"*NOTHING THAT FEELS BAD IS EVER THE LAST STEP.*" [1]

THE ROLE OF POSITIVE EMOTIONS IN EXPERIENTIAL WORK WITH DIFFICULT EMOTIONAL EXPERIENCES

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[1] The title of this paper comes from Eugene Gendlin's book *Focusing* (1981). Here is a larger excerpt of the text from which the title sentence comes: "You feel better because your body feels better, more free, released. The whole body is alive in a less constricted way.... No matter how frightening or intractable a problem looks when it first comes to light, ... at the very next shift it may be quite different. *Nothing that feels bad is ever the last step*" (p. 25-26).

Abstract. The goal of this paper is to show (i) how the moment-to-moment tracking and processing of emotion *to completion* --in an emotionally engaged patient-therapist dyad where the individual feels safe and known-- constitutes a powerful mechanism of therapeutic transformation, and (ii) how positive emotions are sensitive affective markers of that transformational process. Evidence from *transformational studies* is used to elaborate the vital role of positive emotions in the process of change in general, and, more specifically, in the course of therapeutic work with painful and overwhelming emotional experience. It is proposed that these emergent positive emotions are affective markers which signal the operation of healing transformational processes in psychotherapy. Several types of positive emotion that arise spontaneously during moment-to-moment experiential therapeutic work will be described and their role as markers of different transformational processes will be elucidated. The paper begins with examples of clinical work with emotion in AEDP (Accelerated Experiential-Dynamic Psychotherapy), an emotion-focused and attachment-based model of therapy that places the dyadic regulation of affect at the center of both theory and practice.

The goal of this paper is to show, through example and argument, how the moment-to-moment tracking and processing of emotion *to completion* --in an emotionally engaged patient-therapist dyad where the individual feels safe and known-- constitutes a powerful mechanism of therapeutic transformation, and how positive emotions are sensitive affective markers of that transformational process. I begin with two clinical examples of work with emotion in AEDP (Accelerated Experiential-Dynamic Psychotherapy), an emotion- and attachment-centered model that integrates experiential and psychodynamic elements (Fosha, 2000b; 2001; 2002a; 2003).

Vignette # 1. ***"I did the right thing:" Categorical Emotions and the Release of Adaptive Action Tendencies.***

Sam, a man with a history of early abuse, rejection, and betrayal sought treatment for the severe depression that followed the break-up of a relationship. Intensive psychotherapeutic work cleared his depression and led to a long period of being symptom-free and feeling well. However, Sam arrives for the session described below having felt worse in the days preceding it than he had in a long time.

In the session, Sam reports that, for days, he has been in the grips of an emotional pain that

he has experienced in his body, with no thoughts about the reasons for it. I focus on Sam's somatic pain, e.g., exploring where and how he feels it, and encourage him to stay with his experience of it. Tracking his experience moment-to-moment, some possible links emerge between his somatic state and some recent events. By staying connected with and pursuing the painful reactions, the message is that in the therapeutic relationship, deep feelings –his and mine— can be tolerated without the disconnection and humiliation with which his early attachment figures had met his emotions. As his affect deepens, Sam starts to thaw. Thoughts begin to flow. Gradually, the physical experience of pain becomes grief -a categorical emotion- and Sam is overcome by sobs: though his body is shaken by waves of grief, his earlier physical rigidity is no longer present (see Lindemann, 1944, on the symptomatology of acute grief). What is coming up for him are the feelings of loss he had when his relationship broke up. As Sam surrenders to his feelings instead of trying to control them, his affect deepens further. Between the waves of grief, his speech becomes increasing flowing. At the end of a particularly intense wave, Sam takes a *deep sigh* (N.B.), sits up straight, and looks directly at me. Though brimming with tears, his eyes are clear. *He takes another deep breath and there is a pause*. Then he says "I did the right thing….. I know I did the right thing." This is followed by another wave of affect, but this emotion is different: rather than grief, the patient is feeling moved.

Now in full contact with his emotional experience, Sam speaks about how, during the breakup with his girlfriend and in its aftermath, he acted with dignity, honesty, and compassion, the opposite of the ways of his abusive parents. As we focus on his experience of "I did the right thing," he feels a great deal of pride for how he conducted himself. He comes to realize that the emotional pain had been not so much about the loss --though that had been terribly painful for him, he had in fact largely come to terms with-- as about the lack of recognition and acknowledgement of his efforts. He grieved for not having been seen, recognized, or validated.

The full experience of the core affect of grief –with visceral access to its somatic concomitants within a supportive, affect-facilitating, affect-regulating dyadic relationship— released grief's adaptive action tendencies. The moment that signaled the transition toward

resolution and completion was the deep sigh that Sam took: that sigh, and the next sigh and the pause that followed it, were the affective markers that signaled that the wave of grief was completing and another state was emerging. Within seconds of the sigh, the patient accessed a clear and the strong sense of having done the right thing. Here we see how the self-validation that scaffolds and solidifies the patient's positive sense of self emerges from the exploration of the experience of emotional pain associated with loss, and lack of recognition. Having dealt with the negative feelings, the positive feelings are liberated and can emerge.

Vignette # 2. "So Freeing, So Painful, So Wonderful, So True:" Core State[2]

Below are excerpts from a session from a therapy that is in the termination phase. It followed a series of sessions during which Dan[3] *worked through intense emotions, primarily anger and grief, toward significant figures in his early life. The session occurred on March 18, 2003, the day before the US went to war with Iraq, and a couple of days after the patient had seen "The Hours," a movie that deals with loss and transcendence through facing the truth.*

Pt: I am feeling very moved… I am mourning the loss of my mom in some ways… [in some ways] the loss of innocence… I am realizing more and more that people have to do what they have to do. And people will be hurt and there is no way around that. And yes, that will happen. And that's what is. [It's not about] goodness, [it's not about] badness. The choice is whether to live or to be the living dead…

Th: Such a beautiful capturing of essence in one sentence

Pt: Well, it's so close to home for me in light of coming to the end of our work and thinking about where I have come from … I didn't have this image until now but it's been about going into

[2] The term "core state" will be defined below.

[3] Given the ubiquity of the phenomena under description, I imposed upon myself the constraint that all material I used in this paper come from recent sessions. In fact, both vignettes occurred in the same week, at a time when I was actively working on this paper. By chance, and not by initial design, both patients in these vignettes are male. However, given that experiential, empathic, emotion-focused therapy approaches often stimulate the gender question in audiences, i.e., is such an emotion-focused approach more suited to women, I decided that it would be just fine to have examples of males exploring intense emotional experiences and reaping the benefits such experiencing provides. This choice also affected how I dealt with the pronoun dilemma: I opted to refer to the patient throughout the text as "he," and the therapist as "she," a solution which also preserves the ecological validity of these particular male patients working with this particular female therapist.

the river… There is something about being taken by the current and surrendering to the experience of life and… not resisting it … it's profound… it's so freeing, and it doesn't mean that it's happy

Th: Right… it's not about happy because there is so much pain

Pt: But it's free. So painful and so wonderful… and so true

[a little later in the session]

Th: What's inside right now?

Pt: I don't now if I have the words… the same thing… sadness… it's that same feeling, it's like mourning, but like post-mourning… it's sadness but also feeling free… perhaps what makes me anxious is that these are such big and deep feelings and they are scary…. (*very deep big si*gh)….

Th… Very deep… just stay with that

Pt: This whole conversation, what's so great about it, even though I had a moment of anxiety, I think it was a vestige of being in this kind of deeper… feeling place, and then I got anxious and then you helped me get back here, and it feels easy … and it's calm

Th: Uh huh

Pt: I don't know just how to articulate it but I feel like it's being able to be in this place and it's kind of knowing that this how it is… I'm just going to go with this (big shy smile)… It's what's going to hold me when I am not coming here. A kind of comfort with painfulness… It's weird… It's the antithesis of doing anything… I was thinking that for so many people in my family doing is a way of not feeling

[and then again, from the closing moment of the session]

Pt: (*deep sigh*)…. This is not an easy place to get to, you know… I think it's pretty impressive for me to be in this place… This is such a wild time in the world and for me… I just feel so lucky to be [feeling like this]... Isn't it crazy for me to be saying this? But it's true. I feel lucky to be feeling what I am feeling

Th: Can I ask you a question? I am just finishing a paper that I am writing. Can I use some sentences from this session, I mean not describe your "case," but just what you said?

Pt: Of course. Can I ask what?

Th: Yeah... this whole conversation and your talking about the state of being deeply alive and full of pain and yet the calmness of that… That is precisely what I am trying to write about.. I want to quote you, 'cuz you said it so beautifully

Pt: Oh yeah, cuz you have the videotape… Sure… That's so sweet…. What you're really doing is giving me a gift too

Th: Yeah? This session was so gorgeous, so gorgeous, and you said it so beautifully too

Pt: What's the paper on?

Th: It's in part about the role of positive experiences in therapy… and about this stuff which feels somehow good even though it's not about being happy, that's the point of the paper.

Prior to therapy, Dan worried that fully experiencing his feelings would overwhelm him and destroy others. He expended a lot of psychic energy keeping feelings at bay, and spent much time feeling anxious and wracked with self doubt. Through developing a therapeutic relationship where his emotions welcomed and met, Dan was able to access, experience, express, and work through sadness and anger and grief and remorse, which in turn lead to many realizations. Having experienced first hand many, many times the relief and benefits of feeling, and feeling fully, rather than avoiding feeling, he developed more confidence in the validity of his reactions.

By the time of the session above, Dan had become able to, in life and in therapy, feel his feelings, and thus also sometimes access *core state*, a state of calm, relaxation, depth of feeling clarity and often remarkable eloquence, that follows in the wake of intense emotional experience (Fosha, 2002a, 2002b, 2003). In the core state—unhampered by defenses, not made small by fear or shame, but instead enlarged by feeling and dealing (Fosha, 2000b, Chapter 3)— the individual has the freedom to reflect and make meaning of his life. Thus, with the characteristic eloquence of core state, Dan cuts to the heart of the matter.

Exploring the Role of Positive Emotions in Psychic Life

As of late, there is a groundswell of interest in positive emotions and a growing awareness of their importance in promoting psychological health and well being. Positive emotions have been the focus of popular books (Dalai Lama & Cutler, 1998), of popular psychology (Seligman, 2002), of well-designed, rigorous psychological studies (see Seligman, 2002 for references), of works on attachment, brain development and nonlinear dynamic systems (Granic, 2000; Schore, 1996, 2000; Siegel, 2003), and of the most rigorous realms of experimental affective neuroscience (Davidson, 2000; Panksepp, 2000).

However, to date, these contributions, if addressing psychotherapeutic implications at all, have been, at best, generic: Not tethered to the reality of clinical process, these contributions have engaged neither the clinical phenomenology and dynamics of positive emotions, nor how to technically foster their emergence and put them to beneficial therapeutic use in a process usually devoted to the exploration of negative emotional experiences.

In an attempt to rectify this situation, in this paper I will explore the phenomenology and dynamics of positive emotions, focusing on their role as affective markers of transformational processes at work[4]. My exploration will be done in the context of AEDP which places the dyadic regulation of the experience of emotion, and thus the therapist's emotional engagement, at the center of both its theory and its therapeutics (Fosha 2000b, 2001, 2002a, 2003). The work on positive emotions occurs in the larger context of AEDP's focus on emotion as a major agent of change in psychotherapy. Key aspects of AEDP will be highlighted to provide the context in which these positive affective experiences can be experientially explored.

First, I briefly describe AEDP. Then, features of the process of discontinuous, non-gradual change, a process in which the experience of emotion is central, are described based on evidence from *transformational studies*, which involve the study of change processes, particularly those

[4] Whereas in this paper, positive affective experiences are explored in terms of their role as markers of the transformational process, elsewhere (see Fosha 2000b (Chapter 8), 2002a), there are technical discussions of how to work with the positive emotions that emerge in the course of experiential treatment so as to maximize the enormous therapeutic opportunities they provide.

involved in non-gradual transformations. Then, the vital role of positive emotions in the process of change in general, and, more specifically, in the course of therapeutic work with painful and overwhelming emotional experience, is elaborated. Experiential theorists (Gendlin, 1981, 1996; Levine, 1997) have emphasized that the process of change *feels* good, as it activates powerful, adaptive, wired-in organismic tendencies toward self-healing. Building on their work, I propose that certain positive emotions function as affective markers which signal that healing transformational processes are in operation in psychotherapy. Several types of positive emotion that arise spontaneously during moment-to-moment experiential work with intense and painful emotions are then described. A major focus throughout will be the importance of the *moment-to-moment tracking* and working through of emotional experiences *to completion*, so that the state transformation heralded by the positive emotions can be actualized and the most can be made of the therapeutic opportunities residing within the new emergent state.

On AEDP

AEDP roots its conceptual framework within the paradigm that is currently being forged by the explosion of new knowledge emerging from attachment theory and affective neuroscience (Fosha, 2003). The aim of the therapy is not so much to undo pathology, as it is to dyadically co-create new positive experiences with and for the patient, experiences involving adaptive emotions in the context of a supportive, authentic, emotionally engaged relationship. The three distinctive aspects of AEDP that I wish to emphasize are (i) the kind of therapeutic relationship we aim to develop, which is empathic, affirming, affect-facilitating, affect-co-regulating, and emotionally engaged; (ii) the fundamental importance of emotional experience, viscerally experienced, and (iii) the healing-centered --rather than pathology-centered-- orientation of the approach.

In AEDP, we aim to first create an emotional environment in which the patient's resources are most likely to be activated and then work to bring these to bear on therapeutic work with

pathological processes (see Fosha (2003) on working with "self-at-worst" functioning from the vantage point of "self-at-best" functioning). Pathology is understood as adaptive processes gone awry. Like the Gendlin quote of the title suggests, it is AEDP's core assumption that the potential for healing resides within each individual, regardless of how severe the extant psychopathology. In treatment, we seek to engage and entrain two powerful, naturally occurring processes of healing and transformation, i.e., attachment and emotion. Moment-to-moment, from the beginning and throughout the therapeutic process, the co-construction of dyadic processes of affect regulation to foster attachment and experiential access to core emotional experience are the twin foci that inform the presence and activity of the AEDP therapist.

The goal of AEDP is to provide the patient with an experience. The fostering and provision of new and healing emotional experiences is AEDP's method and its aim. AEDP theory, stance, and technique are oriented to ensure that that experience is good. AEDP achieves its aim through entraining and harnessing the healing power of naturally occurring *affective change processes*, such as emotion, dyadic affect coordination, empathic reflection, somatic experiencing, and metatherapeutic processing (Fosha, 2002a).

The key mutative agent in AEDP is the state transformation leading to the embodied (visceral, somatic) experience of core affective phenomena within an emotionally engaged dyad (Fosha, 2000b; Fosha & Slowiaczek, 1997). In order to entrain and harness the transformational power of emotion, emotions must be (a) experienced in a visceral, embodied way; (b) tracked moment-to-moment; (c) regulated; and (d) worked to completion. Core affective experience involves a state transformation in which (a) defense, anxiety and shame, on one hand, and the static of ordinary interaction on the other, are absent; and (b) the individual is absorbed in and by his emotional experience.

Rooted in the experiential STDPs (see also Davanloo, 1990; McCullough, 2003; Osimo, *in press*), AEDP uses specific techniques to achieve these aims. Some of these include: *psychodynamic-restructuring* techniques to bypass defenses against emotional experience as rapidly as possible; *dyadic-relational* techniques to develop the affect regulating attachment bond

and to minimize the inhibiting impact of pathogenic affects like fear and shame; *experiential-affective* techniques to facilitate and work through core affective experience; and *reflective-integrative metatherapeutic* techniques to promote the development of the individual's capacity to construct a coherent and cohesive autobiographical narrative[5]. (Fosha, 2000b; Fosha, 2002a; Fosha & Slowiaczek, 1997).

Through tracking emotional experience moment-to-moment as it is being experienced and expressed by the individual interacting with an attuned and caring other, adaptive core affective experiences[6] can be processed to completion. This completion of the cycle of emotional experiencing is affectively marked by the positive emotions that are the subject of this paper.

Transformational Studies

Clinical experience with AEDP and of other experiential approaches makes clear that the phenomena of the process of change associated with healing experiences rather than occurring slowly, gradually and in small steps, often tend to be rapid, sudden and to occur in quantum leaps, and to often involve discontinuous *state transformations* (Fosha, 2002a).it became obvious that the process of change itself needs to be studied. While psychotherapy has tended to rely upon a theory of psychopathology as its model, given that psychopathology and healing are characterized by qualitatively different processes and operate via different mechanisms, it is increasingly obvious that a theory of transformation is necessary to account for the phenomena of experiential therapies. I am hereby inaugurating *transformational studies* as the term for work from different disciplines concerned with the study of discontinuous, non-gradual transformations (Fosha, 2002a): how do they operate, what are the factors that promote such processes, and what are the phenomena that characterize them are some of the questions that works in transformational studies seek to address.

I have gone for inspiration to a number of sources all of which have explored the phenomena

[5] See Siegel, 2003, for how the capacity for a cohesive and coherent autobiographical narrative is linked to secure attachment, resilience in the face of trauma and other indices of optimal psychological function.

[6] See Fosha, 2000, 2002, on transforming affects vs. affects that need transforming; and Greenberg & Paivio, 1997, on primary adaptive vs. primary maladaptive and secondary emotions.

of mechanisms of transformation involved in big, sudden, lasting change, and not only small, gradual, cumulative change. Thus, AEDP's healing-centered model integrates the contributions (a) of Darwin (1872), William James (1890, 1902), Tomkins (1962-3), and Damasio (1994, 1999) on emotion; (b) of the clinical developmentalists, like Tronick (1998), Beebe and Lachmann (2002), Trevarthen (1993, 2000) and Stern (1998; Stern et al., 1998), on the characteristics of moment-to-moment interaction both between mothers and babies and patients and therapists; (c) of the experiential STDPs on the rapid bypassing of defenses and accessing of visceral core affective experience (Davanloo, 1990; McCullough et al., 2003; Osimo, in press); (d) of experientialists on somatic focusing so as to access the power of the body as its own healer (Gendlin, 1981, 1996; Kurtz, 1990; Levine, 1997); (e) of other emotion-focused experiential therapists (Daldrup et al., 1988; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1994; Johnson, 1998; Kepner, 1993); (f) of William James (1902) on religious experiences and conversion phenomena; (f) of Martin Buber (1965) on "moments of meeting" in the interhuman encounter; and (g) of Ethel Person (1988) on the transformational potential of romantic love and passion.

All these works on transformation, in addition to my own work, (Fosha, 2000b, 2002a, 2003) consider *emotion* as a central transformational agent and document its power to affect transformations in quantum leaps, i.e., state transformations. Listen to what William James has to say about the transformational power of emotion:

"Emotional occasions . . . are extremely potent in precipitating mental rearrangements. The sudden and explosive ways in which love, jealousy, guilt, fear, remorse, or anger can seize upon one are known to everybody. Hope, happiness, security, resolve . . . can be equally explosive. And emotions that come in this explosive way seldom leave things as they found them." (James, 1902, p. 198).

Person (1988) speaks about the transformational potency of a very special emotion, love, more specifically, romantic love:

"Romantic love offers not just the excitement of the moment but the possibility for dramatic change in the self. It is in fact an agent of change. . . . Romantic love takes on meaning and provides a subjective sense of liberation only insofar as it creates a flexibility in personality that allows a break-through of internal psychological barriers and taboos. . . It creates a flux in personality, the possibility for change, and the impetus to begin new phases of life and undertake

new endeavors. As such, it can be seen as a paradigm for any significant realignment of personality and values" (p. 23).

And here is Peter Levine on how emotion fosters the organism's capacity to re-engage in adaptive self-regulation:

"Through transformation, our nervous system regains its capacity for self regulation. Our emotions begin to lift us up rather than bring us down. They propel us into the exhilarating ability to soar and fly, giving us a more complete view of our place in nature" (Levine, 1997, p. 193).

All emphasize the fundamental importance of emotion in producing sudden, discontinuous change. Next, let's consider the nature of emotion as a central mechanism of change and as a central mechanism in AEDP.

Emotion as a Transformational Change Agent: The Categorical Emotions

Adaptive processes, emotions are important regulators and organizers, operating at the interface of psyche and soma, self and other, individual and environment, brain and mind, body and culture. Appraisal processes (Lazarus, 1991) that amplify and make salient that in the environment which is most important to the individual (Tomkins, 1962-3), emotions motivate actions (in self) and responses (in others). Emotion is primary in organizing attachment and how self and other are experienced. For Darwin (1872), as for Bowlby (1977, 1991), the most important function of emotional expression is communication. Through emotions, we are able to communicate to ourselves and to others that which is of importance (Bowlby, 1991).

The *categorical emotions*, i.e., fear, anger, sadness, joy, and disgust, are those emotions wired in by eons of evolution. The grief experienced by Sam in the first vignette is an example of a categorical emotion. Darwin (1872) was the first to describe the phenomenology and dynamics of categorical emotions and appreciate their importance in human adaptation. Damasio (1999) conceives of them as distinct, wired in "neural dispositions" that are induced at a number of highly specific subcortical and cortical brain sites (p. 60-61). Each categorical emotion has a specific and universal biological signature, and is also associated with an *adaptive action tendency* that "…offers a distinctive readiness to act; each points us in a direction that has

worked well to handle the recurrent challenges of human life" (Goleman, 1995, p. 4). In addition, from a psychological point of view, each categorical emotion is a magnet for a complex constellation of feelings, memories, perceptions, sensations, and self-other representations. Even when the categorical emotion is itself negative and/or painful, as in the case of anger or grief, the state resulting from the exercise of the adaptive action tendencies is highly positive. For example, the adaptive action tendencies released by fully experienced anger often include a sense of strength, assertiveness and power, which lead to the rediscovery of psychic strength, self-worth, and affective competence.

The full experience of a categorical emotion involves two state transformations, both highly therapeutic: (1) The first state transformation involves accessing the visceral experience of the emotion: the body, the senses, the muscles, the viscera, the face, the skin, the respiratory system etc., need to be involved. Once defenses and pathogenic affects are no longer prominent[7], the individual gains access to the previously off-limits network of feelings, thoughts, memories, and fantasies associated with the experience of the emotion, which allows the deep working through of dynamic material related to the roots of the patient's pathology. Thus, the experience and expression of core emotion is *the royal road to the unconscious* (Fosha, 2000b, 2003). (2) When the emotion is worked through to *completion*, the second state transformation occurs: the emotion's adaptive action tendencies are activated, and another state emerges. The individual (re)gains access to deep emotional resources, renewed energy, and an adaptive repertoire of behaviors. The individual's new responses reflect access to new emotional information --about the self, the other, and the situation-- that was not accessible prior to the full experience of the emotion.

The Dyadic Regulation of Emotion as a Transformational Agent

All that I have just described occurs in the context of an attachment based relationship. The basic mechanism of attachment has been described as operating through the moment-to-moment

[7] How to get past defenses and the pathogenic affects of fear and shame is what the techniques of STDP are all about.

psychobiological state attunement that mother and infant strive to attain and maintain (Schore, 1996; Trevarthen, 1993). Attachment relationships that promote optimal brain chemistry, engender security, and maximize learning and adaptation are good at minimizing the time spent by the child in negative affect states (stress) and maximizing time spent in positive affect states; they do so not through denial or avoidance of negative emotion, but rather through the dyadic processing of the negative states that can otherwise get derailed, beginning the process by which psychopathology is engendered (Schore, 2000). It is now thought that "the process of reexperiencing positive affect following negative affect may teach a child that negativity can be endured and conquered… Infant resilience is currently being characterized as the capacity of the child and the parent to transition from positive to negative and back to positive affect" (Schore, 1996, p. 709-710). That transition requires attunement, and a focus on the positive emotion-generating properties of adaptive emotional states, including negative ones.

Categorical emotions are intense and thus in need of regulation, for fear, anger, sadness, joy, and disgust, are forces to be reckoned with. Dysregulated emotions do not proceed to completion, and their adaptive action tendencies do not get entrained. Having more of a disorganizing than an organizing effect, dysregulated emotions do not promote adaptive functioning. To the contrary, dysregulated emotions, a consequence of stress, themselves become sources of stress for the individual, reproducing trauma or deprivation --initially externally experienced—within the internal environment of the psyche.

In normal development, and throughout the life cycle, emotions are regulated in a dyadic fashion. Through the dyadic process, the individual is are able to emotionally process what he is not able to process alone (Fosha, 2001). When regulated and fully processed, the transformational potential of emotions and their contribution to enhanced functioning is enormous. However, in considering the *dyadic* aspect of emotion regulation, it is important to emphasize that *dyadic* means *dyadic*: The caregiver's affects are part and parcel of the process of dyadic affect regulation, be it developmental or therapeutic. One cannot do dyadic affect regulation by oneself, for it truly takes two to tango. Furthermore, given phenomena such as affect contagion

and the fundamentally expressive and communicative function of emotion, to do emotion work with a poker face would at the very least be counterproductive.). Both affect work and the construction of the intersubjective experience are best served by the full emotional participation of both members of the dyad.

In AEDP work with emotion, the therapist's part in the dyadic regulation of affect involves not only empathy, contact, affirmation, sharing and bearing, and support. It also involves being emotionally affected by the patient and letting the patient know that. The experience of making an impact on an attachment figure, and being able to have a sense of agency in relational experiences, a profound and healing experience for most people, is all the more so for those individuals with histories of trauma, neglect, abandonment, and loss who felt helpless to affect their dyadic partners.

In an environment where one's emotions are affirmed, scaffolded, and/ shared by the other, it becomes safe to be oneself and to explore all sorts of intense, difficult feelings, without fear of being overwhelmed (the other is there to support) or of being shamed (the other is there, accepting). With safety, and without the pathogenic inhibiting impact of fear and shame, the patient can own and explore all his reactions and the moment-to-moment therapeutic process can become actively healing. Thus, emotion work occurs in optimal fashion in an emotionally engaged dyad within which the individual feels safe (attachment) and known (intersubjectivity).

The Experience of Transformation in the Process of Transformation

Think of the calm that follows a good cry, of the sense of strength and clarity that emerges after the full expression of previously suppressed angry feelings. The lesson of the experiential orientation is that change feels good.

"Another major discovery is that the process of actually changing feels good. Effective working on one's problems is not self torture. The change process we have discovered is natural to the body, and it feels that way in the body. The crucial move goes beneath the usual painful places to a bodily sensing that is at first unclear. The experience of something emerging from there feels like a relief and a coming alive….. One of the chief new principles is that the change process feels good" (Gendlin, 1981, p. 8).

From an experiential perspective, we are interested not only in the process of change, but also in the *experience* of change, and it is *that experience of change* that we seek to foster in our patients. As Gendlin (1981) says,

> "There is a distinct physical sensation of change, which you recognize once you experienced it. … When people have this even once, they no longer helplessly wonder for years whether they are changing or not. Now they can be their own judges of that." (p. 7)

Somatic experiencing aims to change the focus from the head (cognitive, intellectual, verbally dominated) to the body (somatic, sensory, visual) by fostering a process of moment-to-moment tracking of the body's shifting experiences. Thus, in order for the patient to have an emotional experience, including an experience of *transformation*, the body must be involved. By body, I mean something very complex. By body I mean the collection of biological intelligence (Gendlin, 1981), the exquisite feedback and integration between the body and all of the regions of the brain where body state and homeostasis are mediated (Damasio, 1994, 1999). By body, I mean psychesoma (Winnicott, 1949), before psyche and soma split apart.

Key to accessing the experience of the soma and the sense the psyche makes of it is the *felt sense*, "the experience of being in a living body that understands the nuances of its environment by way of its responses to that environment" (Levine, 1997, p.69). The felt sense is the experiential totality of that gestalt of brain and body, psyche and soma, all acting as one. The felt sense is the vehicle through which we experience ourselves as an organism. The felt sense is the psychesoma's narrative. For in the body's felt sense is to be found a gorgeous seamless integrative coherent and cohesive narrative of the psychesoma's experiences as mediated by the brain.

It turns out that change feels good even when it involves dealing with excruciating experiences. By good, I do not mean that the individual feels happy; he may or may not. What I do mean is (i) that the process of therapeutic transformation is accompanied by a feeling of relief and a relaxation of tension; (ii) that the *felt sens*e of what is happening has to do things feeling "right," and "true"; and (iii) that something inside the person says "yes."

> "The change process we have discovered is natural to the body, and it feels that way in the body. The bad feeling is the body knowing and pushing toward what good would be. Every

bad feeling is potential energy toward a more right way of being if you give it space to move toward its rightness. .... It knows the direction. It knows this just as surely as you know which way to move a crooked picture. If the crookedness is pronounced enough .... for you to notice it at all, there is absolutely no chance that you will move the picture in the wrong direction and make it still more crooked while mistaking that for straight. *The sense of what is wrong carries with it, inseparably, a sense of the direction toward what is right*" (Gendlin, 1981, p. 76)

We are experientially zooming in on the moment of transformation which is bathed in positive emotion because it feels deeply right. Positive refers to calm, contact, and having access to a vibrant, embodied flowing somatic experience.

This sense of "rightness" expresses itself implicitly in the therapeutic alliance and its operation. But explicitly --and it is this that I wish to focus on-- it expresses itself through positive affective markers that mark the process of healing transformation. "The melting emotions and tumultuous affections associated with the crisis of change," (James, 1902, p. 238) communicate that the therapeutic process is on the right track. They communicate to therapists what the patient is experiencing; proprioceptively and through his senses, the patient himself receives the same communication from them. These positive affects signal the operation of therapeutic processes and alert the therapist to moments of therapeutic opportunity: that the process is on track, that there has been a relaxation of defenses, that here and now, at this moment in the therapeutic work, resources that have just become available that can be tapped and harnessed to advance and enhance the therapeutic work, and that we should make the most out of this moment of opportunity.

Change involves engaging the healing forces residing within us. It is what results as the adaptive process that emotion represents is moving toward completion. This occurs only when there has been a relaxation of defenses, for defenses along with blocking emotional experience, also block access to the rich resources available within the individual. When we remove the barriers to core emotional experience, we engage the healing forces inside the individual and unleash their transformational power. We restore the flow of natural, healing, reparative and self-correcting mechanisms abundant within the human being. Positive affective markers herald the accessing of these healing forces and the emergence of resources and resilience within the

individual.

The work is not about the promotion of "happy' experiences and trying to get the patient to feel them. Rather, it is about the spontaneous emergence of these positive affects in the course of work with intense emotional experiences. Moments of positive affect experienced in the middle of the exploration of intense, overwhelming, painful, feared-to-be unbearable emotional experiences are not attempts at denial, and do not represent a "flight into health." In dealing with negative feelings, and fully processing them in a dyadically constricted atmosphere of support and help, positive feelings and adaptive resources are liberated. "Becoming resourced" by visceral access to positive experiences is the phrase Peter Levine (1997) uses to describe this process. Working from strength to deal with difficulty (Fosha, 2002a, 2003) is a major aspect of AEDP's therapeutics.

7 Types of Unambiguous Positive Experiences that Mark Transformations

We are now ready to begin a taxonomy of positive affective experiences that are markers of healing transformations that occur when difficult experiences are engaged by an individual who feels supported. Seven types are described below: each of them marks and accompanies one of the adaptive affective processes of change that I have described at length elsewhere (Fosha, 2002a). These positive experiences arise in the moment of transformation. The achievement of the transformational states that these positive experiences accompany can happen in a moment, or can happen with the completion of a much lengthier process (i.e., such as that involved in processing a painful categorical emotion to completion).

-- *Experiences of resonance, contact and being in sync* mark dyadic experiences of affective coordination. They are *the 'we' affects*, or *relational affects* associated with the triphasic (attunement, disruption, & repair) process of dyadic affect regulation. Both attunement and the restoration of the coordinated state upon the repair of disruption are highly positive experiences (Fosha, 2001) with profound motivational properties of their own.[8] These moments

[8] In writing about the importance of positive experiences of affective resonance for the development of secure attachment, Schore (1996) has emphasized how: "The baby's brain is not only affected by these interactions, its

of contact "can happen in a heartbeat."[9] For example, sometimes when the patient is in pain and the therapist shares that pain, there is a fleeting smile that they share. This is a moment of meeting (Buber, 1965; Stern et al., 1998) and not a moment of denial;

--*Experiences of being in contact with the personal sources of resilience and energy/vitality* emerge with (a) the undoing of the pathogenic fear and shame and (b) getting past defenses and barriers against experiencing. Once psychic energy is no longer going into the maintenance of defensive barriers and blocks against experiencing, nor disappearing into the black hole of fear and shame, they become liberated and available for adaptive aims. The counteracting of shame and guilt through the therapist's active support, affirmation, honoring (Graham, 2003)[10] and admiration for the patient, produces an almost palpable release (and relief) of the energy, love, courage, and determination locked away together with whatever feelings the patient felt so much fear, shame and guilt about. Counteracting fear, shame and guilt, and promoting self-compassion, liberates life energy, which becomes available for the therapeutic journey that is still to unfold, which now patient and therapist can travel together;

--Positive experiences mark *the activation of adaptive action tendencies* that come to the fore when a *categorical emotion* has been processed to completion. Sam's experience in the first vignette is an example of how a sense of *clarity*, *relief* and *self-validation* --"I did the right thing"– emerges in the wake of fully processing a somatically wrenching, viscerally experienced wave of deep grief. With the completion of the cycle, grief is replaced by *calm*, *confidence* and *self-compassion*. Other noteworthy examples are (a) the *joy*, *exuberance* and *zest for*

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growth literally requires brain-brain interactions and occurs in the context of a positive relationship between mother and infant" (Schore, 1996, p. 62; see also Trevarthen & Aitken, 1994). This kind of attunement leads to a crescendo , where there is an amplification of the dyadic experiences of affective resonance, which is in turn associated with the release of neurotransmitters that create a chemical environment in the brain conducive to optimal growth and learning. These positive affects create a neurochemical environment highly conducive to new learning in which optimal brain development occurs: "The mother's face is triggering high levels of endogenous opiates in the child's growing brain. These endorphins … act directly on subcortical reward centers of the infant's brain" (Schore, 1996, p. 63). Endorphins (endogenous opiates) trigger "an elevation of dopaminergic-driven, energy-mobilizing, sympathetic-dominant ergotropic arousal and dopamine-mediated elation" (Schore, 1996, p.63), i.e., an energy-mobilizing state in which maximal learning takes place. The child is motivated to enter into such a "reciprocal reward system" because "euphoric states are perhaps the most appetitively compelling experiences available to life forms as so far evolved" (Schwartz, 1990, p. 125, quoted in Schore, 1996, p. 62).

[9] My thanks to Loren Noll.

[10] My thanks to Linda Graham, personal communication and work in preparation, on the importance of *honoring.*

exploration that mark experiences of affective mastery which follow the undoing fear, and (b) the *pride* and *expansiveness* that mark the working though of shame. The entraining of adaptive action tendencies contained within emotional states and the resulting rise in motivation are powerful antidotes for the demoralization our patients feel when they seek our help (see Frank, 1974) ;

-- *Receptive affective experiences of feeling seen, loved, or understood* arise as a result of (a) intersubjective experiences of feeling known, of (b) having the sense of existing in the heart and mind of the other as oneself (i.e., being the object of the other's reflective self function), and of (c) being the recipient of the other's empathy, care, help, or love. For ultimately, empathy is not an activity of the therapist, but rather an experience of the patient. The therapist can *try to be* empathic or can even *feel* empathic but *is* empathic if and only if the patient's receptive affective experience deems it so;

--Bodily states of *relaxation*, *vitality*, contact and *expansiveness* come on line and replace tension, constriction, or "out-of-control" experiences as the process of somatic focusing grounds experience in the adaptive, healing-oriented, self-reparative tendencies of the body. These positive somatic affective experiences result from the moment-to-moment tracking of bodily sensations and responses as there is a shift from in-the-head thinking to in-the-body sensing ("lose your mind and come to your senses");

--*The healing affects* arise in the context of the experiential exploration of the patient's experience of therapeutic transformation as reflected in (a) the individual's recognition and subjective experience of changing (for the better) and (b) response to the affirmation of the transformation of the self. The healing affects include *feeling moved, touched* and *emotional* within the self, and feeling *love, tenderness* and *gratitude* toward the other (Fosha, 2000a);

--*Core state*, is the state of feelingful calm that is accompanied by the subjective feeling of truth and the aesthetic experience of things being "right," regardless of whether they are happy or painful. Given the therapeutic opportunities that core state presents, it deserves a section of its own.

Core State and Its Affective Marker, the Truth Sense

The completion of the full experience of any of the affective change processes sets the stage for the activation of *the core state.* Sometimes core state emerges spontaneously; at other times it happens as a result of the therapist's asking the patient to focus in on how he feels now, at this moment, having gone through a transforming emotional experience and having shared it with an other. The patient has a subjective sense of "truth" and a heightened sense of authenticity and vitality; very often, so does the therapist. In the core state, relaxation, vitality, ease, clarity and well-being predominate.

Therapeutic activities aim to make the most of the healing, transformational opportunities inherent within core state (Fosha, 2002b). Once core state is achieved, the therapy runs itself. The therapy goes faster, deeper, better. With patients in core state, the therapist's activities can be reflective, collaborative, experiential, mirroring, or witnessing. The therapist can validate and receive, or participate in deep collaborative dialogue that is simple, essential and "true." Just being present and listening deeply is sometimes precisely what is needed. When both patient and therapist are in core state (which is not unusual), peak moments characterized as *I-Thou* relating (Buber, 1965) or *True-Self/True-Other* relating (Fosha, 2002b), some of the deepest therapeutic work can take place. For it is here that the integrative and reflective processes that are necessary to translate in-session changes into outside-of-session changes can take place (Mahrer, 1999).

There are two aspects of the positive emotional experience that is the affective marker of core state: feelingful calm and the truth sense. (1) One aspect of the affective marker of core state is the experience of calm, openness to contact, aliveness, ease, and relaxation of a centered self. In core state, there are no defenses, there is no fear, there is no shame. But neither is the body landscape rocked by the turmoil of the categorical emotions. *Feelingful calm* prevails. (2) The other crucial affective marker of core state is the truth sense (Grotstein,

2002).[11] The *truth sense* –and the deep breath of relief and relaxation that often accompanies it-- is the other marker of core state, an affective marker with a very strong aesthetic component. The patient has an experience of being in contact with his emotional truth. Even when the truthful realizations are wrenching, in core state, the relief that comes from facing and accepting the truth trumps the painful nature of the content.[12] A patient referred to the tears he shed at such moments as "truth tears." The truth sense is the internal experience of core state, of relief at correctness. It is the relief and calm that settles in when a picture that's been crooked comes into alignment. There is an internal experience of coherence, of cohesion, of completion. It is an affective experience that is as much aesthetic as anything else. Something inside clicks into place. It is the sense that comes with righting oneself, and with things being right. The truth sense is the sense of coming home (regardless of whether one has been, in procedural fact, emotionally homeless). It is right. It is. That's all. The athlete who performs as he is capable of performing says "yes!" The patient who feels understood says "exactly." Like Dan, the patient in Vignette # 2, says: "I am realizing more and more that people have to do what they have to do…. [It's not about] goodness, [It's not about] badness. The choice is whether to live or to be the living dead…"

Concluding Remarks

The clinical examples of emotion work with AEDP illustrate two types of positive affective responses that emerge spontaneously, highlighting the operation of different therapeutic transformational pathways. In vignette # 1, by fully and viscerally experiencing the categorical emotion of deep grief, Sam is able to access, also fully, its adaptive action tendencies, and, in the process, deepen the consolidation of his sense of self. As the gorgeous title of an Eugene O'Neill play (*Mourning Becomes Electra*) evocatively indicates, and as all Greek tragedy attests to,

[11] I am grateful to James Grotstein who, though his profound work and our personal communications, alerted me to the truth sense, a construct present both in his work and in the work of Bion.

[12] A beautiful example of sense of truth triumphing over agony, when the agony is faced and owned, comes from the following lines from Leonard Cohen's song, *Like a Bird on a Wire*: Having declared "Like a little baby, stillborn, Like a beast with his horn, I have torn everyone who has reached out for me," the singer goes on to conclude with the refrain of the song, another gorgeous example, of the simple eloquence of core state: "I have tried, in my way, to be free."

through mourning --fully experienced and worked through to completion, I might add-- the self comes into its own.

In vignette # 2, Dan's experience, which he articulates with the eloquence that deep affective states confer upon mere mortals, illustrates the profound opportunities for therapeutic consolidation and integration that *the core stat*e affords the individual. It is here that the reflective self function operates freely and deeply as the individual, with a clear sense of his own mind in relation to a clear sense of the minds of other, and a clear sense of the relation between them --past and present, actual and possible-- can make sense of his life, and his place in it. It is in core state, the state for which the truth sense is the affective marker, that Dan articulates -- more eloquently from his heart and mind than any theory can-- the fundamental ethos of experiential attitude toward both therapy and life: there is only one choice, which is between living (with all the pain and difficulty inherent in it) or else being the living dead (that which obtains when defenses rule).

In closing, I wish to offer a few of remarks about the activity of the therapist. (1) At the beginning of the therapeutic journey with a demoralized patient who is weighed down by fear, shame and guilt, and whose psychic resources are under the lock and key of defenses and debilitating symptomatology, the therapist is active, often leading the process: her active efforts and explicit counteracting of the patient's negative self-assessment through empathy, validation, and affirmation play a major part in reversing the process of demoralization and helping the patient begin to feel that he has resources. (2) When the work is focused on the accessing, facilitation and working through of deep affect --when defenses and the pathogenic affects are no longer a prominent part of the clinical picture-- the therapist's activity is that of a facilitator, providing a holding environment and assistance in allowing the operation of the emotion to unfold. The therapist here functions as assistant to Mother Nature, i.e., as the body or the psychesoma's handmaiden, moment-to-moment tracking what the body is communicating via the felt sense, and helping the process stay on track and deepen. This allows the processing of deep emotion to reach its conclusion, when the patient can reap the benefits of that which has been

wired into us by aeons of evolution. (3) Finally, in working with core state experiences, the therapist is a partner, a witness, a fellow human being. The beauty of core state is that it requires nothing of the other, and accepts the other as other, just as it accepts –with equanimity, clarity of vision and compassion—the self as self. When the patient is in core state, the therapist --like the patient-- has maximal freedom, including the ultimate freedom of being just another fellow human being.

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