AEDP: Transformance In Action[1]

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It is a pleasure to have this opportunity to share some aspects of my work with the members of the community for which the GAINS newsletter is such a unifying source of communication, like-minded others whose ethos of healing is informed by attachment theory and affective neuroscience. Such an ethos is also central in the hearts and minds of practitioners of AEDP (Accelerated Experiential Dynamic Psychotherapy), an attachment & emotion & transformation model of treatment I have developed (Fosha, 2000, 2003, 2005), and that is now being embraced by many clinicians who work with adult trauma and other forms of emotional suffering.

This is the first of two communications on AEDP. In this first one, I am very excited to share with you the idea of *transformance*, a concept that I have just recently introduced and elaborated (Fosha, in press), and which I believe to be foundational to the type of work we all share in this community. In addition, I will delineate a series of specific affective phenomena which AEDP's transformance-informed healing orientation has brought to the fore. With this groundwork established, in my next communication, I hope show how the experiential work with intense emotion and transformation in an attachment context that characterizes AEDP becomes a specific methodology for the engendering of security of attachment. But first things first: I want to address the issue of transformation.

We have a fundamental need for transformation. We are wired for growth, healing, and self-righting. We have a need for the expansion and liberation of the self, the

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[1] Excerpted and modified from Fosha (in press). In K. J. Schneider (Ed.) "*Existential-Integrative Psychotherapy: Guideposts to the Core of Practice*." Routledge.

letting down of defensive barriers, and the dismantling of the false self (Ghent, 1990; Schneider, in press; Winnicott, 1960). We are shaped by a deep desire to be known, seen, and recognized (Sander, 1995, 2002), as we strive to come into contact with parts of ourselves that are frozen (Eigen, 1996). Along with needing to be known authentically, we have a need to know the other (Buber, 1965; Ghent 1990; Trevarthen, 2001), a profound and undeveloped aspect of attachment.

Transformance is my term for the overarching motivational force, operating both in development and therapy, that strives toward maximally adaptive organization, coherence, vitality, authenticity and connection. Residing deeply in our brains are wired-in dispositions for transformance. Naturally occurring adaptive affective change processes, such as emotion, dyadic affect regulation, empathic recognition of the self, etc., (Fosha, 2002), are manifestations of transformance. They are the processes through which AEDP accomplishes its therapeutic mission: we seek to facilitate therapeutic change through actively engaging these affective change processes from the first moments of the first therapeutic encounter. Positive vitalizing affective experiences are fundamentally linked with transformance and the moment-to-moment operation of these affective change processes; they mark it (somatic markers), accompany it (vitality affects), and are the result of it (transformational affects). The positive affects are desired states: as such, they themselves become motivational forces (Ghent, 2002; Sander, 2002).

Transformance is the motivational counterpart of resistance: it is driven by hope and the search for these vitalizing energizing positive affects (Fosha, in press). Resistance, on the other hand, is fueled by dread and the desire to avoid bad feelings -- be they deadening or terrifying. Whereas resistance drives processes that eventuate in

disorganization, deterioration, and languishing, transformance drives processes that eventuate in healing and thriving. The affective change processes mentioned above are entrained in order to be able to help the patient access heretofore feared-to be-unbearable emotions and process them to completion: the process of so doing results in state transformations and culminates in the vitalizing positive affects we call transformational affects and core state[2] (Fosha, 2003, 2005; Russell & Fosha, in press). The positive affects and positive affective states that are the culmination of processing intense emotion to completion via these affective change processes in AEDP are identical to the affects that characterize resilience, expansive growth and flourishing on one hand (Frederickson & Losada, 2005; Tugade & Frederickson, 2004), and Indo-Tibetan and other meditative practices on the other (Loizzo, in press). Such positive affects have been linked to altered frontal brain asymmetry and increased immune function (Davidson et al., 2003), enhanced mental and physical health, lower levels of cortisol, reduced inflammatory response to stress, longevity, increased intuition and creativity, as well as resilience to adversity (Frederickson & Losada, 2005). Thus engaging the forces of transformance and thus activating the positive affects that mark it, accompany it and result from it is vital in both therapy and life. And engaging the forces of transformance and harnessing them in the service of therapeutic results is precisely what AEDP is designed, and aims, to do.

In AEDP, the difference between whether we entrain the forces of transformance or the forces of resistance is determined by the attachment relationship. "Attachment decisively tilts whether we respond to life's challenges as opportunities for learning and expansion of the self or as threats leading to our constriction of activities and withdrawal

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[2] Both the transformational affects and core state will be the subject of the next communication and will be discussed there in detail.

from the world" (Fosha, 2006, p. 570). To entrain transformance forces, AEDP seeks to facilitate the co-creation of a dyadic relationship characterized by secure attachment from the first moment of the first session. Evolved to counter fear and protect against danger (Bowlby, 1988; Main, 1999), the attachment relationship is essential for the moment-to-moment regulation of intense emotion, which would otherwise be overwhelming and stressful (Schore, 2001). First through the regulatory powers of the attachment relationship and subsequently through its internalization into our self-regulatory repertoires, we harness the advantages evolution conferred upon us via the full experience of the categorical emotions. When turbulent emotions are regulated and processed to completion, we benefit from the expanded range of thoughts and behaviors they enable (Frederickson & Losada, 1995).

The therapeutic task is to create a safe environment in which the motivation for transformation can come to the fore. Such an environment is then buttressed by therapeutic efforts that help the aforementioned motivation grow stronger than the motivation for maintenance of the status quo (which upholds the principle that "the evil you know is better than the evil you don't," a motto for traumatized people everywhere).

Two different pathways are used by treatments that aim for therapeutic healing. The well-established pathway of seeking to overcome resistance, or fix what is broken, characterizes most systems of psychotherapy. Its assumption, articulated cogently by Alexander and French (1946), is that while resistance-driven functioning is inevitable, a corrective emotional experience is achieved when the repetition scenario unfolds but has a different ending. The road less traveled takes an altogether different pathway: rather than going for fixing what is broken (that comes later), this path involves the activation of

healing tendencies--the forces of transformance-- from the beginning and not just as a result of having worked through the damage of the past.

In AEDP, we don't just seek a new ending, but --and this is crucial-- also a new beginning (Fosha, 2000). As healing is possible from the get-go, we aim *to lead with a corrective emotional experience*. Towards that end, from the beginning, we are on the lookout for glimmers of transformance and resilience, and we focus on these and amplify them. In the right environment,[3] dispositional tendencies toward healing and self-righting that are dormant, frozen, or moribund can begin to emerge (Eigen, 1996; Ferenczi, 1931; Ghent, 1990; Winnicott, 1960). Thus resourced, the patient becomes a partner for the journey ahead. We call this "working with the self-at-worst from under the aegis of the self-at-best" (Fosha, 2002, 2005; Fosha & Yeung, 2006).

In addition to its transformance-based, healing orientation, I will focus here on seven other fundamental and holographic aspects of AEDP:

<u>1. Attachment-Based Stance Sprinkled Liberally with Intersubjective Delight in the Patient</u>: The therapeutic relationship in AEDP aims to be the secure base from which experiential explorations of deep, painful emotional experiences can be undertaken. Key to AEDP's attachment stance is that the patient not be alone with overwhelming emotions. The AEDP therapist, aiming to promote security of attachment, intersubjective contact and to facilitate affective experience, is explicitly empathic, affirming, affect-regulating, and emotionally engaged, broadcasting the willingness to help. Such an

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[3] By *environment* here, I mean the human environment that any dyad co-constructs. In a therapeutic setting informed by an attachment perspective, however, the therapist has a greater role in setting its tone and parameters. As Lachmann (2001) has said, in caregiving dyads, be they mother-infant, or therapist-patient, the bi-directional process of influence characterizing such dyads is indeed mutual, but asymmetric. A similar point is made by Hughes (2006).

attachment relationship obviates the fear associated with intense, stressful-when-not-regulated, emotional experience (see dyadic affect regulation below). Similarly, the therapist's delighting in the patient, while in active intersubjective engagement, is a powerful antidote to the patient's shame and evokes the positive affective experiences associated with health, optimal development and thriving (Trevarthen, 2001). With fear and shame reduced, the defenses erected to protect the self can come down, yielding access to more somatically-based primary emotional experience (Fosha, 2003, 2006; Hughes, 2006; Lamagna & Gleiser, in press; Tunnell, in press).

Two features distinguish AEDP's use of attachment: (1) Attachment is not the *aim of* therapy, but rather the *sine qua non for* therapy. Secure attachment in the therapeutic relationship is what we seek to entrain from the start, so as to optimize experiential work with intense emotions. (2) It is not sufficient that attachment operate implicitly, working as the background hum against which experience takes place. The patient's *experience* of the attachment relationship needs to be a major focus of therapeutic work (Fosha, 2006). When it is, its exploration can deepen and solidify security, and energize a whole new set of explorations (for example, see Fosha, 2006).

<u>2. Dyadic Affect Regulation</u>: AEDP's fundamental goal --*that the patient not be alone with overwhelming emotions*-- is achieved through the process of dyadic affect regulation. The process of dyadic affect regulation proceeds through countless iterations of cycles of attunement, disruption, and then, through repair, the re-establishment of coordination at a higher level. Moment-to-moment affective communication between dyadic partners occurs through non-verbal, right-brain-mediated processes involving fluctuations in gaze, tone of voice, rhythm, touch, and other vitality affects. Right-brain

to right-brain communication is how members of the dyad establish coordinated states. However, if attunement is where self and other resonate, disruption is the realm of being on disturbingly different wavelengths. Disruption occurs when experiences that are outside the coordinated state burst forth. Though invariably accompanied by negative affects, the disruption of coordination, if repaired, is a major source of transformation. Repair involves establishing a new, expanded coordinated state where differences can be encompassed and integrated at a higher, more expansive level. "The flow of energy expands as states of brain organization in the two partners expand their complexity into new and more inclusive states of coherent organization, enabling the infant to do what it would not be able to do alone" (Sander, 2002, p. 38).

The achievement of the new coordinated state is a vitalizing, energizing human experience. It gives rise to new emergent phenomena which transform and expand both dyadic experience, and the experience of each dyadic partner, reflecting how being together changes each of them (Fosha, 2003; Hughes, 2006; Sander, 1995, 2002; Schore, 2001; Tronick, 2003).

3. The Experiential Method: Precise Phenomenology and Moment-to-Moment Tracking of Affective Experience, Moment-to-moment we track fluctuations of the emotional experience of patient, therapist, and the dyad. The steady somatic focus on the patient's experience and its felt sense (Gendlin, 1981) accomplishes three therapeutic goals: it reduces anxiety; it lets the patient drop from a defensive position to one more connected with emotion; and, finally, it increases access to right-brain-dominated, affectively loaded experiencing (Fosha, 2003; Fosha & Yeung, 2006).

The transformational process is guided by the somatic markers of healing transformational processes that Mother Nature wired into our brains and bodies. Invariably positive, these somatic markers--e.g., smiles, deep in-and-out breaths, dyadically coordinated head nods, sideways head tilts, upward gazes--signal moment-to-moment that the therapeutic process is on the right track.

4. Emotion and the Body: Working with Deep Emotions to Completion: Nothing That Feels Bad Is Ever the Last Step. Adaptive, transformational emotional experiences involve the body and are rooted in the deep subcortical regions of the brain. Emotion is both the target and the agent of change. The processing to completion of the somatically-rooted experience of previously unbearable core affects in the here-and-now of the patient-therapist relationship is the central agent of change in AEDP. After defensive blocks are removed and the inhibiting impact of pathogenic shame and fear has been alleviated, we work to facilitate access to the direct somatic experience of subcortically-generated (Damasio, 2001) and right-hemisphere-mediated (Schore, 2001) categorical emotions and other adaptive core affective experiences (Fosha, 2003). We seek to deepen patients' experience, and work it through to completion until the adaptive action tendencies of each emotion are released and the patient's access to resources and resilience opens up (Fosha, 2000, 2004, 2005).

5. Focusing on the Experience of Transformation Itself Becomes a Transformational Process: As all experientialists know, focusing on an experience transforms it (e.g., Gendlin, 1981). IN AEDP, having processed emotional experience to completion, and thus effected one state transformation, we do not stop there. We go for yet another. A major aspect of AEDP is the focus on, and the affirmation of, the

experience of transformation itself, particularly *the experience of the transformation of the self in the context of a healing dyadic relationship*. We call this activity *metatherapeutic processing* since we are exploring what is therapeutic about the therapeutic process, and we call the affects the metatherapeutic exploration yields the *transformational affects*.

Metatherapeutic processing involves alternating between experience and reflection on experience, and then continuing to experientially explore the patient's changing experience upon having articulated something about the experience through having reflected on it. Once each new experience is elaborated through this going back and forth between experience and reflection, it becomes the departure point for the next round of exploration. Having discovered that focusing on and experientially exploring the experience of transformation itself becomes a transformational process, we thus unleash a *cascade of transformations* (Fosha, 2005, 2006; Fosha & Yeung, 2006; Russell & Fosha, in press).

6. Receptive Affective Experiences Are the Stuff That Attachment and Intersubjectivity Are Made of.. It is not sufficient that empathy, care, love, or help be given: to work their potent magic, they must be taken in and used. *Receptive affective experiences* of feeling seen, held, understood, helped or recognized are also rooted in the body, and have a felt sense specific to them: exploring them allows us to know whether, and how, what is being relationally given is being received. Thus, we explicitly explore the patient's *experience* of receiving empathy, or care, or being the object of the other's delight or interest. Once we address defenses and fears that stand in the way of the patient's capacity to take in and use good stuff, we then work to deepen the patient's

receptive capacities. Being able to receive emotionally is necessary if the vitality and security that are the aim of attachment and joyful intersubjective contact are to become integrated mainstays of the patient's core identity and sense of self. .

7. Vitalizing Positive Affective Experiences Associated with Transformance. A felt sense of vitality and energy characterizes transformance-based emergent phenomena. 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 very positive phenomena as energizing growth, healing, and expansive, enriching exploration. We are talking about three related but separate sets of affective phenomena: (i) the somatic markers that signal that the healing transformational process is on track; (ii) the positive vitality affects that accompany transformance experiences; and (iii) the transformational affects that are the emergent phenomena of metatherapeutic processing, i.e., the affects that emerge when the patient's experience of transformation becomes the direct and explicit focus of the therapeutic process.

Rooted in the body, they mark transformational processes on an optimizing path: going beyond symptom relief and stress reduction, we are in the of thriving, flourishing and resilient functioning (Frederickson & Losada, 1995; Tugade & Frederickson, 2004; Russell & Fosha, in press). Moreover, these positive vitalizing experiences are the affective correlates of a neurochemical environment in the brain which is maximally conducive to optimal learning, development, and brain growth (Schore, 2001).

In conclusion, the idea of transformance as the healing motivational counterpart of resistance can function as an organizing construct for healing oriented therapeutic

endeavors. The phenomenological specificity of the new categories of affective experience briefly discussed here can be the signposts guiding that process moment to moment.

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