Making Good Use of Suffering: Intra-relational Work with Pathogenic Affects

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Abstract. The unbearable psychic pain of pathogenic affect presents a formidable challenge to AEDP-trained therapists. As an experiential re-iteration of abandonment in the face of overwhelming distress, it sometimes renders patients incapable of engaging interpersonally, thus limiting the effectiveness of dyadic regulation. Because of the overwhelming distress and the dysregulation that results, pathogenic affect is generally seen as a clinically undesirable state that blocks therapeutic change. In this paper, the author suggests an intra-personal approach to working with pathogenic affect that involves helping the patient shift from a threat-based response to their overwhelming inner experience (i.e. fighting, fleeing, freezing or fawning) to an engagement-based response characterized by "tending and befriending". This is accomplished by helping patients to differentiate their present day state from the archaic pathogenic one and then facilitating moments of open-hearted contact between them. It is proposed that the affects that manifest from such types of self-engagement (i.e. mutual resonance, recognition, compassion, understanding appreciation and tenderness) constitute a distinct affective change process that when experientially tracked, can be used to fuel and reinforce transformational experiences.

Introduction

> You have heard about the art of happiness, but many of us have not heard about the art of suffering. But there is an art. We can learn how to suffer — how to handle the suffering inside of us . . . and that is an art to be learned. If we know how to suffer, we suffer much less and we can make good use of the suffering. Yes. It is like an organic gardener. She knows that the garbage produced by the garden can be useful, so she does not throw away the garbage. She keeps the garbage and transforms it into compost in order to nourish flowers, vegetables . . . suffering plays an important role in in making happiness . . .
>
> Thich Nhat Hanh (2013)

Accelerated Experiential Dynamic Psychotherapy (AEDP) (Fosha, 2000a, 2000b, 2002. 2003, 2008, 2009a, 2009b; Fosha & Yeung, 2006; Lipton & Fosha, 2011; Russell & Fosha, 2008) is a therapeutic approach that poses particular challenges for patients who struggle with self-regulation. With its emphasis on affective experiencing, it is a model that encourages these individuals to attend to the very aspects of body and mind that have been avoided in order to function. Many well-intentioned AEDP trained therapists have

invited such patients to sense into their body, only to discover that rather than the therapeutic response they anticipated, the patient descended into a psychobiological state of hyper or hypo-arousal marked by intense anxiety, shame, cognitive disruption and aloneness. In some such situations, clinicians may discover that the potency of AEDP's intervention-of-choice for addressing intense affect, *dyadic regulation* is considerably weakened by the virulence of the pathogenic affect. Mired in this afflicted state, the patient's receptive capacity becomes too compromised to take in the therapist's presence, support and care.

In this paper, I will propose an "intra-relational" approach to addressing the challenges of working with pathogenic affects. Here the suggested clinical focus will be on helping patients to "tend and befriend" the pathogenic experience in ways that 1) reinforce contact with the present moment, 2) ease the experience of inner aloneness, shame, anxiety and pain, 3) develop capacities for self-regulation, self-reflective capacity and self-compassion and 4) activate core affect associated with moments of self-to-self resonance, affirmation, appreciation, care, understanding and wholeness. Differentiating from and then approaching one's inner distress in this manner can offer our patients a new experience (as the Thich Nhat Hahn quote suggests) of turning the perceived "garbage" of pathogenic experience into "compost" for transformation. This is done by helping the dissociated despair, aloneness, pain, anger and hurt from the past to explicitly exist in the heart and mind of the patient (Lamagna & Gleiser, 2007; Lamagna, 2011; Gleiser, 2014).

AEDP: A Model for Transformation

AEDP is an integrative model of treatment that blends relational, psychodynamic and experiential treatment approaches with a metapsychology informed by affective neuroscience and attachment theory. Its main goal is to evoke, experientially process and integrate states associated with adaptive affective responses/impulses ("core affect") —— states that have been blocked from consciousness due to repetitive attachment failure or trauma. The accessing, tracking and re-integration of these core affects serve to activate innate self-righting mechanisms, action tendencies and internal resources that support optimal psychological functioning. In addition, the positive movement engendered through the experiential work fuels additional rounds of processing — this time focused on the *felt sense of change itself*. The resulting "metaprocessing" (Fosha 2000b) of *transformational affects* (State Three) like pride, mourning, hope, and gratitude, ultimately brings the patient to *core state* – an experience of ease, calm, wisdom, and balance (State Four).

AEDP's views on transformation and psychopathology are very much organized around the polarity of safety/connection —- threat/aloneness. In optimal attachment environments, children experiencing meaningful emotions are able to use their bonds with their caregivers to amplify positive affects and dampen negative ones. Regardless of the valence of the emotional experience, the child ultimately feels some positive affects in having their feelings received and responded to by a receptive and caring other. In pathogenic environments, children's emotional responses are repeatedly responded to inadequately —— with errors of omission (i.e. neglect, withdrawal, distancing, denial) or with

errors of commission (i.e. physical or emotional punishment, blame, ridicule) (Fosha, 2002). There is, in effect, a recurrent pattern of ruptures to the attachment bond — ruptures that do not get repaired adequately, if at all. Fosha (2002) writes:

> These disruptive reactions on the part of the attachment figure . . . elicit a second wave of emotional reactions: fear and shame, *the pathogenic affects* (Fosha, 2001a). What should feel good ends up feeling bad; whereas transformational affects motivate further emotional experience, the pathogenic affects spur the exclusion of emotional experience (p.13).

In other words, in AEDP it is the distress of one's experience *plus the absence of the regulating other* ("unbearable aloneness") that *together* give rise to most forms of environmentally-based psychopathology (Fosha, 2000; 2002).

Fosha has suggested that years later, when these individuals enter therapy and connect with categorical emotions like sadness, anger, fear and joy or with longings for interpersonal connection, they are conditioned to also feel some form of pathogenic affect as an experiential re-iteration of earlier disruption-without-repair experiences. For most psychotherapy patients, the arousal of emotion triggers mild to moderate levels of inhibitory affect (shame or anxiety) called "red signal affects" which in turn, trigger defense mechanisms that preclude the activation of deeper, more distressing emotions. In some patients however, accessing emotional experience brings on intense forms of unbearable psychic pain (Fosha, 2002).

Described with terms like "self-at-worst" and "compromised self" in AEDP literature (Fosha, 2002; Fosha & Yeung, 2006), pathogenic states are viewed as being nonconductive to change-for-the-better and are therefore to be mitigated ("undone"). This is most often achieved through the therapeutic relationship where as in healthy attachment, inner distress is soothed through direct contact with a safe, caring, supportive other (Lipton & Fosha, 2011). AEDP work here involves explicitly tracking the felt sense of the therapist's presence, empathy and care and its moment to moment impact on the patient's state. This quintessential AEDP approach offers the patient the possibility of counteracting the pain, shame, anxiety and unbearable aloneness of pathogenic experience with a new corrective experience.

However, several problems can arise when employing this approach. First, there may be times when the patient's psychic pain is too acute to allow for meaningful interpersonal contact. Second, while relationally counteracting pathogenic affect can offer a new healing experience, for patients who have difficulty internalizing the therapist, it may not offer much help in dealing with their psychic pain between sessions. Skillful AEDP therapists need to learn different ways of approaching pathogenic affects in order to best respond to what is emergently occurring for the patient.

Intra-relational Affective Change Processes

Intra-relational (I-R) AEDP is a variant of AEDP originally developed for clinical work with severely traumatized patients (Lamagna & Gleiser, 2007; Lamagna, 2011). Its aim is to promote a patient's sense of inner safety, security and harmony and (as in standard AEDP) to evoke core affective experiences that promote adaptive psychological functioning.

Working with affective change mechanisms engendered through intra-relational work, clinicians and patients experientially process core affects that arise with meaningful contact with inner aspects of the patient —- affects associated with resonance, recognition, warmth, openness, care and compassion (Lamagna & Gleiser, 2007; Lamagna, 2011). And as when processing categorical emotions (anger, sadness, fear, joy) and relational experience, processing core affects related to intra-relational contact propels the patient through additional rounds of transformational work (State Three – *transformational affects* and State Four – *core state*). Such moments of positive self-to-state contact can be particularly helpful when working with patients who are not yet capable of tolerating affects related to painful events from the past.

The Power of Differentiation: Moving from Being *In* to Being *With*

> A sensing and the object sensed, an intention and its realization, one person and another are confluent when there is no appreciation of a boundary between them, when there is no discrimination of the points of difference or otherness that distinguish them. *Without this sense of boundary — this sense of something other to be noticed, approached . . . there can be no emergence and development of the figure/ground, hence no awareness . . . no contact.*
>
> (Perls, Hefferline & Goodman, 1951, p.118, italics added).

> That which we are looking for, is that which is looking.
>
> St. Francis of Assisi

During moments when our patients become consumed by pathogenic experience, there appears to be little differentiation between the felt sense of who they were in the past disruption-without-repair experience and who they are in the present moment. This "confluence" of past and present, as Perls et al. suggest, interferes with their capacity to maintain enough emotional distance to both experience their affective state and reflectively

make “contact” with it.

Initiating intra-relational affective change processes begins with the therapist helping the patient experience themselves as separate from the pathogenic affects that threaten to overwhelm them. Techniques drawn from other approaches can be used to foster separation between the patient and their pathogenic experience, e.g., psychodrama (“mirroring” and “role playing,” Moreno, 1997), gestalt therapy (“empty chair,” Perls et al, 1951), psychosynthesis/dis-identification (Assagioli, 1971), internal family system therapy (“unblending,” Schwartz, 1995), and Buddhist psychology (“R.A.I.N technique” – **R**ecognize, **A**ccept, **I**nvestigate, **N**on-identification, MacDonald, 2001). Moving from enmeshment with psychic pain to differentiation from it creates the conditions for the formation of a dyadic field within the individual and a multi-layered relational field between patient, therapist and the afflicted inner aspect of self (Lamagna & Gleiser, 2007; Lamagna, 2011). Experientially tracking the sometimes subtle changes-for-the-better that occur with differentiation and maintaining the separation are crucial in the early stages of the work.

Clinical Illustration: Intra-relational Work with Pathogenic Affect

Linda is a 60 year old, married, white, female who presented for treatment two months prior to the vignette below. She came to therapy depressed, anxious, “fragile” and on the verge of leaving her husband of 20+ years. This was precipitated by upsetting incidents with her grown stepchildren during the holidays that left her feeling hurt, dismissed, angry and unsupported by her husband. This experience evoked deeply painful feelings associated with her problematic attachment to her alcoholic, emotionally abusive mother, her abandonment by her father while a young child and recurrent relocations during her childhood. As the oldest child, Linda admitted to having a lifelong need to view herself as strong and independent. In order to do this, she dissociated any and all affects associated with pain, loneliness and vulnerable. This edited transcript of a session illustrates intra-relational affective change processes in the context of pathogenic affect and AEDP’s four-state model of change.

Pt: I don’t know why but I’m terrified. (*voice shaky*)

Th: Yeah.

Pt: I don’t know why. It doesn’t make sense . . .

Th: Um hmm. You are feeling terror now?

Pt: Yes.

Th: Where in your body? **[patient invited to track sensation]**

Pt: I was thinking about it when I was driving down here. It’s like a really, really empty

stomach if I had to feel it. It's like a hunger or the opposite . . . like the dry heaves . . . up in here. (*gestures to mid-abdomen*)

Th: It feels like an empty space?

Pt: Yes . . . hollow.

Th: Uh huh.

Pt: (*anxiously*) I don't know why I'm doing this. **[defenses come to the fore]**

Th: Is it possible that this is coming from a young place —- that this is an old feeling in some ways we are re-experiencing?

Pt: I guess so, but I'm back to the same thing – I'm going through the motions at home . . . Doing everything I'm supposed to keep going. (*pause*) I'm very surprised by this.

Th: The depth?

Pt: After everything happened (the precipitating incidents during the holidays), I anticipated the mourning of something; the death of something. Someone. Me. (*with increasing agitation*) I just can't understand why I'm feeling this so deeply.

Th: Can we just accept for the moment that we are and that we can bring everything to bear to heal this today? Together . . . **[encouraging the patient to stay with her experience. Use of "we" and "together" to emphasize my presence, support and willingness to help her regulate her experience]**.

Pt: (*getting more distressed*) It just hurts so much. (*tears up*) It's still so close — that feeling . . . (*pause*) and I feel afraid of it.

Th: Yes. Let me help you with that feeling. **[Acknowledging her struggle, I again emphasize my readiness to help.]**

[Edit]

Pt: I don't know what I'm feeling. It's too hard for me (*increasingly agitated, gasping with tears in her eyes*).

Th: **[inviting her to take in my presence so as to initiate dyadic regulation]**

Pt . . . can you just check in with me for a second? Can you feel me here with you?

Pt: **[She's not registering me.]** It all hurts too much. I miss my mother. (*breaks into sobs*).

Th: (*softly*) Yes.

Pt: (*sobbing*) I missed so much.

Th: (*slowly, with softness*) Yeah, you did. Keep breathing.

Pt: I keep telling myself I'm doing well. I have this wonderful world around me . . . (*sobs*)

Th: **[For the third time, I try to make her conscious of my attending to her distress.]** Can we work on this together? I really want to help you today.

Pt: (*sobbing*)

Th: First. Can you check in and see that I'm here with you? **[Seeing that the relational option isn't working, I shift focus.]** See if we can ask this distressed part of you if she would be willing to separate out — just a little bit. And if she won't, it's okay. We'll figure out other ways of helping. **[Here I employ the unblending technique from internal family systems (Schwartz, 1995).]**

Pt: I'm just surprised it's so deep.

Th: Okay. Do you have a sense whether there is a willingness for the distress to step back? Did you feel any shifting in your body?

Pt: I'm just able to breathe. (*seems slightly calmer*)

Th: **[I invite her to experientially track the felt sense of this small positive shift.]** Just notice that you can breathe now. (*long pause*) What are you noticing now?

Pt: I just want to know why. (*calmer but still employing intellectualizing defense*)

Th: The why question isn't going to get us out of this.

Pt: (*laughs nervously*) I know.

Th: So ask the why question to move to the side. [**looking to bring focus back to body**] Check in with your body.

Pt: (*sighing*)

Th: Is the distress up, down or about the same?

Pt: I can breathe. That's the best way I can say it. [**This is a small but positive shift that would be helpful to seize upon.]**

Th: Well, we *did* ask for breathing room . . .

Pt: (*laughs*)

Th: Right?

Pt: Yes.

Th: That's what we got. (*pause*)

Pt: (*tears up*)

Th: Some feelings coming?

Pt: (*first with derision, then softening*) This sounds so *soppy*! (*tearing up*) It means I have to trust you. [**Here the patient provides a possible clue as to why efforts at dyadic regulation failed and differentiation is working only marginally at this point.**]

Th: Yes, a little bit.

Pt: And I have to trust that I'll be okay.

Th: Is there in willingness to try trusting me for a few minutes?

Pt: Yes.

Once a sufficient degree of differentiation is achieved (i.e. an absence of defensive or inhibitory responses like self-attack, shame, anxiety, urgency to "fix and forget", minimization, figuring things out, etc.), the aim is to establish empathic contact between the patient-inner aspect of self. Any and all approach/engagement-based affects like sympathetic sadness, warmth, tenderness, interest, concern, compassion and subsequent associations become the focus of moment to moment experiential tracking. This class of core affects becomes the "fuel" that will propel the patient through additional rounds of transformational work.

Th: Can we bear witness to these old feelings with one foot in 2013? That requires some space here. **[Intra-relational work uses distinction in both time and space to assist in the process of differentiation.]**

Pt: Um hmm.

Th: Notice how you feel towards her. Someone who wanted love more than anything. See her with your mom over there **[I gesture to the chair in the corner of the room to reinforce differentiation/space.]** (*pause*) If it feels like it's too much, you let me know.

Pt: (*pause*) It's sad.

Th: Are you feeling *her* sad or sad *for her*?

Pt: Feeling sad for her. [**This is a good sign as it indicates *current* feelings *about the past experience* rather than a triggering of feelings *from the past experience.***]

Th: [**Sensing differentiation, I encourage empathic contact.**] Sad for her? Let her know that and let her know why.

Pt: (*patient cries*) I'm telling her I want to hold her and rock her.

Th: (*softly and slowly*) Hold her. Rock her. (*pause*) We are so sorry it was like this for you.

Pt: I'm feeling . . . (*becoming agitated again*)

Th: *Your* feelings or *hers*?

Pt: *Her* feelings. [**Here the space between the patient ("I want to hold her and rock her") and the part of self bearing the pathogenic affect begins to collapse. Differentiation needs to be re-established to keep the process moving forward.**]

Th: See if she would be willing to step back just a little bit.

Pt: (*crying*) This is *so hard*.

Th: I know it's hard. I am going to help you through this. See if she is willing to trust you. **[empathy and reinforcement of my presence and readiness to help with affect regulation]** All I need is 15 minutes. Are you willing to give me 15 minutes? I guarantee that if you give me 15 minutes, you're going to be in a different space when you leave here. **[I offer this "guarantee" with confidence *only* because I have seen differentiation work successfully for this patient in a previous session.]**

Pt: Umm. (*smiling*)

Th: Is there a willingness to try?

Pt: (*nodding*) [**To reduce any additional re-triggering of pathogenic affect, I educate the patient about the goal of differentiation and invite shared reflection on what triggered her shift back to the pathogenic experience.**]

Th: About 10 minutes ago or so you told me you were feeling sad for her. And it was your feelings in 2013 about what she experienced back then.

Pt: Um Hmm.

Th: And you felt compelled to hold her and rock her.

Pt: Um Hmm.

Th: And as you started to rock her, what was it that happened?

Pt: It was just me wanting it for myself. It was me wanting to be held. It was me wanting to say “mommy”. **[This indicates a merging or “blending” (Schwartz, 1995) with a child state.]**

Th: Was it you saying “I’m here”?

Pt: It started out with me saying “I’m here” *to her* and ended up with me saying “I’m here” to the world (*cries*)

Th: I see. So when you hugged her, you *became* her?

Pt: Yes. [**The patient explicitly confirms that she had slipped back into identifying with her younger self.**]

Th: Okay. Can she see that when that happened the hug went away?

Pt: Um hmm.

Th: Is she willing to stay separate enough to experience that? She needs to keep all of the pain in her body and allow you to be with her rather than you becoming her. Is she willing to try it as an experiment?

Pt: Um hmm.

> Perhaps all the dragons in our lives are princesses who are only waiting to see us act, just once, with beauty and courage. Perhaps everything that frightens us is, in its deepest essence, something helpless that wants our love.
>
> Rainer Maria Rilke, *Letters to a Young Poet*

Buddhist psychology (Brach, 2013; Kornfield, 2008) and internal family systems therapy (Schwartz, 1995) have observed that compassion, self-understanding and love naturally manifest when an individual achieves a state of differentiation unfettered by defenses, shame, anxiety and in this case, unbearable psychic pain. Like these approaches, intra-relational affective change processes make use of this differentiation from these states form the past to further the process of change. For I-R work, affects associated with

interest, openness, tenderness, love, harmony and compassion become the focus of moment to moment experiential tracking. As positive affects come to the fore and are deepened, metaprocessing is employed as well to catalyze, reinforce and integrate the emergent changes in the patient's relationship to inner aspects of him or herself. Continued processing yields further movement through state three (transformational affect) and state four (core state).

Th: Keep seeing her through your eyes. (*long pause*). How you are feeling toward her? **[This question is employed in internal family systems therapy to assess "self energy" – a state of curiosity, calm and compassion. In I-R, discovering that the patient has entered this open hearted state prompts experiential tracking of affects linked to the felt sense of openness, tenderness, empathy.]**

Pt: (*softly*) It's too bad. (*empathy arises*) [**The affects linked to this empathic contact constitutes core affect just as it would if being offered by the Th in relational change processes.]**

Th: Yeah. So sorry it was that way for you then. We are here now. We are here now. (*long pause*) [**After a relatively short time processing feelings of empathy, the patient suddenly moves from State Two core affect to State Three transformational affect.]**

Pt: It's out of nowhere.

Th: Is your heart open or closed?

Pt: Open…….because I admire her. [**The patient moves into feeling a sense of admiration/mastery for having survived the difficult challenges of her childhood —an indicator of State Three: Transformational affect. We track and metaprocess the shift.**]

Th: What do you admire about her?

Pt: To keep on going.

Th: Tell her that.

Pt: To have a normal life. To try and separate all that neurotic, sick stuff.

Th: Do you get that she wanted her mother's love more than anything?

Pt: (*slowly*) Yeah. Yeah.

Th: Let her know we understand that. It's normal.

Pt: Yeah. It's not selfish. (*long pause*) I'm okay now. I can see it. I can breathe. It's not

taking my life away. It sounds so dramatic but these are the *only* words that make sense.

Th: Okay. Let's go with them.

Pt: It may sound corny but I like who I am. I like how I made it in spite of this. **[State Three transformational affects -mastery]**

Th: Just notice. Feel that admiration.

Pt: It's funny. I've never been able to think about my childhood without being very dismissive or I guess feeling it so much I couldn't breathe.

Th: Right. So what's this like? **[metaprocessing of emergent, new experience]**

Pt: It feels "handle-able". (*we both laugh at her new word*)

Th: And when it feels "handle-able", how do you feel towards her?

Pt: I feel sorry but not overwhelmed. I feel admiration, I have to tell you.

Th: Yes!

Pt: I don't know how I did it.

Th: You feel respect, admiration, appreciation, gratitude?

Pt: Um Hmm. (*nods*)

Th: What do you feel drawn to do?

Pt: Acknowledge it. All of it. Me. What it really was.

Th: Let's make room for that. [**The patient shows signs of entering State Four core state as demonstrated by markers like calm, ease, and the emergence of an integrative, "big picture" perspective.**]

Pt: I think there is a moment of clarity coming (*giggles*) I always found myself worrying about what others felt – how others suffered — how it was worse for someone else.

Th: And now? **[inviting attention to the *new* experience of the moment]**

Pt: And now . . . it's not that I don't care. It's just that it doesn't matter for me. There is nothing I could do about it. And I shouldn't have that burden.

Th: Can we ask her (the part) what it is like for her to have you and I bear witness to her in

this way today? [**metaprocessing**]

Pt: It makes it mean something. That it is not imagined. And it's not self-pity and it's not . . . It is . . . It *was*. [**The patient sees her pain placed appropriately in the past and as it really was — not through the lens of dismissive defenses and not consumed by the feelings themselves.**]

Th: I like your correction. (*both laugh*). It *was*, yes. It really was. See how it sits with you to allow that . . . [**inviting attention to the new experience that is unfolding in the moment**]

Pt: I don't have to fix it. I didn't know I thought that, but I guess I did somehow.

Th: What's it like to know you don't have to fix it? **[metaprocessing]**

Pt: It's *so* freeing. For this moment, I can think about it without getting sucked into a hole. [**The afflicted sense of self and associated pathogenic affects now appear to be integrated, neutralizing its negative impact on her.]**

Th: What does that say?

Pt: It takes away some fear that I've always lived with. [**With the pain neutralized/integrated, the fear and perceived fragility dissipate.**]

Th: What's that like? (*pause*) What do you get to feel more when there is less fear? [**metaprocessing — attending to the new**]

Pt: Stronger.

Th: And in this moment how are you feeling towards her (the afflicted part of herself) and her empty stomach and all that?

Pt: I see it in perspective. It was sad. It was hard. Sometimes it was terrible. Sometimes it was okay (*smiles*)

Th: Right.

Pt: I still had fun. I still found meaning. [**Again patient indicates an integrative transformation of her pathogenic experience. Good and bad are both there and available as part of her true experience.**]

Th: This is big. This is big.

Several days after this session, the patient sent the following email message that indicated that the shift observed in session held: "This may sound corny but as I sit here listening to

the rain and enjoying it, I want to let you know I'm doing well. Churchill said "If you're going through hell, keep going . . . thanks for helping me through."

Conclusion

Accelerated Experiential Dynamic Psychotherapy is a clinical approach whose primary focus is on creating the conditions that facilitate change-for-the-better in our patients. Though at first glance pathogenic affects may be seen as a formidable challenge to this goal, the activation of intense pain can also provide an opportunity to heal, accept and integrate heretofore overwhelming experience resulting from chronic trauma and neglect. Intra-relational work does this by differentiating the patient's past pain and aloneness from their here and now experience, and with the pain brought to a tolerable level, facilitating moments of meaningful connection between the patient and inner aspects of self. This contact, when unfettered by defenses, shame and anxiety, evokes intra-relational core affects associated with self-to-self resonance, appreciation, care, compassion and understanding, which, when experientially processed, fuels the patient's movement through AEDP's four state model of change.

References

Assagioli, R. (1971). *Psychosynthesis: A collection of basic writings.* New York: Penguin.

Brach, T. (2013). *True refuge: Finding peace and freedom in your own awakened heart.* New York: Bantam Books.

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

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

Fosha, D. (2002). The activation of affective change processes in AEDP (Accelerated Experiential-Dynamic Psychotherapy). In J. J. Magnavita (Ed.), *Comprehensive handbook of psychotherapy. Vol. 1: Psychodynamic and object relations Psychotherapies* (pp. 309-344). New York: John Wiley & Sons.

Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disordered attachment. In M. F. Solomon & D. J. Siegel (Eds.), *Healing trauma: Attachment, trauma, the brain and the mind*, (pp. 221-281). New York: Norton.

Fosha, D., & Yeung, D. (2006). AEDP exemplifies the seamless integration of emotional transformation and dyadic relatedness at work. In G. Stricker & J. Gold (Eds.), *A casebook of integrative psychotherapy* (pp. 165-184). Washington DC: APA Press.

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. (2009a). Emotion and recognition at work: Energy, vitality, pleasure, truth, desire & the emergent phenomenology of transformational experience. In D. Fosha, D. J. Siegel & M. F. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development, clinical practic*e (pp. 172-203). New York: Norton.

Fosha, D. (2009b). Positive affects and the transformation of suffering into flourishing. In W. C. Bushell, E. L. Olivo, & N. D. Theise (Eds.), *Longevity, regeneration, and optimal health: Integrating Eastern and Western perspectives* (pp. 252-261*)*. New York: Annals of the New York Academy of Sciences.

Hanh, T. N. (2013, July, 8). *First Dharma Talk of the First Week of the Summer Opening* [Video file]. https://youtu.be/RNWv9biEGKY

Kornfield, J. (2008). *The wise heart: A guide to the universal teachings of Buddhist psychology.* New York: Bantam Books.

Lamagna, J. (2011). Of the self, by the self, and for the self: An intra-relational perspective on intra-psychic attunement and psychological change. *Journal of Psychotherapy Integration*, *21 (3), 280-307.*

Lamagna, J., & Gleiser, K. (2007). Building a secure internal attachment: An intra-relational approach to ego strengthening and emotional processing with chronically traumatized clients. *Journal of Trauma and Dissociation 8 (1),* 25-52*.*

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.

Gleiser, K. (2014). The role of recognition in healing from neglect and deprivation. *Transformance: The AEDP Journal*, 1 (1).

Moreno, J. L., & Fox, J. (1997). *The essential Moreno: Writings in psychodrama group method and spontaneity.* New York: Springer*.*

Perls, F. S., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy.* New York: Dell.

Schwartz, R. (1995). *Internal family systems therapy.* New York: Guilford Press.

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