

The Dyadic Regulation Of Affect

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ABSTRACT

Accelerated Experiential-Dynamic Psychotherapy integrates experiential, relational and psychodynamic elements. *Deep authentic affective experience* and its *regulation through coordinated emotional interchanges between patient and therapist* are viewed as key transformational agents. When maintaining attachment with caregivers necessitates excluding particular affects, patients' capacity to regulate emotion becomes compromised. Being in an emotionally alive therapeutic relationship enables patients to better tolerate and communicate affective states; doing so, in turn, fosters security, openness, and intimacy in their other relationships. A clinical vignette will illustrate how using the therapist's affect, and focusing on the patient's experience of it, contributes to the repair of affect regulatory difficulties.

KEY WORDS: core affect, dyadic regulation, mutual coordination, core state.

“...the human brain is inherently dyadic and is created through interactive interchanges”

(Tronick & Weinberg, 1997, p. 73)

Accelerated Experiential-Dynamic Psychotherapy (AEDP) integrates experiential and relational work within a psychodynamic framework, and is rooted in a developmentally-based affective model of change (Fosha, 2000; Fosha & Slowiaczek, 1997). In this therapy, (a) the experience of deep authentic affects, such as grief, anger, or joy, and (b) the process of open and direct emotional communication through which affective experiences are managed and fine-tuned within the patient-therapist relationship, are viewed as key transformational agents. Intervention strategies are drawn from short-term dynamic (Davanloo, 1990; McCullough Vaillant, 1997) and experiential (Gendlin, 1991; Greenberg & Paivio, 1997) psychotherapies. The stance of AEDP therapists is affirming, empathic and emotionally engaged. They seek to help patients make use of processes that occur naturally in optimal development but are compromised in those with affect regulatory difficulties. These processes, viewed as crucial in promoting and maintaining psychological health are: (1) fully experiencing emotions so that their adaptive contributions to functioning are maximized; and (2) using emotionally significant relationships to regulate affective experiences that are too intense or painful for the individual to manage alone. Whatever stands in the way of the patient's being able to reap the benefits of these processes becomes the focus of therapeutic intervention. In AEDP, therapists' use their own emotions is not only accepted but believed to be central to the treatment of patients' affect regulatory difficulties. This will be shown in the clinical vignette that concludes this paper. Before the vignette, the ideas briefly introduced thus far will be further developed, so that the rationale for the dyadic handling of the patient's intense affects can be clarified.

Emotion Theory and Psychodynamics: Adaptation, Core Affect, and State Transformation

How Emotions Serve Adaptation.

According to emotion theory (Darwin, 1872; Lazarus, 1991; Tomkins, 1962-3), emotions are crucial vehicles for adaptation. They convey information about the individual's appraisal of the environment, focus attention on what is most important to her/him, and thus motivate actions (in self) and responses (in others). However, the most essential information that emotions convey is information about the self in relation to and with others. AEDP's affective model of change asserts that (1) emotions are crucial to establishing trusting, open and intimate relationships, and that, in turn, (2) secure, emotionally open relationships play a major role in the individual's ability to manage difficult emotions.

Core Affect and the Release of Adaptive Action Tendencies

The psychodynamic contribution to emotion theory is the notion of *core affective experiences*, or *core affect* (Fosha, 2000), which are the experiences that come to the fore when fear, shame and feeling-avoiding strategies, i.e., defenses, are not in the picture. Core affective experiences include *the primary emotions* (anger, joy, fear, etc.), *self experiences and self states* (feeling vulnerable, lonely, powerful, etc.) and *relational experiences* (feeling close, distant, alienated, intimate, etc.). The visceral experiencing of core affect, in concert with an accepting other, produces a transformation in the patient's emotional state, in which adaptive resources accessed and released. In emotion theory, the new capacities accessed by the visceral experience of emotion are called *adaptive action tendencies*, and it is their power to heal and enhance the individual's functioning that we seek to tap in our therapeutic efforts.

The Dyadic Regulation of Affective Experience

The dyadic model of emotion regulation proposes that the individual's affect-regulatory capacities are based in how mother and infant mutually coordinate their emotion-handling strategies to adapt to one another (Schorer, 1994, 1996). The idea of *mutual coordination of affective states* comes from the mother-infant interaction literature (Beebe & Lachmann, 1988; Tronick, 1989; Tronick & Weinberg, 1997) and this model is here applied to all aspects of dyadic emotional communication. The dyad can consist of mother and child,

therapist and patient, or partners in a relationship, and the process is that of emotional communication. In the optimal dyadic regulation of emotion, each partner is open and communicates to the other, who responds openly in turn. The partners remain engaged and oriented toward one another even when things get difficult. Mutual coordination does not mean perfect empathy and flawless mutual attunement. It means being motivated to maintain connection and communication even in the face of discord and difficulty without withdrawing into oneself and closing up or putting up a wall.

Although emotions are sources of enhanced adaptation, they are often intensely painful and overwhelming and, without support, people can feel unable to cope with them. Optimally, children and their caregivers pool their emotional resources. Throughout the lifecycle, through the emotionally-based interaction with a sensitive, responsive, helpful other, a person is able to manage that which is felt to be too much to do alone. S/he receives assistance with the regulation of her/his affective experience, and difficult emotions can be handled through the dyad. The dyadic regulation of affective states enables the individual to experience, express, and adaptively make use of her/his emotions. Eventually, s/he becomes able to do for her/himself what was initially accomplished through the relationship, that is, the individual becomes able to have full affective experiences.

The experience of core affect in the context of the patient-therapist relationship is fundamental to AEDP's understanding of how change takes place. AEDP's stance and therapeutic techniques aim to (1) minimize the impact of anxiety and shame, (2) make the avoidance of feeling unnecessary, and (3) facilitate the experience of core affect. Through being fully grounded in bodily-felt emotional experience, the resources released by the experience of emotion can now transform the self and inform effective action. It is precisely here, in the state transformation ushered in by the visceral experience of core affect, and reflected in the resultant *core state*, that change happens.

In the core state, profound opportunities for deep, rapid, and mutative therapeutic work exist, resources for adaptive living come to the fore (Fosha, 2000; Greenberg & Safran, 1987; McCullough Vaillant, 1997) and ease, calm, relaxation and clarity prevail. There are three aspects of the core state: *core emotions* involve being viscerally in touch with primary

emotions, such as grief, disgust, and rage; *core self experience* refers to feeling “authentic;” “like myself,” “alive,” “real,” and/or “true;” and *core relational experience* occurs when both members of a dyad feel “in sync,” “close,” or “connected” with one another. When patients experience this core state --whether the focus is on emotions, self experience or relational experience-- they gain access to new information and deep adaptive coping capacities within themselves which allow them to respond more effectively to life’s problems. Examples of the adaptive capacities that come to the fore when core affect is fully experienced are: the strength and assertiveness facilitated by the full experience of anger; the clarity about one’s basic needs and the resolve to address them often brought about by authentic self experience (Greenberg & Paivio, 1997); or the capacity to trust, crucial to deepening intimacy, that comes with close and open relational experiences. The visceral experience of core affect accesses and releases these *adaptive action tendencies*, and it is their power to heal and to enhance the individual’s functioning that we seek to tap in our therapeutic efforts.

The capacity to fully experience one’s feelings, particularly when they are intense and/or painful, is greatly enhanced by being able to do so together with a supportive, empathic and emotionally present other who is willing to share experiences and help with their management. This is the essence of *dyadic regulation*: the individual has expanded affect regulatory capacities resulting from the combined resources of the dyad, which s/he eventually internalizes, that is, makes her/his own. Being in an emotionally-connected relationship based on empathic attunement and support enhances the person’s capacity to feel without needing to develop strategies to minimize, numb or mute feelings.

The Development of Affect Regulatory Difficulties.

However, individuals are often in life situations that are far from optimal and they are unable to forge such relationships with their primary caregivers. Instead of eliciting the caregiver’s help and support, the person’s emotions elicit the caregiver’s discomfort, withdrawal or even attack. Emotions, intense and overwhelming to begin with, become further

aversive as they disrupt the connection with primary caregivers and become associated with inhibiting 'red light' affects, such as fear and shame. A key factor in the development of affect regulatory difficulties is the patient's unwanted aloneness in the face of intense and thus overwhelming emotional experiences. The emotional aloneness that results when emotions disrupt attachment ties is so unbearable that it must be avoided at all costs. When affects threaten their bond with the other, people must find ways to blunt, postpone, mute, mask or distort the experience of emotions. Instead of experiencing feelings, and using them to navigate through life, they develop ways of avoiding them. Denial, numbing, or selective focusing on certain affects at the expense of others, are instituted to compensate for the failure of key emotional figures to provide support with affective regulation. In the short-run, such defenses protect the individual from experiences too fraught with fear, shame, pain and humiliation, and help preserve the connection with the other. Unfortunately, the protection these strategies afford comes at a high price. The individual loses access to the adaptive potential associated with the emotions, thus forsaking the growth and enrichment of self and relationships that emotions promote. The chronic avoidance of affective experience --in any or all of the realms of emotion, self and relationship-- leads to the chronic difficulties in functioning and living that we view as psychopathology (Fosha, 2000). This is a two-pronged understanding of the origins of psychopathology: overwhelming affective experience *and* the failure to dyadically regulate those intense affective experiences in emotionally significant relationships.

Patients' affect regulatory difficulties reflect the inadequacy of their resources to deal with emotions directly and fully. In AEDP, the aim is to counteract the patient's unbearable aloneness in the face of feelings that necessitated reliance on strategies against experiencing. The moment-to-moment emotional communication with an affirming, empathic, open and emotionally-engaged therapist creates an environment where the patient feels safe to feel. Patients grow increasingly capable of processing emotions without being overwhelmed and needing to exclude major parts of their psychic life. Through dyadic interaction with the therapist, the coping repertoires of two individuals are accessed and combined. Affects, too intense for the individual to manage alone, turn out to be dyadically regulatable. The

therapist scaffolds the patient's affects so that the patient can optimally benefit from them. The affective procedural solutions of the dyad eventually become internalized in the individual's own repertoire, rendering emotion-avoidant strategies unnecessary. How to most effectively work with characteristic defensive avoidance in order to access core affective experiences is at the heart of AEDP's approach to treating affect regulation difficulties (Fosha & Slowiaczek, 1997). In addition to being necessary to the process of dyadic regulation, the therapist's use of her/his own affect can also be understood (1) as a way of disarming the patient's defensive avoidance, and (2) a way of helping the patient feel safe, that is, not alone.

The Dyadic Regulation of Core Affect: Optimal Development, Affective Psychopathology, and Psychotherapy

How Mutual Coordination Is Adaptive.

Schore (1996) has discussed how the achievement of coordinated emotional states produces "excitement and pleasure" in the dyad which deeply affects the development of the baby's brain: "The resonance of the dyad permits the intercoordination of positive affective brain states. ...[T]he baby's brain is not only affected by these transactions, its growth literally requires brain-brain interaction and occurs in the context of a positive affective relationship between mother and infant....[The] affective regulations of brain growth are embedded in the context of an intimate relationship and...promote the development of cerebral circuits" (p. 62).

The dyadic regulation model applies to emotional events across the life span, and to therapy. Again, what cannot be handled individually, often can be handled well dyadically. In mutual coordination language, "two psyches are better than one." Tronick (1998) recently proposed that the adaptive function of connection and relatedness is the "dyadic expansion of consciousness." The more vulnerable members of dyads get access to capacities that are not quite theirs, but that become theirs through the interaction and their functioning is enriched. Tronick and Weinberg (1997) give the example of a baby whose muscle development does not yet allow her to sit up on her own. The mother props up the baby in

response to the infant's cries of frustration because she cannot control her posture. The propping up facilitates the infant's ability to communicate gesturally during social interaction - a complex action beyond the infant's own ability. There has been a *dyadic expansion* of the baby's capacities.

The Caregiver and Mutual Coordination.

The function of dyadic affective communication is to express the child's intentions to the caregiver and to communicate the extent to which s/he is succeeding or failing in fulfilling her/his intentions and goals. Essential to this process is the child's affect as a vehicle of expression and communication of intentions to the caregiver. Equally essential is the caregiver's capacity to read appropriately the child's communications and her/his willingness to take appropriate action. The caregiver's affect, in turn, communicates to the child that her/his intentions have been registered and also informs the caregiver's own actions vis-à-vis the child. Therefore the baby's successful engagement with the world of people, things, and emotions depends on the effectiveness of the child-caregiver communicative system in facilitating the child's intentions through the caregiver's actions and responsiveness. Furthermore, through the affective communication process, the child-caregiver bond deepens, the security of the attachment grows and the child's ability to explore and make the most of opportunities for learning and growth expands. This applies to the affective realm as well. The more secure the child, the greater her/his capacity to tolerate, and thus benefit from, a variety of affective experiences -- positive and negative, mild and intense (Fosha, 2000; Schore, 1994; Tronick & Weinberg, 1997).

Both Members of the Dyad Are Transformed.

Just as the goal of the child-caregiver affective communication system is to facilitate the child's developmental agenda, the goal of the therapeutic endeavor is to facilitate the patient's transformation. However, when the dyadic process of affect regulation works its magic, there is a necessary interweaving of emotional experiences. Not only is the baby --or patient-- transformed, but so is the caregiver. Though not symmetrical, the process of dyadic regulation is bi-directional and mutual (Beebe & Lachmann, 1988). Parents are nurtured

through parenting, teachers learn from students, and therapists' own wounds heal as they help patients heal theirs. It is one of the many reasons why these endeavors, *when engaged in genuinely*, are so gratifying. Having an impact on the other has a deep impact on the self. As stated earlier, the experience of core affect involves a state transformation. So does the achievement of mutual coordination (discussed below). It evokes a particular affective state in both partners and thus, through the affect it engenders, it also changes both partners. However, without the more experienced partner's affective involvement in the regulatory process, the less experienced partner cannot fully realize the adaptive potential of core affect. Dyadically regulated, affects can be fully experienced and the patient benefit from their intrinsic adaptive properties.

Affective Markers of Achieved and Failed Coordination.

In striving to reach and maintain mutual coordination, both partners regulate their own affect through interacting with the other. While affective attunement emphasizes the caregiver's efforts to emotionally be where the child is, mutual coordination emphasizes the striving of both partners to be in tune with one another so as to reach a coordinated state. The coordinated state itself is highly pleasurable and thus rewarding to both (Schorer, 1996; Tronick, 1989), and is accompanied by its own affective marker: positive relational affect. On the other hand, lapses of mutual coordination, or "normal interactive errors," are accompanied by negative affect. Thus, the success and failure of mutual coordination have respective affective markers. Both members of the dyad are highly motivated to restore mutual coordination when it is disrupted, and to transform negative affect into positive affect. In optimally functioning dyads, moments of miscoordination, *and* the associated negative affect, motivate efforts toward reparation and positive affect. Gianino and Tronick (1988) report that in these dyads, mutual coordination occurs approximately 30% of the time, while the rest of the time is spent in mis-coordination and attempting to repair it.

For instance, mutual coordination occurs when the infant's squeal of delight is matched by the mother's excited clapping and sparkling eyes. Note, however, that coordination resulting in shared positive affect also occurs when negative affects are matched - while the mother is still smiling, the baby turns away frowning and the mother sombers in response. In

the affective sobering of both, coordination is restored. Soon the dyad's matched sobering (mild negative affect) is followed by shared smiles (positive relational affect), marker of the restored coordination.

Affective Markers of Achieved and Failed Coordination in Therapy.

In terms of therapy, mutual coordination involves openness and keeping the interaction going, without either partner getting defensive, withdrawing or attacking. If both negative and positive affects can be kept in the interpersonal space between partners, defensiveness around emotional matters need not come into operation. This applies all the more so to the coordination of negative affects. If the dyad can tolerate dealing with negative affect and remain engaged, eventually, positive relational affect will accompany such exchanges. The therapist's empathy to the patient's sorrow is one example of the mutual coordination of negative affects. Another is the child's anger at the parent and the parent's capacity to hear it and remain engaged and connected. This is an important point. Clinicians, particularly psychodynamically-oriented ones, tend to regard the positive feeling following the expression of negative affect as defensive. From the current perspective, it is not defensive, it is the core relational affect that accompanies the achievement of mutual coordination (Fosha, 2000).

Positive relational affects--the "hum" of the dyad working effectively-- produce feelings of safety which only enhance the patient's ability to do the difficult exploratory work of therapy. The patient's capacity to experience and work through, *without anxiety or avoidance*, previously avoided affects is a reflection of the health of therapeutic relationship.

On the other hand, pervasive negative relational affects --the "jangle" of the out of sync dyad-- indicate that something is amiss in the therapeutic interaction. If this is the case, the patient's core experiences will be unavailable for exploration until the interactional error is repaired. Here efforts to circumvent emotional experience through blocking, numbing, avoidance, shutting down or walling off --the concept of *defense*-- joins the concepts of core affect and mutual coordination. There is an important distinction between negative relational affects, and negative categorical affects. *Negative relational affects*, such as stuckness, discomfort, distance, flatness, lack of connection, etc., are not core affective experiences. They arise when efforts to restore mutual coordination have failed and emotion excluding strategies

have been instituted. Negative relational affects accompany resistance and therapeutic stalemates. On the other hand, *negative core affects*, such as anger, fear, or emotional pain, *are* core affective experiences. If one member of the dyad is able to express such feelings, and the other member is able to remain engaged and respond genuinely, then the relationship is healthy. There is no need to exclude these feelings. In such a situation, (core) positive relational affects will eventually emerge.

Thus, there are two indicators of a healthy therapeutic relationship: (1) the presence of positive relational affects, which marks the achievement of mutual affective coordination in the patient-therapist interaction; and (2) the flow of deep therapeutic work, proceeding in the absence of blocks and aversive affects (such as shame or guilt), and including the experience and expression of negative and positive affects. The latter can only take place in a safe environment, where the dyadic regulation of emotion can proceed without disengagement (Fosha, 2000).

The therapist's affective and thus state-transforming experiences in the dyad, are crucial to maintaining the open emotional dialogue, which is crucial to the patient's therapeutic transformation. It is this deep, genuine and open emotional involvement between patient and therapist that "cures," because it was precisely the caregiver's emotional withdrawal from the process of mutual coordination that originally made the person feel alone, terrified, and needing to avoid his/her affects in order to psychically survive.

The Role of the Caregiver's Affect Intolerance in the Development of Chronic Affect Regulatory Difficulties.

Caregivers' comfort with affectivity enables them to deal with the other's emotions without their own anxiety being a major source of disruption. Caregivers' comfort also models for their dyadic partner how feelings can be integrated with ongoing functioning. The more vulnerable dyadic partners have the experience of having their affects responded to, as well as of their caregivers competently managing affect.

When the caregiver's emotional availability and responsiveness is compromised, dyadic affective regulation cannot proceed optimally. One way the child attempts to repair this failure of mutual coordination is through the *exclusion* of those emotions which produce

aversive reactions in the caregiver, thus triggering the caregiver's own need to avoid feeling and rendering her/him unavailable and unresponsive. The good news with such exclusion is that mutual coordination is restored; the bad news is that the restored attachment comes at a high price. Eventually what can not be communicated to the m/other cannot be communicated to the self (Bowlby, 1991). The individual's personality becomes restricted and distorted as certain emotions, along with the relational information they contain, become excluded from experience.

For example, a parent is uncomfortable with tears and humiliates the child for crying. The experience of vulnerability becomes associated with shame and at all costs the child tries to avoid such experiences. Over time, the child develops a certain kind of hardness: along with avoiding vulnerability, a preference for responding to situations with anger rather than with sadness develops and becomes entrenched in the individual's personality. Along with vulnerability, the individual loses the capacity for sensitivity to others. Eventually her/his relationships suffer.

What the caregiver can and cannot tolerate directly influences the development of the individual's affect regulatory capacities. The more intact the caregiver's affective competence, that is, the less thrown off s/he is by the emotional responses the child evokes in her/him and the more directly and openly s/he can engage with the child, the more unrestricted the child's emotional development will be. The more compromised the caregiver's affective competence, that is, the more the child's emotions make the caregiver anxious, ashamed, guilty or overwhelmed, leading to her/his own defensiveness, the more the child's development will be restricted and distorted. In order to escape frightening aloneness, which the child experiences as a result of the caregiver's emotional disengagement, s/he misshapes her/himself to adjust to the caregiver. A secondary mutual coordination is reached, based on the exclusion of that which, however vital it might be to the child, is threatening to the caregiver (Main, 1995). The more this type of exclusion is required to maintain the other's availability and responsiveness, the higher the cost to the individual. The dyad's affect regulating strategies, optimal or compromised, become reproduced in how the individual manages her/his own affective experience. For example, if the child's primary affects are met

with disapproval or contempt by the caregiver, the child not only learns to exclude those affects from her/his repertoire; s/he will also internalize the caregiver's reactions to affect. The child will show disapproval or contempt toward her/his own affects, which will only increase the aversiveness of emotional experience and intensify efforts to avoid it.

Use of the Therapist's Affect to Counteract the Patient's Patterns of Avoiding Emotional Experience.

When patients arrive for therapy, their condition reflects their history of dyadic affective regulation. Patients defensively exclude affective states that could not be mutually coordinated with their significant others. The therapist's emotional presence and affective responsiveness are crucial in fostering a different learning process. They indicate that whatever is going on with the patient is not triggering unbearable discomfort in the therapist. Nevertheless, while the therapist's affective presence and responsiveness are necessary, they are not sufficient. For full therapeutic benefits to accrue, the patient must *recognize* and *experience* the therapist's presence, and responsiveness. They can't merely be given by the therapist; they have to be received by the patient.

Patients' capacity to take in and benefit from the affective relationship with the therapist will be limited and distorted by their previous reliance on strategies to avoid emotional experience, which must be therapeutically addressed. The therapist's use of her/his own affect and explicit focusing on the patient's experience of her/his affect are powerful tools. They can be used to restructure patient defenses and help manage feared affects, which then can become the focus of expanded dyadic regulation.

There are several strategies of intervention that make use of the therapist's affect and facilitate the patient's experience of it. Among them are:

- *explicit empathy* ("It pains me to think of how you suffered"), *affective resonance* (tensing as the patient is describing a tense situation) or *anticipatory mirroring* (expressing the emotional reaction the patient would most likely feel, were s/he able to do so);

- *affective self-disclosure*, which involves the explicit expression of the therapist's own emotional experience ("When you speak in such a monotone, I feel very distant from you");
- *the exploration of relational experience*, the "we" realm ("When you are able to express anger to me and I don't back away from you, there is such a sense of relief and connection between us");
- *focusing on the patient's experience of the therapist's empathy, affectivity, and of the relational connection* ("What do you see when you look into my eyes?"); and
- *encouraging the awareness and experiential elaboration of receptive experiences, and their aftermath* ("How do you feel when you see how moved I am by what you are telling me?" "What's it like for you when you feel understood by me?").

In the vignette that follows, the patient articulates the devastating consequences of chronic self reliance and avoidance of intimate contact, strategies initially instituted to protect a vulnerable self against emotional pain. The vignette illustrates the therapist's use of her own emotional reactions in working with the patient's defenses. The therapist zooms in on the patient's *experience* of the therapist's affective involvement. The therapist's aim is to help the patient experience and make explicit the connection between them. That there is a connection is not sufficient to restructure the patient's fears that closeness is futile and leads to pain. Again, the patient needs to be aware that she has made a connection and that, furthermore, the connection made her feel good and brought her relief. Through dyadically regulating intensely negative experiences, such as despair and loneliness, with an emotionally engaged therapist, the patient is able to fully experience intense negative affects without being overwhelmed by them.

Case Illustration: Light at the End of the Cave

The following case illustrates how the therapist's use of her emotional responses to the patient is used to help the patient manage painful feelings, which the patient was previously unable to bear alone. The patient, is a 35 year old single professional woman who sought treatment when her chronic depression exploded into acute feelings of pain, despair and

hopelessness, accompanied by suicidal ideation. Though she had always had good friends, she had never had an intimate relationship. As she put it, “I’ve never even been kissed.”

Two themes that emerged from the start were that her emotions would drive others to reject her and that intimate contact was fraught with danger and pain, and was thus to be avoided. These fears were rooted in her early experiences with her parents: her feelings and her yearnings for emotional connection, having been met with dismissal and disgust by her parents, became excluded from expression. Wary of the pain and shame which, in her experience, invariably accompanied emotional closeness, the patient developed a brittle self reliance which, in turn, led to the excruciating isolation and loneliness which brought her to treatment.

The clinical material, all from the ninth session of treatment, will be presented in terms of moment-to-moment affective shifts, with a focus on those interventions that use the therapist’s affect, noting whether these are followed by deepening of affect and relatedness or by heightening of distancing and aversive affects (fear or shame). In the first segment, the patient outlines her avoidant style and her patterns of self-protection. Terrified of getting hurt, she defends her core sense of self (the “tender” and “soft” part of the self that is “sensitive to everything”) through putting up a wall between herself and others. Although she speaks about her mistrust of people, nevertheless the therapeutic environment has made her feel safe. She is able to relate openly to the therapist, and to reveal ever-deeper aspects of her innermost experience. She begins by speaking of what it is like for her to be in therapy.

Note: Nonverbal aspects of the clinical material are italicized and in parentheses, and the moment-to-moment analysis of the clinical material is bracketed and highlighted.

Pt: Coming to therapy feels good. . . . This is my time to focus on me and stuff. . . . But it also feels . . . uncomfortable . . . like . . . it’s scary [**aversive affect**]

Th: Yes

Pt: I don’t like to open myself up . . . I feel exposed, I feel vulnerable, and I do not want to get hurt. And so I clam up and just go on like if nothing bothers me . . . [**relational defense**]. So . . . all that soft part of me (*very soft, tender tone*), it’s like *really* inside, it’s *really* inside

(*cups her hands together*) [**core self experience**] and I don't let people get to it. . . . Because I have been hurt already in the past . . . [**origins of defenses**]. Maybe I don't want people to get that Because that's me. . . . I do not want to open myself that much, I will open myself up to a certain point, and it's really tender, too . . . really tender [**core self experience**]

Th: Uh huh

Pt: (*soft, tender, hurt voice*) So . . . it's not something that I expose to people or anything . . . I . . . put a wall around it, . . . in there it's all soft and sensitive to, to everything . . . really . . .

[**relational defenses to protect the vulnerable core self**]

Th: (*soft tone*) It's tender [**affective resonance**]

Pt: Yes, it's very, very soft...

Th: Yes, and it feels private [**empathic elaboration**]

Pt: So it's inside here (*cups her hands*) and I don't want people to get to it, I'd be crazy to, I think, in this world. . . . You got to have . . . logically, you got to have a self-defense. . . .

When I get to heaven (*voice cracking*), I can allow that to come out. . . because it can never happen, I don't think, in this world (*her eyes welling in tears*).

Experientially Exploring The Consequences Of Defenses

In the following segment, the patient articulates the emotional consequences of doing without intimate emotional connection: depression, loneliness, isolation, and at times, suicidal despair. The quality of her experience is "empty" and "black." The aim of therapeutic activities is to bypass the patient's habitual roadblocks against her own internal experience. The therapist accesses a deep affective state within herself (note the slow, feelingful tone of voice). She hopes to engage the patient, through the operation of resonance and mutual affective coordination, in a more affective mode of being. This in fact happens as the patient slows down and her experiencing deepens. Note how the therapist's mirroring of the patient's experience easily bypasses the patient's attempts to avoid experiencing feelings (i.e., her pressured, matter-of-fact speech), allowing the patient to contact the depth of her despair. This is the first and crucial step in their eventual transformation. The aim of the work is to reduce the patient's avoidance of (1) core affect by facilitating her visceral experience

through the mirroring and amplification of painful feelings, and of (2) intimacy by experiential focusing on the emotional nature of the therapeutic relationship. The patient's painful feelings of loneliness and despair become the stuff of mutual coordination.

Pt: Life is just empty for me... Is there more than this? and if there is no God, and if there is no happiness at the end, that's my light at the end of the tunnel.... If you take this light away, it's pretty dark.... [**emotional consequences of distancing**]

Th: (*soft, deep, somber tone*) It's dark [**affective resonance**]

Pt: Yeah (*slows down, despairing affect deepens*)

Th: (*deeper, somber tone, slower speech, deep sigh*) It's dark

Pt: So what, you go through life proving, you go through life working, I mean this is ... (*pressured speech*) [**non-verbal defense**]

Th: OK, OK... If for a moment, (*slowing down*)..... or two (*joking tone*)

Pt: Or two (*laughs*)

Th: If instead of doing the "so what" with a joke, or "that's life," [**urging patient to relinquish defense**]

Pt: Uh huh

Th: If you let yourself stay with this feeling (*slowing down, sobering*), the sense of emptiness, this inner sense of (*deep sigh, grave tone of voice*)... having to work so hard to keep something away. [**affective resonance**]

Pt: Yeah... (*also slowing down and sobering*) it's tiring. [**deepening experience**]

Th: It's very exhausting (*amplified exhausted intonation*)... Mmmmmmm.... [**amplifying affective experience**] I mean right now it seems to me like we're sort of approaching this from the outside because it's a scary place to be [**empathic identification of fear**].

Pt: Yeah, it is...mmm... I don't know... Sometimes I wonder, Is this it? Is this what life is about?.... It feels empty... (*pained tone*) [**deepening of despair**]

Th: Which means what? When you say that you feel empty.....

Pt: So, so..... Is that what life is about? That's it?

Th: In this dark moment, (*deep slow pained tone of voice*) what is that emptiness like?

[invitation to experiential elaboration]

Pt: It's black.... (*long pause*) **[deep affect of despair]**

Th: Black.... (*long pause*). **[affective resonance]**

Pt: It's like.... I don't have to be here... if I thought of it that way. **[deep despair, the result of relational distancing defenses]**

Th: Mmm huh

So far, the work has focused on the experiential elaboration of the patient's negative affects. The therapist's own empathic and deep affective response, conveyed non-verbally, mirrors and amplifies the patient's painful affects. Patient and therapist share a deep experiential appreciation of how the patient's depressive and suicidal ideation are the consequences of her walling off and the resulting isolation. There is a progressive deepening of the patient's affective experience, with its expression less and less hampered. Trust in the dyadic companion is implicit in this emotional relaxation. Although it is crucial that she has let the therapist in, she needs to be aware that she has done so, otherwise the benefits of the in-session affective contact will erode rapidly outside the session. The patient will persist in thinking of herself as isolated person, the events of the therapy notwithstanding. To reap the benefits of the emotional connection with the therapist, the patient needs to recognize *that* it has occurred and to process how it feels to be connected.

The Experience Of Sharing Emotions And Feeling Understood

The first intervention in what follows is a key intervention. It shifts the focus from the patient's experience of her negative affects (affect work) to the patient's experience of sharing those negative affects with the therapist (relational work). This addresses head-on the patient's difficulties with relational experiencing by asking her to describe the experience of sharing her feelings with a receptive other. The therapist invites the patient to reflect on how the therapist exists in the patient's psychic space, that place previously deemed private and off limits to others. The very fact that this therapeutic conversation is taking place is evidence of

bypassing her characteristic avoidance of relational closeness. This is an example of acting *as if barriers against connection are not there*, permitted by the patient's deep affective absorption. This work takes place in the *core state*, the state ushered by being able to deeply experience her despair through sharing it with her therapist. New experiences, previously feared to be overwhelming, are seamlessly forged. We find ourselves in the context of a corrective experience of intimacy, the patient's claims of having renounced it to the contrary. As illustrated here, in the core state, a different reality prevails, and patient and therapist are seamlessly riding that wave, with little fear or reticence in sight. Feeling understood, the patient's experiences deep relief.

Th: To me... (*deep sigh*) about this profound dread-filled place.... this blackness... this isolation... **[affective resonance]** mm... this private hell **[amplification]**, what is... how can I say this.... what is it like to talk about it with me? What's it like for *you*? **[invitation to elaborate her experience of sharing her until-now-private pain]**

Pt: Well, it's sort of like... it's like we are walking through or hiking (*starts to brighten up*), and we are walking through this cave that's get darker and darker, and gets really really dark. **[accepts invitation; the brightening up is the positive affect associated with her focusing on her experience of mutual coordination]**

Th: Mmm huh

Pt: And ... there is this little hole in the wall maybe (*makes small circle shape with her hands*) and I kind of like go like this to you (*makes beckoning motion with her hand*)

Th: Uh huh

Pt: (*animated*) And I open this door and it already feels like we are crowded in like this, and there is this tunnel with this wide opening that's getting narrower and narrower, and there is a door to that hole and I am opening this door and I am telling you like "Dr. Fosha, look inside, open the door" **[patient invites the therapist to join her]**

Th: So you have been in there ...

Pt: Yeah, that's how I feel... I guess it's nice to show someone that this is how I feel....

[relational breakthrough: owns her desire to share her emotional reality with another] I

guess since you sort of made me think more about who I am, I feel you are a part of it too because you sort of sparked it in me unknowingly, or what ever but... So I feel like you are part of it, part of the process of me showing you me, putting the mirror in front of my face, and me even looking at myself and examining... examining myself and... **[experiential elaboration of relational closeness and affective sharing]**

Th: (*deep, slow tone*) Where am I? Or how am I, maybe even more than where am I, how am I?

Pt: In this whole scenario?

Th: Uh huh

Pt: You're sort of right behind me... **[patient feels she is in charge of process]**

Th: So what's that feel like? At this time when we're in this cave, going to this place that's darker and darker and darker

Pt: Right

Th: And you turn and I am there behind you, and you are telling me about it, and I ... see it with you

Pt: Yes, it's the first time, you're the first.... And it feels like you don't mind seeing it, I feel you are not offended, you are not taken aback by it, you're not like "yeah, right Barbara, I don't want to see that"... You *want* to see it, like you always prod me..... And I am showing it to you, so there is an understanding I get from you that this is where I am coming from ... I guess there is a nurturing understanding about my situation ... So it's like ... I see where you coming from.... And you are trying to get a better understanding of who I am, so I am allowing you to look at it... **[articulation of her new experience of being with an affirming other]**

Th: ...yeah

Pt: And you're a very safe person to show it to because.... naturally we kind of talk about all this stuff these last weeks... Because you try to understand and you don't make light of it, or... so it's OK for me to show you..... Because it makes me feel that I can show it to somebody, so it makes me feel like there is someone with me. **[experience of not being alone]** Maybe you don't quite understand what's happening when I open the door, but.... I

am sharing with someone “this is what I have to live with, this is how I *really* feel”... And I never show people that side of me so... I don’t know, it just feels mmm... (*moved, tears in her voice*) comforting ... It feels like a little bit of a relief too.... Like maybe there is somebody else in this world (*fighting back tears*) that might have an understanding of who I am (*cries*).

Undoing Pathogenic Aloneness

The therapist encourages the patient to elaborate her experience of the therapist’s presence in her inner world. This work continues in new territory. In the first part of what follows, we focus on the patient’s experience of the therapist’s presence and emotional response to her. In the second part, the patient is asked what she sees in the therapist’s eyes and how that makes her feel. In addition, this segment includes an illustration of an interactive error, the therapist’s, and its interactive repair.

Th: You are telling me....

Pt: Uh huh

Th: that what is developing is the sense that though, in a way, this is your journey, but in a way it’s our journey and I am there with you in some way. [**promoting intimacy through explicit acknowledgment of emotional involvement**]

Pt: (*nods through tears*) (*moved*) Yeah, definitely... I couldn’t put it into words but it’s like you just said, that we going through this thing together. Yes... that’s pretty much what it feels like..... (*pause*)

Th: Oh, that’s a lot, that’s a lot..... (*pause*) [**acknowledgment of work done thus far**] Because I wonder also, *I have told you* how I feel at different times... But I wonder what you see?.... What you see in my face, what you see in my eyes in response to what you are telling me? [**encouraging patient to verbalize her experience of the therapist’s non-verbal affective responses**]

Pt: (*the patient looks very carefully at the therapist’s face, much like a baby surveying the mother’s face*) Oh, like you understand where I am coming from, and you’re sort of there, like we are in this trip together so.... I feel like there is a connection you know... That’s how

I feel, like there is a connection, and there is an understanding... mmm... compassion... You really feel where I am coming from, and... amm, you know..., I feel like a certain amount of... the feeling of trust. ... Because honestly, your face, you know, like every time I talk to you, like you're *really feeling* it (*laughing, scrunches up her face in imitation of therapist's expression*)... Like when I am telling you things, you *really* get a good feeling for where I am coming from, it's like you almost got a pained feeling on your face ...

Th: Well, yeah...

Pt: (*interrupting, laughing*) I don't know if that's just how you are, but you definitely, you're looking very pained ...**[the negative affect becomes transformed into positive affect]**

Th: At times, the things you are talking about are very painful (*pained tone of voice*), and ... I was wondering about that,.... you know, what that feels like for you.. I mean when you are very much in touch with (your) pain.... it is a very, very difficult, very painful, almost unbearable way to feel... And then you see my reaction, of also feeling very pained by it.

[interactive error: the therapist has not recognized that the patient has moved on to the positive affect associated with mutual coordination]

Pt: It's funny though, but it makes me feel like someone out there understands (*upbeat tone, smiling*) so I don't have to dwell on it... **[presses forward; gives therapist a chance to catch up]**

Th: Mmmm (*matches mood, smile in voice*) **[joins patient; interactive error corrected]**

Pt: It's like a relief, thinking that there is another someone in this world that understands where I am coming from... It feels good (*energetic voice, increasingly brightening mood*) so I can put in a box for a while. I don't feel all alone in that world, someone's looked at it, so that I am not by myself. When I discovered that this is how it made me feel, I told my friend, it's weird, but I was all happy after last session... **[sharing emotional pain with another deepens the experience and then transforms it; relief and happiness become associated with affective sharing]** Because it's like "oh, someone knows, I don't have to hide it all the time, someone else knows out there (*big sigh of relief, bright smile*) And I can move on... It's nice that I can be real with you, I don't have to be anything I don't want to be. I can be me. I can be myself. That's nice ... I can be myself. **[affirmation of real, authentic, core self]**

experience] At work I am not myself, I mean, I am myself but I am not, you know what I mean (*referring to reliance on defenses and the distortion of self experience*)

Th: I know what you mean

Pt: I can be my self and it makes me feel... It feel a little like when you show people this side of you, this private part of yourself it makes you feel a little bit lighter, (*takes a deep breath*), you know, I can breathe a little bit better too... **[core state; affective marker of relief and light feeling]** I guess it's the whole process that's cathartic or whatever. It just feels better too, because someone else has seen it too. You don't feel all alone... And, in a way, that's a good feeling too.

The patient is able to release her depressive preoccupation with negative and painful affect because "someone out there understands, so I don't have to dwell on it." As long as a vital experience only exists in the patient's inner world, it cannot be relinquished. To relinquish it before it is acknowledged, means to get rid of an authentic aspect of the patient's experience that contains crucial personal history. The patient's preoccupation with it preserves history. However, once an experience is shared and grasped by another person, that is, once it gains reality and validity, it no longer needs to be a source of preoccupation. It exists. It can be put aside and room can be made for new experiences.

In addition to the transformation of depression and isolation into good feeling and connection, the therapeutic work has also helped the patient transform the sense of helplessness that made her feel suicidal. The patient gets in touch with her own capacity to cope and with that comes a joy about being able to feel real and authentic.. The negative affect of despair turns into the positive affects associated with mutual coordination; with that, the potential for adaptive engagement in the world is released. Blackness turns into light. The patient gains clarity about and access to her many resources. New adaptive options can come to the fore. As the patient says, when someone understands, "you are not all alone."

This session proved to be pivotal. The patient's new experiences with the therapist led to a more consistent willingness to be open, which enabled us to make it through the emotional storms associated with working on the painful aspects of her past. It also inspired the patient

to work hard to overcome her fears of rejection and, with the therapist's help, to have the courage to take the risks necessary to be in a relationship.

Isolated, lonely and depressed when she started therapy, at termination, the patient was involved in a loving, committed relationship. Though depressive feelings would occasionally return, she could identify the triggers for her state; aware of slipping into old patterns of withdrawal and isolation, more often than not, she would actively work to reverse the process. One of the last pieces of therapeutic work involved helping the patient share with her partner the nature of her struggles and enlist her partner's help in countering her avoidant tendencies. Her partner was not only willing to lend a hand, but felt moved and honored by the trust. At follow-up, one year after the termination of treatment, the patient continued to be free of chronic depression and the occasional bouts of depressive feelings were short-lived. She continued to be deeply involved in a relationship where emotional communication was valued by both partners. In-session experiences became translated into outside of session behaviors: The sharing of emotional experiences to deepen intimacy and solve problems, initially a new experience with the therapist, became an ongoing aspect of her everyday interpersonal life.

CONCLUSION

The therapist's emotional presence, experience and expression are powerful tools in the therapeutic process. They counteract the intolerable experience of aloneness through forging a connection which allows patients to feel safer to explore previously frightening emotional experiences. The therapist's affect is particularly useful in challenging and bypassing patients avoidance of core affect and of intimate relating. Patients can deal with their affect regulatory difficulties by bringing them into a connected, emotionally-safe, emotionally engaged relationship. Together with a therapist who does not back away, they can take more risks to feel intense feelings. Through its dyadic regulation, core affective experience can be tolerated, viscerally experienced, even enjoyed. It also opens the door to deep emotional resources which the patient can now put to good use in order to live a fuller, more authentic

life. In the process, the patient also (re)gains trust, hope and interest in what relationships have to offer.

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