Wired for Healing

Thirteen Ways of Looking at AEDP

By Diana Fosha

Inspired by Wallace Stevens' poem, *Thirteen Ways of Looking at a Blackbird,* this paper represents musings on thirteen of AEDP's many aspects. The Stevens poem [see Appendix] modeled a liberating structure for describing AEDP's fundamentally holographic, ever-emergent, non-linear, complex and dynamic nature.

I like the idea of 'ways of looking.' The choice of which one, or which combination, is most salient for any patient-therapist dyad, in any particular session, at any given moment, is neither uniform nor dictated, neither proscribed nor prescribed. It is emergent. It is how the uniqueness of each dyad, each session, each moment, declares itself. Precision and rigor in AEDP clinical work do not come from a how-to manual: AEDP work is deeply informed by a change-based understanding of clinical process, i.e., transformational theory, and is guided moment-to-moment by an articulated phenomenology, i.e., the phenomenology of the transformational process. The 13th way of looking at AEDP—"this is what I did, and this is what happened"—begins to articulate a dialectic principle of phenomenology-based and transformational theory-informed practice.

The ways of looking need not belong to parallel categories. Some are about stance, some are about technique, some are about ethos or theory, and some are about phenomenology. Each of these thirteen ways of looking at AEDP contains, assumes, and implies within it all the others. And yet, through each, we access a singular perspective.

One last thing: Note that the title of this paper is not *the* thirteen ways of looking at AEDP. *These* thirteen ways are organized around transformational theory, transformance, and the essential role of phenomenology in AEDP. At a different time, with a somewhat different focus –be it technique, or trauma, or attachment, or whatever– a very different set of thirteen aspects would have almost certainly emerged. So here goes, thirteen ways of looking at AEDP, c. 2010:

I. Transformational Theory

AEDP uses transformational theory as the mainstay of its conceptual framework. The notion of *transformance* (see below for definition) is part of a larger project of developing, articulating and elaborating *transformational theory*, i.e., a theory of and for a therapy which is change-based, rather than psychopathology-based (Fosha, 2002, 2005). Understanding how healing transformational processes –their dynamics, their phenomenology– work and how they can be effectively and systematically harnessed in treatment is central to such an endeavor.

Most models of therapy rely on theories of psychopathogenesis, i.e., how psychopathology comes about, regarding treatment as the undoing of pathology, i.e., the “fixing what is broken” approach. Alternately, they apply to therapy principles of basic psychology –perception, cognition, memory, information-processing. These principles,while fundamental, are necessary but not sufficient: they were not intended to, and in fact do not, account for the quantum nature of the change phenomena obtained and privileged by experiential methods.

AEDP is the first and to date only psychotherapy approach that roots itself in transformational theory, and locates itself in the field of *transformational studies:* that field of endeavor devoted to studying the features, characteristics, dynamics, and phenomenology of discontinuous change processes. By studying naturally occurring transformational processes –in babies and their caregivers, in moments of meeting, in Tibetan monks, in intense emotional situations, in resilient individuals, in people in love — we hope to reliably and systematically become able to entrain quantum change processes in therapy.

II. Wired to Heal: The Birth of Transformance. Healing From the Get-Go

At the heart of transformational theory is the understanding that people have a fundamental need for transformation. *Transformance* is the term for the overarching motivational force that pulses within us, moment-to-moment guided by the process of recognition and the sense of “this feels right” (Fosha, 2009a). The thrust of transformance is toward maximal vitality, energy, and authenticity of self experience (Fosha, 2008, 2009a). Unlike the conservative motivational strivings under the aegis of resistance, which consume and drain psychic energy, transformance-based motivational strivings, when actualized, are energizing and vitalizing.

Three interrelated foundational assumptions are at the heart of AEDP’s healing oriented theory and practice:

i. We are wired for healing. We are wired for growth and healing, for self-righting and resuming impeded growth (Eigen, 1981; Ghent, 1990; Winnicott, 1960). Innate dispositional tendencies toward growth, learning, healing, and self-righting lie wired deep within our brains and press toward expression when circumstances are right (Doidge, 2007; Emde, 1983; Gendlin, 1996; Sander, 2002; Siegel, 2007). Wired for healing and resuming impeded growth, we seek opportunities to do so. Together with the need to relieve suffering, it is this wiring which propels us into treatment.

ii. Healing is a process, not just an outcome: it awaits activating from the get-go: Like other basic adaptive psychological processes, e.g., attachment, emotion, information-processing, healing is an evolutionarily wired-in process with its own phenomenology and dynamics. Healing is not *just* the outcome of successful therapy, but rather it is a process to be engaged in therapy and harnessed in the service of therapeutic work. It is there to be entrained from the get-go, from the very first moment of the very first session with the

patient, and then thereafter throughout the course of the therapy.

iii. *Healing transformational experiences feel good*: healing transformational experiences are invariably accompanied by positive affects: they feel good. By “good” and “positive,” I do not necessarily mean happy, but rather that these experiences feel right and true.

Naming is a sacred activity, a recognition and celebration of existence. By having names for healing oriented processes and phenomena such as, for example, *transformance*, healing can come into its own as a systematic process to be studied and understood so as to be better entrained in psychotherapy.

III. At the Nexus of Science and Clinical Process Are Phenomena: The Phenomenology of the Transformational Process

At the nexus of neuroscience and clinical process lie phenomena. The phenomenological sensibility informs both clinical and conceptual aspects of this work: our goal is to extend the work on the phenomenology of emotion (Darwin, 1872; James, 1890, 1902; Tompkins, 1962, 1963) to include the positive affective phenomena associated with cascading transformational processes. A commitment to descriptive phenomenology can substantively contribute to the emergent conversation among clinicians, affective neuroscientists and developmentalists, thereby trumping territorial battles fought through different traditions of terminology that impede rather than foster progress Fosha, 2003, 2009a, c; Fosha, Siegel & Solomon, 2009).

In conditions of safety, the transformational process unfolds in a regular way that is systematic and reproducible, as has been written about extensively (Fosha, 2008, 2009a, 2009b; Fosha & Yeung, 2006; Gleiser, Fosha, & Ford, 2009; Russell, in press; Russell & Fosha, 2008). Here I will only briefly summarize its features for the purposes of supporting the discussions that follow.

Four states and three state transformations characterize the transformational process that is set in motion when, in conditions of dyadic safety, we seek to process (i) heretofore unprocessed painful emotional experience to completion, and then, in keeping with AEDP’s transformational focus, also process (ii) transformational experience. Each state is phenomenologically distinct. It is for this reason that AEDP technique and intervention methodology are rooted in phenomenology. It tells us where we are, how we are doing, and where we need to go.

State 1 work has two aspects: to detect, focus on and amplify glimmers of transformance; and to minimize the impact of defenses, dysregulation and inhibiting affects (e.g., anxiety). The goal is to help the patient “drop down” into somatically-based, limbically-generated and right brain mediated emotional experience. This is achieved through building safety, and either restructuring defenses and inhibiting affects (S. Shapiro, 2010; Suter, 2009), or being able to bypass them (Fosha, 2000). State 2 work involves the processing of core emotional experience and follows a wavelike pattern: first accessing, then deepening, then

processing and working through to completion each emotion. Completion is marked by the positive affects that emerge as the adaptive action tendencies of each emotion are released. However, what is usually the end in other emotion-focused treatments is, in AEDP, the beginning of the next phase of transformational work: State 3 work involves the processing of transformational experience with the same systematic rigor with which emotional experience was processed in State 2. We call this *metatherapeutic processing*. It capitalizes on the discovery that experientially focusing on the *experience* of transformation activates a transformational process of its own (Fosha, 2000). Specific *transformational affects*, invariably positive, accompany each type of metatherapeutic process identified to date. Traveling down the transformational spiral, fueled by positive vitalizing energizing affects, culminates in the accessing of State 4, core state, a state of calm, clarity, flow and expansiveness, whose affective marker is the *truth sense*. Core state manifests the integration of affect and cognition, of experience and reflection. In core state, therapeutic results can become deeply consolidated as the patient becomes able to construct a cohesive and coherent autobiographical narrative (Fosha, 200, 2003, 2005), the hallmark of secure attachment and resilience in the face of trauma (Main, 1999).

These four states and three state transformations have their parallel existence in the experience of the therapist (Schoettle, 2009). While the exploration of the *phenomenology of dyadic experience*, whether applied to couples (Mars, 2010; Tunnell, 2006, in press) or to the patient-therapist dyad, is beyond the scope of this paper, it is clear that it is an important area that needs to be explored.

The phenomenology of the transformational process describes an arc, unfolding through the directional thrust of emotion, moment-to-moment kept on a progressive track by vitality affects signaling the operation of transformance. A psychoevolutionary perspective of survival at one end is organically linked with aesthetics, spirituality, and the quest for personal truth at the other. The experiential processing of emotions shaped by eons of evolution, and also by processing transformational experience, relieves suffering and naturally culminates in experiences of aliveness, hope, faith, clarity, agency, simplicity, compassion, coherence, and both truth and beauty.

IV. Surprise the Unconscious: Be a Transformance Detective!

“The river is moving.
The blackbird must be flying.”

Wallace Stevens, *Thirteen Ways of Looking at a Blackbird*, XII

Given that we are wired for growth, for healing, and for self-righting, we might as well put that wiring to good use in treatment. As AEDP therapists, we are on the lookout for evidence of ttransformance, and we make use of it when we detect it. Assiduous detectives, we look for glimmers—or even better yet, actual rays—of resilience, strength, courage, hope, integrity, curiosity, and unsuspected capacities (Fosha, 2009b). From the get-go, we invite patients into a healing relationship (Pando-Mars, 2009): Compassion

toward suffering, delight in the person of the patient, and empathy for her/his experience are all part of that invitation. The welcoming and valuing of emotions is another important part (Pando-Mars, 2009).

Our job as transformance detectives is immeasurably assisted by the fact that transformance at work is visible: *positive somatic/affective markers* invariably accompany it. These *positive somatic/affective markers*, e.g., deep sighs, fleeting smiles, head nods, sideways head tilts, operating moment-to-moment, signal that the transformational process is on track (Fosha, 2008, 2009a, 2009b; Russell & Fosha, 2008).

Mary Main spoke about the efficacy of the Adult Attachment Inventory (AAI), one of the most robust research tools ever developed, as being based in “surprising the unconscious” (Main & Goldwyn, 1998). One way to get a lot of therapeutic traction is to surprise the patient’s unconscious.

Conditioned by past experiences of being unmet, *moments of meeting* take the patient’s unconscious by surprise. Having hit a wall, their resources overwhelmed, patients come to therapy expecting to have the worst in themselves exposed. It is surprising, and also disarming when, instead, they are met not only with compassion and empathy, but also with delight and appreciation. Such a disconfirmation of expectations can rapidly soften defenses, yielding access to more viscerally felt, right-brain-mediated emotional experiences.

Pathology-based treatment models locate the corrective emotional experience (Alexander & French, 1946) in old scenarios getting repeated in therapy, but having a different ending. In AEDP, we do not believe that to be the only route: we also seek to entrain new patterns, and adaptive patterns at that, from the get-go: we believe that it is possible to *lead with a corrective emotional experience*, and thus, we aim to do so. By being transformance detectives, and by working to foster a therapeutic environment where the forces of transformance can come to the fore, often a corrective emotional experience can be entrained *before* the old patterns have a chance to re-assert themselves.

What then comes to the fore is the patient’s self-at-best. A resonant, collaborative relationship develops between the transformance-facilitating therapist and the patient’s self-at-best. It is thus that safety is co-constructed, and can be co-constructed early on. This early activation of the patient’s resources and strengths, enhanced through a safety-engendering therapeutic relationship, will stand the patient in good stead. No longer alone, and with their resources activated, the patients can risk taking on those feared-to-be-unbearable emotions. We call this “*working with the self-at-worst from under the aegis of the self-at-best*” (Fosha, 2000) and it is a fundamental principle guiding AEDP work.

V. The Central Role of Positive Affects and Positive Affective Interactions in Transformational Work

“The patient needs to have an experience, a new experience, and that experience should

be good. The aim and method of AEDP is the provision and facilitation of such experiences from the first moments of the first contact, and throughout thereafter." (Fosha, 2002)

In the past, positive affects and positive developments in therapy have gotten a bad rap. They have been regarded with suspicion and skepticism, even disdain, with a whole vocabulary to express why such phenomena should not be deemed clinically significant: flight into health, compliance, superficial, Pollyannaish, trying to please, etc. It is one more reflection of the bias toward pathology in our field: countless explanations for why something that appears good is really not, yet much fewer understandings of why something that appears good can indeed be good.

More recently, great strides have been made in understanding the deep role of positive experience in human development. *The Infant Mental Health Journal* (2001, volume 22) and the *Journal of Psychotherapy Integration* (2008, volume 18, issue 2), to name just two, have each devoted a full issue to exploring the role of positive emotion in development, and psychotherapy, respectively. The work of Fredrickson and her colleagues on the broaden-and-build theory of positive emotion and on flourishing (e.g., Fredrickson, 2001; Fredrickson & Losada, 2005), and of Keltner, Haidt and their colleagues on positive emotions from an Ekman perspective (e.g., Ekman, 1984; Haidt & Keltner, 2004; Keltner, 2009; Keltner & Haidt, 2005) are filling in the gap. And just last year, the New York Academy of Sciences issued a volume exploring immunological, genetic, physiological and psychological aspects of such experiences (Bushell, Olivo, and Theise, 2009).

Positive affects and positive affective interactions are both the constituents and the wired-in affective markers of healing transformational processes and adaptive experiences. Given that the experience of change –change for the better, that is– feels good and right, and given that positive, resonant, attuned, dyadic interactions have been shown to be the constituents of healthy, secure attachments and the correlates of neurochemical environments that are conducive to optimal brain growth (Schore, 2001), AEDP is both guided by these moment-to-moment signals and markers, and aims to facilitate their occurrence.

A felt sense of vitality and energy characterizes transformance-based emergent phenomena. Positive affective experiences are fundamentally linked with transformance and the transformational process (Fosha, 2009a, 2009c; Fosha & Yeung, 2006; Russell, *in press*; Russell & Fosha, 2008): they mark it (somatic markers); they accompany it (vitality affects); are the result of it (transformational affects, core state, adaptive action tendencies) and are causative of it. For when they themselves are experientially explored, they give rise to further transformational processes, leading to non-finite, recursive, cascading transformational spirals, where more begets more. Thus, positive affects are (1) causative of, (2) correlates of, and (3) the result of transformance-based practices. AEDP, along with others interested in exploring the progressive motivational forces of transformance operating in development and in therapy (e.g., Buber, 1965; Eigen, 1996; Gendlin, 1981; Ghent, 1990, 2002; Sander, 1995, 2002; Schore, 2001; Trevarthen, 2001),

recognizes these positive affective phenomena as playing a vital role in engendering security, energizing growth, and enriching expansive exploration.

What distinguishes AEDP's take on the positive emotions from that of much of the current positive psychology is that positive affective phenomena are not viewed as occurring in contradistinction to emotional suffering. To the contrary. Positive affective phenomena associated with resilience, thriving, creativity, etc., arise in the context of working with stress-based, traumatizing, painful emotional experiences (Fosha, 2004). When the processing of emotional experience is followed by the processing of transformational experience, the processing to completion of the negative emotions of psychological suffering naturally culminates in *flourishing*.

VI. Things That Feel Right: A (Non-Exhaustive) List

— Secure attachment (Lyons-Ruth, 2006; Schore, 2001, 2009)

–Receptive affective experiences associated with being the recipient of care, empathy, understanding, help (Fosha, 2000, 2009a, b; Lamagna, in press; McCullough Vaillant, 1997; McCullough et al, 2003)

–Experiences of attunement (Tronick, 1989, 2002)

–Experiences of successful repair (Tronick, 1989, 2009)

–Intersubjective experiences: (Trevarthen, 2001, 2009)

–Resilience (Russell, in press)

-Somatic/affective markers (e.g., deep sighs, fleeting smiles, eyes opening wider, sideways head tilts, head nods) that indicate that the transformational process is on track

–Vitality affects with a felt sense of vitality and energy associated with emergent transformance based processes (Fosha, 2008, 2009a, 2009b)

–Post-breakthrough affects: the feelings of relief, relaxation, clarity etc that emerge in the wake of experiences processed to completion

–Adaptive action tendencies that emerge when the categorical emotions are processed to completion: e.g., strength and empowerment in the wake of anger processed through; the capacity to take protective action in the wake of fear processed to completion

–Play, interest, curiosity (Panksepp, 2001, 2009; Trevarthen, 2001, 2009)

-The transformational affects associated with metatherapeutic processing– all the affects associated with transformational experience and the positive transformation of the self

–The mastery affects of joy and pride

–The healing affects, i.e. affects that are both (i) the result of healing; and (iii) result in healing and thus are healing in and of themselves. The two kinds of healing affects are: feeling moved within the self, and feeling gratitude, love and tenderness toward the other

–Core state and its many manifestations (see Fosha, 2009c for a detailed discussion; also Russell, *in press*; Yeung & Cheung, 2008)
a. naturalness: ease, flow
b. well-being
c. calm
d. energy: centered, relaxed and/or energetic, vital, vibrant
e. clarity, transparency, simplicity, innocence
f. photisms, i.e., phenomena associated with light
g. effectiveness: action, competence, confidence, initiative, agency
h. integrated harmonious functioning and the optimization of mental capacities: integration, flexibility; the coherent and cohesive autobiographical narrative
i. contact and relatedness: openness, connection, I-Thou, True Self-True Other
j. compassion, self-compassion, kindness
k. expansiveness and liberation of the self: creativity, enthusiasm, exuberance, spontaneity, playfulness, generativity
l. generosity
m: faith, hope
n. extreme positive affects: joy, bliss, passion, ecstatic states
o. a sense of the sacred; humility; awe
p. truth, wisdom, essence, knowing: the “truth sense”

It is likely that different clusters of emergent positive affective phenomena are manifestations of different neuro-psycho-bio-chemical processes (Fosha, 2009c). It would be interesting to explore which different practices give rise to which set of clusters, and, in turn, what basic mechanisms, and thus what specific effects, might be associated with each of them. Do, for instance, experiences of hope and faith have different underlying neurotransmitter circuitry than experiences of playfulness, spontaneity, exuberance, and creativity? Do extreme positive affects reflect different kinds of bidirectional communication between aspects of the ANS and the CNS than do states where kindness and compassion are in the forefront? Might one or the other have a differential impact on plasticity, or resilience? And if so, are the respective roles they play in a patient’s healing different?

VII. Undoing Aloneness

Aloneness—unwilled and unwanted aloneness—in the face of unbearable emotions is central to AEDP’s understanding of how transformance is thwarted and how attachment trauma comes to burrow its way in the psyche. In turn, *undoing the patient’s aloneness in the face of intense emotional experience* is central to AEDP’s therapeutic mission (Fosha, 2000).

When the parent can support and help the child deal with intense emotions, the result is secure attachment, reflecting the capacity to “feel and deal” (Fosha, 2000, p. 42). When the parent is accepting and there to help, the child feels secure that her/his emotions will be met and will not experienced as being “too much,” or “weak,” or “disgusting” or “shameful,” or “evil” or “destructive.” However, when the parents themselves cannot “feel and deal,” they cannot help their kids do the same.

Kids with insecure or disorganized attachment have learned that their emotions trigger their caregivers. The child’s emotions not only render the attachment figure incapable of being of help, but also may also sometimes trigger outright attack, rejection, or neglect. These children come to feel that their emotions, and by extension, they themselves, are “too much,” or “weak,” or “disgusting” or “shameful,” or “evil” or “destructive.” If the attachment bond is to be salvaged, the child has to get rid of the troublesome emotions, and institute what Bowlby (1980) called “defensive exclusion:” the child must exclude from her/his repertoire any emotions that dysregulate the attachment figure. Defensive exclusion works, though at a serious cost: not only is the attachment bond misshaped, i.e., insecure or disorganized, *but the child is then alone with the intense emotions that were overwhelming to begin with, and that become only more so, compounded as they are by the disruptive attachment experiences*. Compensatory protective mechanisms, i.e., defense mechanisms, emerge in the context of such relational ruptures marked as they are by affect regulatory lapses. Insecurely attached kids institute defenses that lead them to either “feel but not deal” (*resistant attachment*; Fosha, 2000, p. 43) or “deal but not feel” (*avoidant attachment*; Fosha, 2000, p. 43), thus reflecting the intergenerational transmission of attachment trauma. In disorganized kids, defensive strategies eventually fail and “not feeling, and not dealing” (Fosha, 2000, p. 44) turns into *disorganized attachment*, with dissociation as a measure of last resort.

Clinically, in AEDP treatment, it is crucial to undo the patient’s unwilled and unwanted aloneness. “Being with” is necessary but not sufficient. When it comes to the regulation and processing of heretofore feared-to-be- unbearable emotions, which were too much for the patient to deal with alone, “going beyond mirroring” (Fosha, 2000) and actually helping is essential (Piliero, 2010). It is what *dyadic* affect regulation is all about.

VIII. “Going beyond mirroring:” AEDP’s Therapeutic Stance and the Interweaving of Attachment and intersubjectivity

Just as we are wired to heal, we are also wired to care.

From the get-go, AEDP therapists strive to actively and explicitly foster secure attachment by offering a new experience of emotional safety, where the patient is not alone with overwhelming emotion and transformance strivings can come to the fore. The stance is intentionally positive (Lipton & Fosha, in press). In a clear-cut departure from neutrality, the AEDP therapist takes a page from security-engendering mothers and resilience-fostering caregivers: the aim is to maximize time spent in positive attuned interactions and the positive affects that accompany them, and to as rapidly as possible metabolize the stress-

full negative affects associated with misattunements and disruptions, and restore coordination and positive affective experience (Schore, 2001). The positive tone of the relational experience is crucial for the patient's "*felt security* and stress modulation" (Lyons Ruth, 2006, p. 606; emphasis, mine). The therapeutic relationship aims to be the secure base from which fear, anguish, shame and distress can be dyadically regulated, and from which experiential explorations of deep and painful emotional experiences can be risked. This secure base supports exploration, and all that eventuates in flourishing.

Following Lyons-Ruth (2007), Trevarthen (2001) and Tronick (2002), who regard attachment motives for care and protection as different from intersubjective motives for companionship and play, AEDP's stance is conceived as having two inextricably intertwined and yet separate strands: *attachment* and *intersubjectivity*. The attachment strand involves the asymmetric aspects of the relationship and the dyadic affect regulation of overwhelming emotional experiences (Fosha, 2001; Schore, 2009). The intersubjective strand references the symmetric aspects of the relationship and shared experiences of companionship, play, interest and enjoyable mutuality (Trevarthen, 2009). Attunement is crucial to both. Right brain to right brain communication (Schore, 2003) involving gaze, tone and affective communication through other non-verbal and paraverbal channels is the foundation for AEDP's therapeutic stance and crucial to the fostering of both attachment and intersubjective processes lending each dyad the uniqueness of its therapeutic path.

Thus, AEDP goes "beyond mirroring," its stance involving, as a patient said, "both leading and following" (see case described in Fosha, 2006). In the attachment strand, we go beyond mirroring by our active, sleeves-rolled-up engagement and willingness to help. We meet all signs of pain, suffering and fear, with empathy, dyadic affect-regulation, broadcasting radical acceptance (Osiason, 1996) and our willingness to help (Lipton, 2010). Making sure that the patient is not alone with overwhelming emotional experience; such an attachment relationship obviates the fear associated with intense, stressful-when-not-regulated, emotional experience (Frederick, 2009; Greenan & Tunnell, 2003, Chapter 2; Piliero, 2004, 2010). In the intersubjective strand, we also go "beyond mirroring" when we *lead* with affirmation and celebration of the patient (Russell, in press; Tunnell, 2006), and we also self-disclose her/his impact on us (Prenn, 2009, in press). We focus on, and delight in, the quintessential qualities of the self of the patient — the therapist's delight a powerful antidote to the patient's shame (Hughes, 2006; Kaufman, 1996; Trevarthen, 2001). The therapist's initiative in celebrating the patient makes the patient feel wanted and valued, as does the therapist's self disclosure of being affected by the patient: little does more to undo shame (Kaufman, 1996; Prenn, 2009; Winnicott, 1963). Both strands are woven into a therapeutic relationship that can be dyadic, explicitly empathic, affirming, mutual (though often asymmetric), affect regulating, mutually enjoyable and emotionally engaged. And one that is fundamental in helping patients do the work they need to do (Piliero, 2004).

IX. "Nothing that feels bad is ever the last step:" Processing Emotions to Completion.

The somatically based, visceral experience of core emotional experience in the here-and-now of the patient-therapist relationship is one of the central agents of change in AEDP, and crucial to healing trauma (Fosha, 2003; Fosha, Paivio, Gleiser, & Ford, 2009; Gleiser, Ford & Fosha, 2008). While this applies to the variety of core affective experiences AEDP works with (see Fosha, 2000, chapter 12), here I wish to privilege the categorical emotions. They include: fear/terror, anger/rage, distress/anguish, enjoyment/ joy, sadness/grief, disgust, surprise/startle, interest/excitement (Damasio, 1994; Darwin, 1872; Tompkins, 1962, 1963), as well as the innate emotions of human relating (Bowlby, 1980; Johnson, 2009). The categorical emotions, also called the *vehement emotions* by Pierre Janet (1889), are often harder and darker and more intense to deal with, but the therapeutic rewards that come from processing them to completion are just as intense (Ossefort-Russell, 2010). It is also why dyadic affect regulation is crucial: this time, the patient is not alone dealing with these forces of nature.

Why do the categorical emotions hold such a special place in AEDP? Universal phenomena, each categorical emotion has a distinctive biological signature, i.e., a deep-rooted bodily response with its own specific face, body, physiology and arousal pattern. Emotions provide a rapid appraisal of the environment: they heighten the salience of particular cues that need to be attended to, enhancing motivation and focused attention. This appraisal leads to body arousal, the release of adaptive action tendencies and a re-appraisal. Emotions are in essence impulses to act, the instant plans that evolution has instilled in us for survival, with each emotion offering a distinctive readiness to act that points us in a direction that has worked well to handle the recurrent challenges of human life (Fredrickson, 2001; Goleman, 1995; James, 1890; Lazarus, 1991). The categorical emotions are also the primary signaling cues between attachment figures (Johnson, 2009), communicating to other and self salient information about the state of the organism at the moment of emotional arousal (Bowlby, 1991),

In therapeutic work, emotions are powerful vehicles for “unlocking the unconscious” (Davanloo, 1990): Each emotion, once accessed and viscerally experienced, acts as a magnet for experiences that are organized under its aegis: its activation “lights up the network” (F. Shapiro, 2000). Each emotion draws to it and facilitates the emergence of emotion-specific constellation of memories, perceptions, fantasies, relational configurations and ways of being. It is this that allows the working-through of traumatic experience.

The notion of processing to completion is crucial in AEDP (Fosha, 2000; Frederick, 2009). It is yet another instance in which we see transformance-based phenomena inextricably intertwined with and marked by positive affect, for the completion of an emotion and the priming and release of the adaptive action tendencies associated with it are always positive (Gleiser, Ford, & Fosha, 2008). It strongly links the psychodynamic emotion-processing work of AEDP with natural, evolutionary, adaptation-based, wired-in, affective change processes and their neurobiological basis (Junqueira, 2006, 2008).

Finally, a word about the title of this section (and of a previous paper; Fosha, 2004):

“Nothing that feels bad is ever the last step.” It is a phrase that comes from a paper by Eugene Gendlin (1981, p. 25-26). It makes explicit the fact that the natural process of dyadically regulating and working with negative, vehement, overwhelming emotions, culminates not only in trauma resolution and enhanced adaptive functioning, but also in feeling good. It feels good –read “right”—to do the work, and the completion of emotion processing leads to deeply positive affective experiences of resilience, energy, effectiveness, clarity and vitality.

X. Thrival and Survival. And their Respective Emotions. (And Attachment and Intersubjectivity Redux)

Before discussing the distinctive role that negative and positive emotions play in mental life, I wish to introduce a new term to the AEDP lexicon. The term is *thrival*: it refers to the organismic evolutionary striving toward flourishing, development and growth, all processes marked by, resulting in and resulting from the positive emotions. Coined by Benau (2010), thrival is in counterpoint with survival. What we are calling thrival was once thought to be a luxury item, icing on the cake. But as we are coming to understand more and more, the positive affective experiences and processes subsumed under the realm of thrival or flourishing (Bushell, Olivo & Theise, 2009; Fosha, 2009c; Fredrickson & Losada, 2005; Keltner, 2009; Keyes & Haidt, 2002; Porges, 2009; Trevarthen 2009) play a vital role in all aspects of human health and mental health: positive emotions and interactions correlate highly with a stronger immune system, cardiac health, attachment security, good marriages, resilience in the face of trauma, well-being, longevity and just about anything good you can think of.

Emotion theory is rooted in adaptation (Damasio, 1994, 1999; Darwin, 1872). Given that emotions have long been deemed the “ancestral tools for living” (Panksepp, 2009, p. 1), Fredrickson (2001) asks the question “what is the adaptational value of positive emotions relative to the negative?” In the course of answering this question, she introduces the broaden-and-build theory of positive emotions, a powerful and highly influential model, highly congruent with the ethos of AEDP — especially its metaprocessing therapeutics.

Focusing on their differential adaptive functions, Fredrickson (2001) differentiates between the *negative emotions*, for survival, and the *positive emotions*, for expansion of capacities and growth, i.e., for *thrival* (Benau, 2010). The negative emotions, e.g., fear, or sadness, or disgust, serve adaptation through *narrowing* our focus to the challenges most salient for survival. By contrast, positive emotions are *broadening* of experience, attention and consciousness, and fuel the self and body with positive energy for exploratory pursuits and new learning, thus *building* the resources of the self. New thoughts, choices and, most important, new capacities arise spontaneously and lead to new pursuits and experiences, which, accompanied by positive affect, bring more energy into the system and recharge the spiral yet again. This is the essence of the broaden-and-build theory of positive affects that Fredrickson (2001) proposes.

In parallel fashion, in AEDP, we can broadly say State 2 work is for processing the

emotions –mostly negative—that arise in response to changes in our world that bear on our survival, be that survival physical or psychological (Damasio, 1999). On the other hand, State 3 and 4 work is for processing the transformational emotions –mostly positive– that arise in response to changes in one's self that bear on thrival (Benau, 2010; Fosha, 2009a).

The positive emotions that accompany the transformational processes that AEDP works with in States 3 and 4 are by their very nature recursive processes, where more begets more. This is not a satiation model or a tension reduction model, but rather an appetitive model. Desire comes in the doing. The more we do something that feels good, the more we want to do more of it. As we exercise our new capacities, they become part and parcel of who we are, new platforms on which to stand and reach for the next level (Ghent, 2002; Tronick, 2009). Thus, recursive cycles of healing transformation and emergent phenomena give rise to new transformational cycles and new phenomena, and those to the new capacities that translate into broadened thought-action repertoires. We are in the realm of *thrival*. As Benau (2010) writes: "I have always assumed subtle sensorimotor cues can evoke a limbic brain "survival response," but not until now did I realize that subtle cues also elicit what I call "thrival responses," at least when there is more safety than otherwise in the relational field. Isn't this the essence of a True Other? … Something in the patient brings forward in the True Other exactly what the patient needs on some level, and then the patient feels "met" or "seen." We talk about "traumatic reactions" being "triggered." Now I want to say that my patients "triggered" a "thrival caretaking response" in me, and in turn, my caretaking response "triggered" a "thrival" energetic/somatic/affective response in them."

And now back to attachment and intersubjectivity. In keeping with Bowlby's adaptation fused ethological slant, attachment has its evolutionary function in being central to the survival of the immature organism. Translated into psychological terms, in attachment, because of dyadic affect regulation, the more vulnerable partner is able to process the mostly negative emotions encountered in the course of survival, emotions that s/he would not be able to cope with alone. The realm of intersubjectivity is also vital for the individual (Trevarthen, 2009) but in a different way: connection, companionship, play, curiosity, creativity, culture, and the expansive pursuits of the human spirit use the vehicle of the positive emotions to substantively contribute to enriching the individual's existence and thus promote optimal, even enhanced, adaptation.

So, on one hand, we have survival, and attachment, and State 2 work with the negative emotions; on the other hand we have thrival and intersubjectivity and State 3 and 4 work with the positive emotions. These two fundamental strands are inextricably intertwined in life and therapy, but can be instructively separate in theory.

Barbara Fredrickson's profoundly influential broaden-and-build theory of positive affects is resoundingly confirmed by AEDP metatherapeutic work, which is all about recursive emergent processes and the amplification of positive emotional states enhancing the individual's adaptation through thrival.

XI. The Intimacy of Emergent, Here-and-Now, You-and-Me Metatherapeutic Work with Transformational Experience: “Is there more?”

For the therapist though, metatherapeutic processing can be a challenging experience. However deeply positive transformational experience is, it is new. Anxiety is not an uncommon experience. This anxiety is, in part, evoked in us by the tremendous intimacy of those moments when there is nothing but the patient and the therapist and the process. Here and now. You and me. What has just happened. What we have just done. Because of the emergent nature of processing transformational experience, which, by definition is new, what is happening is unscripted, unprecedented, and thus, for us therapists, can be so much more exposing, more vulnerable, more bare. To paraphrase Wallace Stevens (1917, IV):

A patient and a therapist
Are one.
A patient and a therapist and a transformational experience
Are one.

Having struggled mightily with such anxieties, an AEDP therapist wrote of his own emergent confidence, which now allowed him to really hang in there with transformational experience: “I wonder if something in me is more quiet and confident, has more faith in the process, less anxious and thus less unconsciously joining with the patient’s fears and defensive (survival) responses, is more sure we will find something good, even if I don’t know what that will be.“

His saying “I am more sure [within myself that] we will find something good,” brought to mind one of my favorite clinical examples. It comes from a case that Eileen Russell and I used for our 2008 paper (Russell & Fosha, 2008), where Eileen Russell is the therapist. She and her patient have done a lot of good work, processing-of-the-traumas-of-the-past work bearing fruit in the patient’s newfound resources. As the patient becomes increasingly confident, in the session in question, patient and therapist together explore his newfound capacity to assert himself. As they focus on his experience of confidence, hope emerges. As they focus on his experience of hope, an unprecedented zest for life emerges. Every time they experientially explore one capacity, a new one comes to the fore. With tenderness, interest, and genuine curiosity, the therapist keeps asking: “Is there more?” And every time she asks, there is.

It makes me wonder, (always at this phase of things) is there more?

XII. “Existing in the heart and mind of the other:” Receptive Affective Experience, and Making the Implicit Explicit and the Explicit Experiential

Earlier, we saw how, in AEDP, we work with transformation not just as a process, but also as an *experience*, having noted that the experiential exploration of the *experience* of transformation initiates another round of transformation. The same is true of attachment

and the various experiences –care, empathy, love, understanding—that constitute it. Attachment is not only a process we entrain, allowing it to do its work quietly, humming in the background. Attachment is also an experience. Bringing attachment to the experiential foreground and explicitly working with the *experience* of attachment is integral to the patient's having a new experience of secure attachment in AEDP.

Here is have yet another principle of AEDP practice: *make the implicit explicit, and make the explicit experiential.* And then reflect on it.

To work with the *experience* of attachment means to work with the patient's *receptive affective experiences* of the therapist's presence, care, compassion and love—in other words, what it feels like for the person to receive presence, care, compassion and love and to feel understood, cared for, or delighted in (Fosha, 2000, 2008; Lamagna, in press; McCullough Vaillant, 1997; McCullough et al, 2003*). Receptive affective experiences* are also emotions. If categorical emotions are about putting something out, i.e., *ex*pressing, receptive affective experiences are about taking something in. They register the impact of experiences upon the self. Also rooted in the body, receptive affective experiences have a felt sense specific to them that can be explored in terms of sensations: exploring them allows us to know whether, and how, what is being relationally given by the therapist is actually being received by the patient.

Peter Fonagy has written eloquently of how feeling understood is a biological imperative (Fonagy et al., 1995). The child's sense of "*existing in the heart and mind of the other*" (Fosha, 2000, p. 57) is foundational to an individual's eventually internalized sense of security of attachment and thus resilience in the face of adversity. The felt sense of "existing in the heart and mind of the other" and of doing so as oneself, is rooted in that Other's capacity to respond to us sensitively, empathically and contingently, in other words, just right, to our needs, experiences and communication. Vital, also, is our receptive capacity to register that that is in fact the case. The attachment figure offering and the self receiving is the relational transaction that constitutes secure attachment, and is how "the sense of existing in the heart and mind of the other" develops.

It is not sufficient that empathy, care, love or help be given: to work their potent magic, they must be taken in. For empathy to count, the patient must receive and *experience* that empathy. The benefits of these receptive experiences cannot be reaped if barriers to receptive experiences are in place. And barriers to receptive affective experiences are precisely what attachment trauma leaves in its wake (Wais, 2008). In individuals with attachment trauma (Lipton, 2010; Lipton & Fosha, in press), the felt sense of existing in the heart and mind of the other as oneself is compromised. The *felt sense* of attachment is either that they or their feelings don't exist for the Other (avoidant attachment) or that they exist only as a projection (disorganized attachment) or as a narcissistic extension (ambivalent attachment) of the caregiver. In insecure or disorganized environments, barriers against such negative receptive affective experiences are necessary to protect the core from corrosive shame and one's identity from being totally overwhelmed by them (Fosha, 2009b).

But barriers are barriers. They keep out not only what they were meant to keep out, i.e., negative experiences, they also keep out much that is good. To engender secure attachment in treatment, it is crucial that we work to deepen the patient's receptive affective capacity. We do so both by (i) working with attachment as an experience and (ii) working to bypass the barriers against receptive affective experiences.

To bypass that receptive barrier often requires that we *explicitly* express how the patient exists in our heart and mind (Fosha, 2002; Lipton & Fosha, in press; Prenn, 2009, in press), i.e., how we feel about and with the patient. And because self-disclosure is such a potent intervention (Prenn, 2009), metaprocessing the patient's reaction to it is essential. Receptive affective capacity is also enhanced when we actively and explicitly explore the patient's experience of us, i.e., the self's experience of the Other—all the more so when the experience is positive, as secure attachment-engendering experiences are (Schore, 2001). A (deceptively) simple way of doing this is through asking the question "what is your experience of me?," and then experientially exploring the patient's experience with the same interest, curiosity and rigor as we would any other emotionally laden experience. In working to develop and deepen receptive affective capacity, we are promoting here the development of *emotional mindfulness* (Frederick, 2009, 2010) with respect to receptive affective experiences. *Making the implicit explicit and the explicit experientia*l, with respect to both the expressive and the receptive aspects of attachment *experiences* of and for both members of the dyad is at the heart of the methodology by which AEDP seeks to heal attachment trauma, engender secure attachment and promote joyful intersubjectivity.

XIII. "This is what I did, and this is what happened:" The Ever-Emergent, Phenomenology-Guided Method of AEDP

AEDP is a method whose precision and rigor comes from the wired-in nature of somatically rooted affective/relational phenomena: moment-to-moment, they guide clinical work. Transformational theory, the theory of adaptive affective change processes, provides a map to understanding of affective and relational dynamics. Key here is (i) a familiarity with the invariant phenomenological features of emotional, relational and transformational experience (Darwin, 1872; Fosha, 2009a; James, 1890, 1902; Levine, in press; Tompkins, 1963; Tronick, 1989) and (ii) a capacity to read moment-to-moment fluctuations in the unfolding affective experience of patient, therapist and dyad. There is a precise phenomenology of the transformational process. There is an equally precise phenomenology of resistance-based phenomena. The impact of interventions can be evaluated by these phenomenological criteria.

Thus the motto of AEDP practice: "this is what I did and this is what happened." It makes us eternal students, eternally open to learning. It makes clear why videotaped based learning, teaching, self-study and supervision is essential. It allows the dialectic between freedom and rigor, between spontaneity and accountability, between uniqueness and invariance.

With some noteworthy exceptions, AEDP is not about proscriptions or prescriptions about

when to use what type of intervention. AEDP is about using phenomenological guidelines to assess how a given intervention just made by the therapist, (i.e., the “this is what I did,”) is actually working, (i.e., the “this is what happened”). And the “this is what happened” is construed in terms of the phenomenology of the transformational process (and its dialectical counterpart, the resistance process), which is the in-the-moment feedback for and from the patient’s deep body-brain-psyche-self and dyadic experience about this intervention.

What “this is what I did, this is what happened” means is that, in AEDP, the unit of intervention is not the therapist’s intervention*: in AEDP, the unit of intervention is the therapist’s intervention and the patient’s response to it*. What follows the intervention gives us essential feedback about the intervention and guides the next one. Did this intervention deepen somatic access or is the patient now more in her/his head? Did this intervention lead to more anxiety or better regulation? Did the felt sense of being in contact increase or decrease?

In this way, each patient-therapist dyad creates something of a dyad-specific manualized treatment—but one that is ever emergent, never fixed. It is in this way that the change process, ever emergent yet systematic, guides AEDP work with ever greater phenomenological precision and ever greater specificity, which allows deep attunement to the needs and characteristics of each patient. It is how we learn what constitutes safety for *this* patient, and the shape that her/his transformance strivings will assume when those universal, yet unique and specific to each person, conditions are met.

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Appendix I – The Wallace Stevens Poem

Thirteen Ways of Looking at a Blackbird

Wallace Stevens

I
Among twenty snowy mountains,
The only moving thing
Was the eye of the blackbird.

II
I was of three minds,
Like a tree
In which there are three blackbirds.

III
The blackbird whirled in the autumn winds.
It was a small part of the pantomime.

IV
A man and a woman
Are one.
A man and a woman and a blackbird
Are one.

V
I do not know which to prefer,
The beauty of inflections
Or the beauty of innuendos,
The blackbird whistling
Or just after.

VI
Icicles filled the long window
With barbaric glass.
The shadow of the blackbird
Crossed it, to and fro.
The mood
Traced in the shadow
An indecipherable cause.

VII
O thin men of Haddam,
Why do you imagine golden birds?
Do you not see how the blackbird
Walks around the feet
Of the women about you?

VIII
I know noble accents
And lucid, inescapable rhythms;
But I know, too,
That the blackbird is involved
In what I know.

IX
When the blackbird flew out of sight,
It marked the edge
Of one of many circles.

X
At the sight of blackbirds
Flying in a green light,
Even the bawds of euphony
Would cry out sharply.

XI
He rode over Connecticut
In a glass coach.
Once, a fear pierced him,
In that he mistook
The shadow of his equipage
For blackbirds.

XII
The river is moving.
The blackbird must be flying.

XIII
It was evening all afternoon.
It was snowing
And it was going to snow.
The blackbird sat
In the cedar-limbs.

The articulation of the principle is new. The practice is quintessential AEDP.

There is considerable empirical evidence, particularly from the growing neuroscientific evidence of plasticity in adult brains, for these foundational assumptions. However, presenting that evidence is beyond the scope of this paper. The interested reader is referred to Bushell, Olivo, & Theise (2009), Doidge (2007), Fosha (2009c), and Siegel (2007), among many works on the topic.

As already stated, access to transformance-based processes assumes that work with State 1 phenomena, i.e., defenses, dysregulation, inhibiting affects, has already taken place. It is also true that especially in patients with histories of severe

trauma, positive experience often triggers another round of dysregulation, or of pathogenic affects (Lamagna, in press; Lamagna & Gleiser, 2007). When that happens, it is a signal that another round of work with traumatic experience is on order.

Right brain to right brain communication is necessary but not sufficient for the entire AEDP endeavor. AEDP is an equal opportunity employer for all parts of the brain and nervous system: the role of the left brain in regulation, and of the integrative structures of the brain, e.g., insula, anterior cingulate, pre-frontal cortex, cannot be underestimated.

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