OK...can you let me give you the blanket?

Pt: Yeah

Th: OK, what is that like? **(making encounter more explicit and experiential.)**

The emergent imagery has facilitated a “moment of meeting” (Sander, 1988; Stern, 1998). As the patient struggles to try something new, the therapist reaches in to offer comfort and “goes beyond mirroring” (Fosha, 2000b). The therapist meets the patient’s vulnerability with her own, accepting the patient’s invitation and drawing out the imagery into an even more deeply shared experience.

Pt: ...it's cautious...but it's like, just, give me a second (*eyes closed, hands to neck*) OK to warm up... **(deepens visceral experience of taking in warmth and comfort from imagined blanket,**

and by extension, from the Th)...and, you know...

Th: Yeah...this, this is so important (*slowing down*)...just you letting me bring you water and letting me closer (**makes more explicit the Pt's state 2 receptive affective experience**)

Pt: (*nodding, looking at therapist*) yeah.

Th: Letting me give you a blanket.

Pt: Yeah.

Th: That is, that's so..*(drawing out the words for emphasis)* I think, even before you jump over the hurdle.

Pt: Yeah (*hugging self, eyes closed*) (**appears to be taking in Th's presence**)

Th: This is really important...just to let yourself be comforted.

Pt: Mm, hmm (*hand on chin, finger to lips*).

Th: ...not so alone... (**makes "we-ness" more explicit, the undoing of aloneness.**)

Pt: Mm, hmm (*nodding*)...and you know, it's funny because, it's, it's, I feel like I should be looking for my mom...

Th: oh...uh, huh.

Pt: But she's nowhere in this... (*eyes widen, nods head; then closes her eyes, hands gesturing away from face; then looks at therapist*) in my brain, she's just nowhere, and I think that's what's been...ah...you know...a continual missing link. (**new insight comes forward, state 2 self-experience in deeper understanding of her autobiographical narrative, along with state 2**)

grief arising from contrast between new experience with therapist and insecure attachment with her mother)

The slower pace, the therapist's voice and other right brain mediated communication has drawn out the imagistic as well as the in-the-room, in-the-moment relational experience. The explicit elaboration of the experience engages left brain processing, followed by a deepening of her receptive affective experience and more right brain mediated imagery ("she's nowhere in this") and then a left-brain mediated explicit understanding of "a continual missing link." In receiving support and warmth from the therapist, she becomes acutely aware that her mother has not responded to her attachment needs. The secure attachment experience opens up pain/ grief around her insecure attachment with her mother.

Th: Mm (*with feeling*) **(Th resonates with Pt's grief)**

Pt: So I don't receive the comfort from her.

Th: Right...what do you feel right now? **(encourages somatic focus to deepen state 2 grief)**

Pt: (*eyes closed, hands to heart*) Well, it's sad but it's...it's also just normal...on some level (*looks at therapist, glimmer of sadness*).

Th: So a part of you is waiting for her to show up.

Pt: Yeah...she won't (*shakes head, glimmer of resentment*)... you know...I think that's the holy grail I keep looking for... (*gesturing arms in circle into herself*) **(Pt articulates centrality of her quest for maternal nurturing.)**

Th: Mmm (*drawn out*)...mm, hmm **(coordinated relational experience.)**

Pt: ...that motherly instinct to come in, for her to come in, and I know she's not capable so, it's like I won't even let her in the scene...so that's maybe why I'm so...you know, cautious... **(Pt identifies adaptive value of her defense)** ...is that, well it's not my mom, there's some grief in that *(voice cracks, eyes water)*...I can feel that there's some like, oh **(deepening sadness which is both state 2 grief and also state 3 mourning the self due to explicit awareness of how her defenses were necessary and costly.)**

Th: *(slowly, with tenderness)* So what is that grief? I mean, what does that feel like? **(Th encourages more explicit somatic awareness of sadness.)**

Pt: Well I feel sad...I have a lump in my throat like, oh, it's not going to be my mom...*(starting to cry, then inhales and looks at therapist)* but yet I'm happy that there's someone there that will help me **(dual experience of mourning the loss as well as state 3 gratitude for the Th's emotional support)** and I think that's always been the piece that...*(shaking head)*...she's just not able.

Th: Yeah, yeah...and you so want that **(validating attachment longings)**

Pt: I've always wanted that.

Th: Wow **(Th shares emotional impact of patient's insights.)**

Pt: So that sort of puts the *(looking down, hands hover over left shoulder)* ...maybe she was the hurdle...

Through the improvisational exploration of emergent imagery, which facilitates an unfolding intersubjective experience, we witness the breakthrough of the unconscious. The patient's courage is met by that of the therapist, leading to a deeply felt receptive affective experience. In its wake, insight emerges about her mother's emotional absence and her anxious/ambivalent

attachment manifesting as the “hurdle” in her ability to move forward. As the session continues, the patient gains more perspective, processes anger, navigates fears about abandoning her mother, grieves the impact of this enmeshed relationship on her own development, and accesses increased clarity and motivation about her desire and will for more authentic engagement in her future life.

Discussion

In 2008, Fosha coined the term “transformance,” knowing that it is hard to be on the lookout for something one cannot conceptualize and name. Similarly, here, we want to invite experiential, affect-oriented therapists to recognize emergent imagery and the co-creation of viscerally felt imaginal experiences as one of the primary entry points to doing deeper work in the unconscious and to facilitating deeper healing. This focus is particularly helpful for patients who have much *more access to their imaginal than to their somatic experience*. We wish to emphasize that the exploration of emergent imagery should still incorporate somatic and emotional elements in order to fully process and integrate the therapeutic experience.

While the clinical example in this article can certainly be thought of as a portrayal, the ways in which it emerged and evolved were powerful and divergent enough to be worthy of further scrutiny and curiosity. The therapist is just getting to know this new patient and there is very little agenda other than the co-creation of safety, the regulation of anxiety, and making space for whatever emerges. Like traditional portrayals, the therapist is guided by the desire to facilitate a healing experience, yet the exploration begins with an image (in this case symbolic, the meaning of which is unknown to both patient and therapist) instead of more clear biographical details or wished-for experiences. Exploration of emergent imagery moves forward with less clarity about possible destinations, more spontaneity and more improvisation.

This patient, like many, has more access to spontaneous images that communicate her state as well as her “felt sense” of what

she is attempting to do with the therapist (Gendlin, 1981) than she does to language for her emotions. Meister Eckhart wrote: “When the Soul wants to experience something, she throws out an image in front of her and then she steps into it.” In the case of psychotherapy, the soul is accompanied by another soul who can catch the image and is willing to step into it with her.

Here we advocate for a more organic use of imagery as a frequently available entry point to access both affect and the unconscious. Exploration of imagery may have unique potential to capture meaning, to birth new stories and to organize new narratives (Singer, 2006). Often images are not fully conscious but come forward with inquiry and curiosity. In attending to these in the patient (as well as in the therapist) we may begin to access the “unthought known” (Bollas, 1987). For example, one may begin with a simple image (e.g., a piece of a dream or a recurrent symbol or memory fragment) the meaning of which is presently unclear to the therapeutic dyad. In a highly creative process, the dyad may soon find itself in an unscripted movie in which one or both may also be actors. Visual imagery’s fluid nature and capacity to portray a shifting storyline also allows it to more easily bypass defenses, as seen in the clinical example above when the patient says, “...your brain, it just goes and you don’t have control over it.” This fertile exploratory process straddles what is happening imaginally with what is happening somatically and in other channels of experience (energetically, motorically, etc) as well as relationally in the here-and-now between the patient and therapist.

Conclusion

Philosophers and healers have long recognized imagery's powerful role and clinicians can draw from a rich history of imagery's use in depth-oriented psychotherapies. Research on imagery, particularly visual mental imagery, suggests extensive involvement of diffuse cortical regions and networks and the critical role imagery plays in many key cognitive and affective functions. By drawing on right brain mediated processes, the explicit and experiential exploration of imagery likely facilitates interhemispheric coordination and enhances brain functioning. From its inception AEDP has utilized metatherapeutic processing for integrating somatic, imagistic and relational experience with more left brain mediated linguistic reflection as an essential transformational tool. In this article, we have advocated an expanded explicit focus on imaginal experience in AEDP and other experientially oriented psychotherapies. In addition to portrayals, which are quite powerful in facilitating change, we have argued for a more spontaneous and open-ended exploration of emergent imagery which frequently arises as an entry point in therapeutic work. Moreover, we suggest that spontaneous imagery is sometimes more accessible for patients than interoceptive awareness of the body or the ability to articulate discrete feeling states. Due to the intersubjective and fluid nature of visual mental imagery, it has tremendous potential for accessing unconscious material, for tapping into the potential for play, for facilitating relational transformation and for bringing new landscapes and autobiographical narratives into being.

References

- Achterberg, J. (2002). *Imagery in healing: shamanism and modern medicine*. Boulder, CO: Shambhala.
- Aristotle (1984). *The complete works of Aristotle*, Vol. I and II, ed. J. Barnes, Princeton, NJ: Princeton University Press.
- Aydin, C. (2018). The differential contributions of visual imagery constructs on autobiographical thinking. *Memory*, 26(2), 189-200.
- Banich, M.T. (2003). Interaction between the hemispheres and its implications for the processing capacity of the brain. In Hugdahl, K. & Davidson, R.J. (eds.), *The Asymmetrical Brain*, MIT Press, Cambridge, MA. Pp. 261-302.
- Blackwell, S.E. (2018). Mental imagery: From basic research to clinical practice. *Journal of Psychotherapy Integration*, 29(3), 235-247.
- Bollas, C. (1987). *The Shadow of the object: Psychoanalysis of the unthought known*. New York: Columbia University Press.
- Bowlby J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books
- Breuer, J., & Freud, S. (1895). Studies on hysteria. *Standard Edition*, 2. London: Hogarth Press.
- Bromberg, P.M. (2003). Something Wicked This Way Comes. *Psychoanalytic Psychology*, 20(3), 558-574.

Damasio, A. (2018). *The Strange Order of Things: Life, Feeling, and the Making of Cultures*. New York: Pantheon.

Damasio, A. (2010). *Self comes to mind: Constructing the conscious brain*. New York: Pantheon/Random House.

Davanloo, H. (1990). *Unlocking the Unconscious: Collected Papers of Habib Davanloo, MD*. Hoboken, NJ: John Wiley & Sons Inc.

Dijkstra, N., Bosch, S.E., van Gerven, MAJ. (2019). Shared neural mechanisms of visual perception and imagery. *Trends Cogn. Sci.* 23, 423-434.

Ellenberger, H.F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York: Basic Books.

Faranda, F. (2014). Working with images in psychotherapy: An embodied experience of play and metaphor. *Journal of Psychotherapy Integration*, 24(1), 65–77.

Faranda, F. (2016). Image and imagination: Deepening our experience of the mind. *Psychoanalytic Inquiry*, 36(8), 603–612.

Fosha, D. (2000a). Meta-therapeutic processes and the affects of transformation: Affirmation and the healing affects. *Journal of Psychotherapy Integration*, 10, 71-97.

Fosha, D. (2000b). *The transforming power of affect: A model for accelerated change*. New York, NY: Basic Books.

Fosha, D. (2001). The dyadic regulation of affect. *Journal of Clinical Psychology/In Session*. 57 (2), 227-242.

Fosha, D. (2005). Emotion, true self, true other, core state: Toward a clinical theory of affective change process. *Psychoanalytic Review*, 92 (4), 513-552.

Fosha, D. (2008). 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. (2009). 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 practice*, pp 172-203. New York: Norton.

Fosha, D. (2013a). A heaven in a wild flower: Self, dissociation, and treatment in the context of the neurobiological core self. *Psychoanalytic Inquiry*, 33(5), 496–523.

Fosha, D. (2017). Something more than “something more than interpretation:” AEDP works the experiential edge of transformational experience to transform the internal working model. In S. Lord (Ed). *Moments of meeting in psychoanalysis: Interaction and change in the therapeutic encounter*, pp 267-292. New York: Routledge.

Fosha, D. (2021a). How AEDP works. In D. Fosha (Ed.) *Undoing aloneness and the transformation of suffering into flourishing: AEDP 2.0*, pp. 27-53. Washington DC: APA Press.

Fosha, D. (Ed.) (2021b). *Undoing aloneness and the transformation of suffering into flourishing: AEDP 2.0*. Washington DC: APA Press.

Fosha, D. (2021c). "We are organized to be better than fine:" Building the transformational theory of AEDP. In D. Fosha (Ed.) *Undoing aloneness and the transformation of suffering into flourishing: AEDP 2.0*, pp. 377-400. Washington DC: APA Press.

Gendlin, E.T. (1981). *Focusing*. New York, NY: Bantam.

Gleiser, K. (2013). Seeing the invisible: the role of recognition in healing from neglect and deprivation. *Transformance: The AEDP Journal*, volume 3. www.transformancejournal.com

Jung, C.G. (1916). *Collected papers on analytical psychology*, trans. C.E. Long. Oxford, UK: Balliere, Tindall & Cox.

Keogh, R. & Pearson, J. (2014). The sensory strength of voluntary visual imagery predicts visual working memory. *Journal of Vision*, 14(12), Article 7.

Kosslyn, S., Gannis, G., and Thompson, W. (2001). Neural foundations of imagery. *Nat. Rev. Neurosci.* 2(9), 635-642.

Lamagna, J. (2021). Finding healing in the broken places: Intra-relational AEDP work with traumatic aloneness. In D. Fosha (Ed.) *Undoing aloneness and the transformation of suffering into flourishing: AEDP 2.0*, pp. 269-292. Washington DC: APA 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.

Liu J, Spagna A, Bartolomeo P. (2022). Hemispheric asymmetries in visual mental imagery. *Brain Struct Funct*, 227(2):697-708. doi: 10.1007/s00429-021-02277-w. Epub 2021 Apr 22. PMID: 33885966.

MacKisack, M., Aldworth, S., Macpherson, F., Onians, J., Winlove, C., Zeman, A. (2016). On picturing a candle: The prehistory of imagery science. *Frontiers in Psychology*, 7, 1-16.

Marothi, R. & Keri, S. (2018). Enhanced mental imagery and intact perceptual organization in schizotypal personality disorder. *Psychiatry Research*, 259, 433-438.

McGilchrist, I. (2009). *The Master and his Emissary: The Divided Brain and the Making of the Western World*. New Haven, CT: Yale University Press.

McGlischrist, I. (2021). *The Matter with Things: Our Brains, Our Delusions, and the Unmaking of the World*. London: Perspectiva Press.

Medley, B. (2021). Portrayals in work with emotion in AEDP. In D. Fosha (Ed.), *Undoing aloneness and the transformation of suffering into flourishing: AEDP 2.0*, pp 217-240. Washington, DC: APA Press.

Nanay, Bence (2016). Imagination and Perception. In Amy Kind (ed.), *Routledge Handbook of the Philosophy of Imagination*. New York: Routledge.

Pando-Mars, K. (2011). Building attachment bonds in the wake of neglect and abandonment: Through the lens and practice of AEDP, attachment and polyvagal theory. *Transformance: The AEDP Journal*, 1(2). www.transformancejournal.com

Panksepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions*. Oxford University Press.

Panksepp, J. & Northoff, G. (2009). The trans-species core SELF: The emergence of active cultural and neuro-ecological agents through self-related processing within subcortical-cortical midline networks. *Consciousness and Cognition*, 18, 193-215.

Panksepp, J. & Biven, L. (2012). *The Archaeology of Mind: Neuroevolutionary Origins of Human Emotions*. New York: W.W. Norton & Co.

Panksepp, J., Normansell, L., Cox, J.F., Siviy, S.M. (1994). Effects of neonatal decortication on the social play of juvenile rats. *Physiol Behav.* Sep;56(3):429-43.

Pearson, J.L, Cohn, D.A., Cowan, P.A., & Cowan, C.P. (1994). Earned- and continuous-security in adult attachment: Relation to depressive symptomatology and parenting style. *Dev and Psychopathol*, 6(2), 359–373.

Pearson J. & Kosslyn SM. (2015). The heterogeneity of mental representation: Ending the imagery debate. *Proc Natl Acad Sci U S A*. 2015 Aug 18;112(33):10089-92.

Pearson, J., Naselaris, T., Holmes, E. A., & Kosslyn, S. M. (2015). Mental imagery: Functional mechanisms and clinical applications. *Trends in Cognitive Sciences*, 19(10), 590–602.

Pearson, J. (2019). The human imagination: the cognitive neuroscience of visual mental imagery. *Nat Rev Neurosci*, 20(10), 624-634.

Perls, F.S. (1973). *The Gestalt approach and eye-witness to therapy*. New York: Bantam Books.

Pollack, L., & Slavin, J. (1998). The struggle for recognition: disruption and reintegration in the experience of agency. *Psychoanalytic Dialogues*, 8(6), 857-873.

- Porges S.W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. New York: W.W. Norton & Co.
- Prenn, N. (2009). I second that emotion! On self-disclosure and its metaprocessing. In A. Bloomgarden and R. B. Mennuti (Eds.), *Psychotherapist Revealed: Therapists Speak About Self-Disclosure in Psychotherapy*. New York: Routledge.
- Reik, T. (1948). *Listening with the third ear: The inner experience of a psychoanalyst*. New York: Farrar, Straus.
- Roisman, G.L., Padron, E., Sroufe, L.A., & Egeland, B. (2002). Earned-secure attachment status in retrospect and prospect. *Child Dev*, 73(4), 1204–1219.
- Russell, E. M. (2015). *Restoring resilience: Discovering your clients' capacity for healing*. New York: Norton.
- Russell, E. M. (2021). Agency, will and desire as core affective experience: Undoing disempowerment to foster the emergence of the agentic self. In D. Fosha (Ed.) *Undoing aloneness and the transformation of suffering into flourishing: AEDP 2.0*, pp 241-266. Washington DC: APA Press.
- Russell, E. & Fosha, D. (2008). Transformational affects and core state in AEDP: The emergence and consolidation of joy, hope, gratitude and confidence in the (solid goodness of the) self. *Journal of Psychotherapy Integration*. 18 (2), 167-190.
- Schore, A. (2012) *The Science of the Art of Psychotherapy*. New York: W.W. Norton & Co.

- Shine, J. M., Keogh, R., O'Callaghan, C., Muller, A. J., Lewis, S. J., & Pearson, J. (2015). Imagine that: Elevated sensory strength of mental imagery in individuals with Parkinson's disease and visual hallucinations. *Proceedings. Biological sciences*, 282(1798), 20142047.
- Singer, J. L. (2006). *Imagery in psychotherapy*. Washington DC: American Psychological Association.
- Siviy, S.M. & Panksepp, J. (1987). Juvenile play in the rat: Thalamic and brain stem involvement. *Physiology and Behavior*, xx, 39-55.
- Stern, D. N. (1998). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. London: Karnac Books.
- Stern, D. (2004). *The present moment in psychotherapy and everyday Life*. New York: Norton.
- Suler, J.R. (1989). Mental imagery in psychoanalytic treatment. *Psychoanal. Psych.*, 6: 343-366.
- Thomas, N.J.T. (2009). Visual imagery and consciousness. In W.P. Banks (Ed.) *Encyclopedia of Consciousness*, pp 445-458. Amsterdam: Elsevier.
- Tronick, E.Z. (1998). Dyadic expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, 19, 290-299.
- Van Essen D. (2004). Organization of visual areas in macaque and human cerebral cortex, in *The visual neurosciences*, eds Chalupa L. M., Werner J. S., pp 507-521. Cambridge, MA: MIT Press.
- Welling, H. (2005). The intuitive process: The case of psychotherapy. *Journal of Psychotherapy Integration*, 15(1), 19-47.

Winnicott, D. W. (2005). *Playing and reality* (2nd ed.). New York: Routledge.

Yeung, D., Fosha, D., Ye Perman, J.H., Xu, Y. (2019) After Freud meets Zhuangzi: Stance and dance of the self-in-transformation with the other-in-contemplative presence in AEDP.

Psychological Communications, Quarterly Vol. 2, No. 3. Shanghai, Shanghai Mental Health Center