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Commentary on: *The Effect of Integrating Music Listening With an Attachment- and Affective-Focused Short-Term Psychotherapy in an Individual With Relational Trauma: The Case of "James"*

**A Bridge Over Troubled Water: Commentary on Paul Blimling's
Case of "James" Integrating Music Listening into AEDP**

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Editor's Note: Richard Harrison is a Registered Psychologist and Certified Accelerated Experiential Dynamic Psychotherapy (AEDP) Therapist and Supervisor with over 20 years' experience as a clinician, educator, supervisor, and group facilitator. He was trained and supervised in AEDP by its founder, Diana Fosha, and has taught with her at AEDP Immersion Courses in Vancouver and London, England. Dr. Harrison maintains a full clinical caseload with individuals and couples at the Vancouver Couple & Family Institute, and he teaches and supervises graduate students in the Counselling Psychology and Psychiatry Departments at the University of British Columbia.

ABSTRACT

The integration of music listening into Accelerated Experiential Dynamic Psychotherapy (AEDP) is explored through discussion of Dr. Paul Blimling's (2019) composite case study, "James." AEDP is a healing-oriented, non-pathologizing, experiential therapy model in which the therapist actively seeks to harness glimmers of resilience from the outset of treatment, and to co-engage safety within the therapy relationship in order to unleash the transforming power of attachment and emotion (Fosha, 2000, 2003, 2009, 2018). Blimling's incorporation of music listening into the treatment of a highly defended, initially hostile patient helped bypass defenses, foster attachment within the therapy relationship, and access and co-regulate the patient's affective experience. Key AEDP change mechanisms in the treatment included: undoing aloneness; affirmative work with defenses; dyadic affect regulation; emotion processing; and (to a lesser extent), metatherapeutic processing (metaprocessing for short). The latter is a unique and important contribution of AEDP to our field. Since the publication of Fosha's *The Transforming Power of Affect* (2000), AEDP itself has evolved from an attachment- and emotion-focused model to also focus increasingly and explicitly on transformational experience as an agent of change. The *experience* of positive change itself is now seen as an equally important AEDP change mechanism, alongside attachment and emotion processing. Metatherapeutic processing of patients' experiences of positive change, which involves a recursive alternation between exploration of new experience and reflection on that experience, frequently results in an expansive spiral of the transformational processes and affects identified by Fosha (2009, 2018). In addition to affirming Blimling's choice of AEDP and his sensitive and skillful integration of music listening into the treatment, I envision how the transformational process described in the

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case study might have been further expanded, deepened, and consolidated, had the therapist more assiduously and experientially explored the patient's experiences of positive change.

Key Words: music listening; experiential therapy; transformation; emotion theory; trauma treatment; Accelerated Experiential Dynamic Therapy (AEDP); attachment; positive experience; positive change; phenomenology; case study; clinical case study.

INTRODUCTION

I am pleased to share my response to Dr. Paul Blimling's (2019) creative and artful hybrid case study of "James," a client with relational trauma. In this commentary, I address and affirm Blimling's decision to incorporate music into an attachment-based, affect-focused therapy, as well as his choice of Accelerated Experiential Dynamic Psychotherapy (AEDP) as a theoretical framework and treatment approach with this patient. I begin by describing foundational elements and understandings of AEDP, including the therapeutic stance. Subsequently, I explore how Blimling's decision to incorporate music listening facilitated the therapeutic process in the Case of James. Along the way, I clarify aspects of AEDP theory as applied in this interesting case, identify the AEDP change mechanisms involved in key moments, and offer suggestions for ways that AEDP might have further contributed to the transformational process.

Additionally, I describe some of the important ways the theory and practice of AEDP has evolved since Diana Fosha, founder of the model, published her seminal book, *The Transforming Power of Affect* (2000). This text is cited by Blimling throughout his dissertation and appears to have been his primary reference with regard to AEDP; consequently, the case study reflects an earlier period in the development of the model.

Specifically, AEDP is currently in what Fosha calls its "Second Avatar"¹ and now focuses as much on the transformational potential of the *experience of therapeutic change*, and how change begets change, as it does on the healing power of attachment and emotion. In the final section of this commentary, I envision how the patient's growth and positive changes, creatively facilitated by Blimling's incorporation of music listening into an affect-focused, attachment-based therapy, could have been deepened and further consolidated through *meta-therapeutic processing* (Fosha, 2000, 2009, 2018), i.e., through experiential exploration of the patient's *experience of therapeutic change*. Meta-therapeutic processing (metaprocessing for short) is a unique and major contribution of Fosha and AEDP to the field of psychotherapy, and one which has become an increasingly central component of AEDP over the past ten years.

I draw upon not only theory, but also my own clinical experience and observations, as well as those shared by many AEDP colleagues, in order to imagine and envision how this intervention could have been applied more assiduously in the Case of James to powerful effect.

¹ Fosha (2018, p. 5) calls the period from 2000-2008 "AEDP's *First Avatar*," and the period from 2008/2009 to the present constitutes the "*Second Avatar*" of AEDP.

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Specifically, I imagine how recursive, alternating rounds of *experiences of positive change* and the *experiential processing of these therapeutic experiences* could have unleashed an expansive transformational spiral, characterized and fueled by the associated transformational affects and meta-therapeutic processes identified by Fosha (2000), which she and others have further elaborated and delineated in the second avatar of AEDP (Fosha, 2009, 2018; Iwakabe & Conceição, 2015; Russell, 2015). Remarkably, when we attend to and explore these transformational phenomena, predictably and almost invariably they deepen and expand, they broaden and build! And we find ourselves in the realm of flourishing.

Below, I briefly address some foundational principles and core elements of AEDP, and speak to the appropriateness of Blimling's choice of AEDP as the treatment modality in the hybrid case of "James."

PRINCIPLES AND ELEMENTS OF AEDP

AEDP is Healing Oriented

AEDP is a healing-oriented, non-pathologizing, experiential therapy model in which the therapist actively seeks to harness glimmers of resilience from the outset of treatment, and to actively co-engage safety within the therapy relationship in order to unleash the transforming power of emotion and attachment (Fosha, 2000, 2003, 2009, 2018). From the first moments of interaction and onward the therapist is on the lookout for manifestations of the innate human potential for self-righting, growth and repair that is always waiting in the wings to be met and nourished, and which come to the fore under conditions of relational safety. Diana Fosha (2008) coined the term "transformance" (in contradistinction to the psychodynamic concept of *resistance* as a motivational force) to describe this strong, neurobiologically based drive that pulses towards growth and healing, which is always there as dispositional tendency to flourish.² This motivational drive towards self-righting, self-healing and resuming impeded growth is ever present as a potential, alongside the rigid, stuck places that manifest as psychopathology. Moreover, transformance is "marked, moment-to-moment, by positive affective/somatic markers" that "cue the therapist that the therapeutic process is on the right track" (Fosha, 2018 p. 7)³. Consequently, from the get-go, the AEDP therapist is on the lookout for, and seeks to access, privilege, and nurture manifestations of this capacity for optimal development, which is our birthright, woven into our brains, bodies, and beings through eons of evolution.

AEDP is Experiential

Above all, AEDP is an experiential therapy. This is not merely talk therapy or insight-based therapy; rather, AEDP is a "bottom up," phenomenological approach. The goal of therapy is to provide patients with a *new experience*. This may (and often does) lead to greater insight;

² The concept of an innate, organic potential for wellbeing is not unique to AEDP. Carl Rogers wrote about a self-actualizing tendency and Carl Jung described the teleological potential for wholeness within people (Wedding and Corsini).

³ Fosha notes that "positive" does not necessarily mean happy; rather, that the patient's subjective felt sense of the experience is one of being "true" or "right", in the way that a crooked picture on the wall *feels right* once properly aligned.

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however, AEDP is a *body-based* treatment, and experience precedes meaning-making. We *sense* before we make sense:

The patient needs to have an experience, a new experience. And that experience should be good. From the first moment of the first contact, and throughout treatment thereafter, the aim and method of AEDP is the provision and facilitation of such experiences (Fosha, 2002).

The Healing Power of Emotion

As AEDP therapists, we privilege the positive, but that is not the whole story! AEDP goes far beyond positive psychology. We create relational *experiences conducive to growth*, so that the people we treat can reconnect with the rich inner resources of their emotions, the “ancestral tools for living” (Panksepp, 2009, p. 4), built into our biology, which many of our patients learned to defensively exclude (Bowlby, 1988) in response to cues from important attachment figures in earlier relational environments. Fosha initially called AEDP “the affective model of change” (2000, p. 1). Emotion theorists and affective neurobiologists have helped us understand that emotions are wellsprings of adaptation (Fosha, Siegel, and Solomon, eds., 2009). Fosha explains how emotions empower us:

Each categorical emotion is associated with a set of adaptive action tendencies, evolutionarily dedicated to endowing our bodies with the resources to contend with the situation that evoked the emotion to begin with (Firjda, 1986). Emotion is the experiential arc between the problem and its solution: Between the danger and the escape lies fear. Between novelty and its exploration lies joyful curiosity. Between the loss and its eventual acceptance lies the grief and its completion (Fosha, 2009, p. 177).

Undoing Aloneness

AEDP views symptoms and pathology as the sequelae of *unbearable aloneness* in the face of unwilling and unwanted overwhelming emotional experience (Fosha, 2000, 2009, 2018). The patient's symptoms and stuck places (i.e., psychopathology) developed initially as the individual's best efforts at adaptation in a maladaptive, skewed environment (e.g., in relationship to an abusive or neglectful parent). Consequently, an overarching goal and method of AEDP is to *undo aloneness*, through the therapy relationship, which we view as a real relationship (albeit, one with clearly delineated parameters and professional boundaries), and one which is powerfully facilitative of corrective experiences of emotion in connection:

People disconnect from their emotional experience, afraid of being overwhelmed, humiliated, or revealed as inadequate by the force of feelings, only to pay the price later in depression, isolation, and anxiety. If affect-laden experiences can be made less frightening in the therapeutic environment— that is, if patients can be helped to feel safe enough to feel— then they can reap profound benefits, for within core affective states are powerful adaptive forces and processes with tremendous therapeutic potential (Fosha, 2000 p. 13).

Thus, AEDP teaches us to actively foster a felt sense of security and connection within the therapeutic relationship, so our patients are no longer alone with painful, frightening emotions, and thus can relinquish defenses developed to ward off feared affective experience. These

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defenses may have been adaptive and even lifesaving in the past, but have become overgeneralized, rigid, and maladaptive in the present. In AEDP, we use the therapy relationship as an attachment relationship, resource our patients with resilience, soften defenses, and go together to places too overwhelming to experience alone. We help undo our patients' aloneness so they can reconnect with and access the innate, evolutionary wisdom of their emotions and process these to completion, in order to reap their benefits and live more freely and fully in the present and onwards. *And then we build on these experiences of change.*

AEDP is Change-Based

The experience of therapeutic change is itself an agent and mechanism of change in AEDP. Change begets change. When explored assiduously, moments and *felt experiences* of transformation amplify, extend, reinforce, and consolidate positive change, thereby fostering an ongoing transformational process, fueled by alternating iterative rounds of experience and reflection on experience. I address this aspect of AEDP in more depth in the latter section of this commentary.

The AEDP Therapist's Stance

As mentioned above, in AEDP we view the therapy relationship as a *real* relationship. The AEDP therapist allows (and actively encourages) the patient to see and know the *person* who occupies the professional role of therapist. The AEDP therapeutic stance is actively and emotionally engaged; embodied; empathic; validating and intentionally positive; affect-facilitating; and judiciously self-disclosing. AEDP therapists purposefully strive to bring themselves into the therapeutic relationship with their patients in a way that is relationally reparative. Thus, the AEDP therapeutic stance "includes everything that the therapist does and is in order to make the patient feel seen, respected, and cared about" (Fosha 2018, p. 24).

THE CHOICE OF AEDP AS THE TREATMENT MODALITY IN THE HYBRID CASE OF "JAMES"

Blimling's hybrid case of "James" concerns an adult male, age 52, who experienced relational trauma as a child, having been abandoned by his father, and having suffered abuse and neglect from his mother. James had become increasingly isolated since the recent death of his older sister, from whom he was separated in childhood, and was relying on harmful coping strategies that put him at increased risk.

I strongly endorse Blimling's choice of AEDP as the treatment modality for this patient, for whom trust is a major issue, and for whom connection is of paramount importance. James very much needed to be seen and accompanied in his suffering. He needed a therapist who could help melt his angry wall of defense. It was as though he were waging a war on the world (and against himself) to ward off his pain. AEDP is ideally suited to a patient such as this who is suffering relational trauma and highly defended. Because AEDP tracks phenomenology moment-to-moment, and has a unique approach towards softening and *melting* rather than confronting defenses, the model is particularly effective in connecting and building an alliance with patients such as James, who was reluctant to engage in treatment.

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Defense Work: Going With Rather Than Against the Current of Resistance

Blimling describes his patient James' presentation as "distrustful and derogatory towards the therapist" (p. 126). He experienced James as confrontational, irritable, and vehement that he did not need or want therapy (which he equated with being crazy). James said he was only attending because his niece (who was his sole remaining attachment) refused any further contact with him until he sought treatment. Moreover, James explicitly stated that he was not interested in working with Blimling due to his "obvious lack of experience and credentials" (p. 129). So, this was not an easy patient with whom to establish rapport!

Blimling accurately identifies the patient's position here as defensive. In AEDP we think of defenses as protective strategies. Rather than confronting and challenging James' defenses, which risked engaging them more forcefully, Blimling chose instead to validate them, which is a classic AEDP move—to soften or melt the defenses by joining with them instead of pushing against them: "I told James that I understood his concern—after all, I did look young, and what reason did he have to trust me with his difficult story and inner experience?" (p. 130). Blimling then offered to do everything he could to help find James another clinician, if after four sessions the patient didn't feel he could trust him.

Here, side by side with James' defenses—his mistrust and devaluing of the therapist, his stubborn pushing away—we can also see glimmers of James' transference strivings. The patient's insistence that he would be better served by continuing to work with the more experienced supervisor, with whom he'd had his initial intake—can be construed as defense and resistance, and rightfully so—yet, at the same time, James' determination to see a more experienced clinician is also a manifestation of his desire to *access an experienced helper* in order to *preserve an important, deeply valued relationship* with his niece. Thus, alongside his resistance, we see the transference: James is highly motivated to see a "real" doctor, one who is not "a kid," who can help him keep his niece in his life. His desire to get help from an older, wiser other, and to repair and maintain a relationship with a loved one are healthy, adaptive longings; albeit they are all but wholly masked by James' defensive attitude and strategies. In AEDP, we want to be on the lookout for these strivings for wellbeing, and to affirm them. When Blimling finds a way to join with James in these intentions, by offering to help him find another therapist if he proves unsatisfactory, he is being what Fosha calls a *transference detective*, he is meeting and responding to the transference strivings. This is an important mechanism of change in AEDP.

Perhaps the therapist could even have gone a step further here, beyond validating James' mistrust of his youthful appearance, to *affirm* and *respect* the positive, healing-oriented motivation behind the patient's defense, i.e., to acknowledge and affirm how James was understandably wanting to advocate for himself and take a stance on his own behalf, in order to get the best and most experienced help he could, in order to ensure that he did not lose a valued connection with his niece. Validating the patient's defenses in this manner might have further contributed to their softening. The therapist could then build on this by asking: "How is it for you that I understand and *respect* your desire to get the best help available?" i.e., to metaprocess (and

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help the patient attend to and hopefully take in) the experience of being understood, even in his defensive devaluing of the therapist.

MUSIC LISTENING: A BRIDGE OVER TROUBLED WATERS

Blimling presents a strong rationale for incorporating music listening in AEDP as a means of bypassing strong defenses, and his decision to do so with James was inspired and effective. The patient had expressed an interest in music and the arts. In suggesting that his patient bring in music that mattered to him, the therapist was creatively responding to something this guarded patient had offered and shared about himself. This was an inspired and effective way to begin to build a relational bridge to and with James, across the troubled waters of mistrust, anger, fear, and shame emanating from the patient, that kept the therapist distant, and left the patient alone with overwhelming affective experience. For reasons described below, music listening was a creative and innovative way of working with James' defenses.

Blimling describes how music facilitates attachment and connection. He discusses the universality of music's appeal, and how mothers across all cultures instinctively use "motherese," highly intonated, preverbal, musical speech, a form of right-brain to right-brain communication, to facilitate attachment (Blimling, p. 119; Trevarthen, 2009). Moreover, music facilitates social bonding in later life as well; it helps people develop and articulate a sense of identity, identify and express values, and experience a sense of belonging. Blimling suggests: "This relational and self-defining aspect of music is central to its utility within psychotherapeutic practice. (p. 119). I concur wholeheartedly and know this to be true from my own experience, both professional (when for example, discussing a shared interest in music has helped me build a connection with a highly avoidant patient) as well as from personal experience.⁴ Fosha herself quoted musician and punk rock poetess Patti Smith in in *The Transforming Power of Affect*: "Those who have suffered understand suffering and thereby extend their hand."⁵

⁴ Music listening played a tremendous role in my identity development, and frankly, helped me not only to know myself but also to regulate and contain challenging emotions during earlier, trying times. In the spirit of an AEDP therapist who does not want to remain shielded to the reader, I offer a personal example of the importance of music to my sense of identity. When I presented my genogram in a family-of-origin group that was part of a Bowenian Multigenerational Family Systems Training program, I brought David Bowie's album, *Aladin Sane*, to be included with photographs of my family members. For me, Bowie had been an important figure in my development, an internal companion for many years in whose music I recognized significant aspects of my experience that were insufficiently reflected elsewhere. In this sense, Bowie was for me an attachment figure, as it were, whose image deserved to be included in my genogram alongside those of my family members. He was part of my tribe, along with many others from the pantheon of rock and roll who, with a nod to Blimling's patient James and songwriter Don Mclean, may indeed have "saved my mortal soul."

⁵ The music of Patti Smith was also a point of connection between Diana Fosha and myself. During my initial training in AEDP, different snippets of song lyrics came to my mind throughout the week (e.g., words from a T Rex song; "Deep in my heart, there's a house that can hold almost all of you." In our closing circle on the last day of the training, as a way of saying goodbye, I told fellow participants how I'd been hearing bits of music all week, and at that moment the song that came to me was "Paths that Cross" by Patti Smith (1988). Diana Fosha replied, "I love Patti Smith! I have her photograph on my office wall along with Charles Darwin and William James." The lyric goes: "Speak to me heart/ all things renew/ hearts will mend/round the bend/ Paths that cross/ cross again/ Paths that cross/ Will cross again" (Smith, 1988).

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Music is highly evocative, and Blimling cites research findings that attest to music's power to elicit emotionally rich memories, corroborated by neurobiological findings that the sensory experience of music activates the limbic system, specifically the hippocampus, i.e., parts of the brain responsible for emotions and memory. For all of these reasons, music listening can integrate seamlessly into AEDP and is a lovely way to invite a patient into experiences of emotion in connection and facilitate the processing of core affective experience to completion.⁶

Blimling's invitation for his patient to bring in music was a key change moment in this therapy. This is an example of the AEDP therapist stance of going *beyond mirroring*, beyond empathy, to reach out and actively attempt to *undo aloneness*. Here, the therapist creatively co-engendered an emerging, nascent sense of safety by inviting the patient to engage in a culturally familiar activity (shared music listening) rather than insisting that James participate in an alien and threatening experience (i.e., talk therapy). It is also a subtle example of two other AEDP change mechanisms: 1) affirmative work with defenses and 2) dyadic regulation of affect. Rather than confronting the patient's defenses and challenging them, Blimling temporarily *bypasses* James' defenses against relating (and feeling) by inviting that he and his patient listen together to music that is important to James. This was also a creative way to begin to coregulate James' affective experience, which the patient feared.⁷

Offering to listen to music *with James* was a way that the therapist used himself and his presence to *accompany the patient in his emotional experience*, thereby making the feared experience more tolerable. In this way, Blimling metaphorically extended his hand. This in turn helped James begin to approach and allow-- rather than avoid-- feelings he feared would overwhelm him (and might indeed have done had he again been alone with them). Because music is so evocative of emotional memory, Blimling's suggestion that they listen *together* to music important to and chosen by the patient was a form of dyadically regulating and titrating James' exposure to feared affective experience.

Moreover, James got to choose whether he brought in music, and which music he brought in. This collaborative approach fostered an emerging sense of safety in the dyad, which was imperative in working with this patient. In AEDP, we know that asking permission builds safety (Fosha & Prenz, 2017; Prenz, 2011) and facilitates affective experiencing and exploration. Consequently, we are purposeful about working collaboratively and asking permission. This is in keeping with psychotherapy outcome research that has shown how working collaboratively strengthens the therapeutic alliance and contributes to positive outcomes in treatment (Norcross, 2010). At this crucial juncture in the therapy (and throughout treatment, for that matter), Blimling artfully responded to and navigated the troubling waters of his patient's wariness and hostility: by asking permission and co-engendering safety at the patient's own pace, all the while

⁶ It is worth noting that core affective experience is not comprised solely of emotional experience; it can also encompass relational experiences, authentic self-states, and other experiences of congruence. (Fosha, 2000).

⁷ Blimling later learned that James had stopped listening to music altogether, because he so feared the feelings this would evoke.

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seeding the possibility of James' feeling known and *felt* by another, through the incorporation of music listening into the treatment.

James responded to Blimling's invitation and brought in the Bill Withers song, "Lean on Me," which the therapy pair listened to together. That James chose such a highly evocative, attachment-infused song is a "green light"—an indication (signal affect) that transference is coming to the fore in response to the affect-facilitating relationship offered by Blimling.

"Lean on Me" could be read as a metaphor for how the AEDP therapist seeks to spread the weight of the patient's suffering across the therapeutic dyad, so that it becomes bearable and ultimately, transformative:

Sometimes in our lives/ We all have pain/ We all have sorrow...
If there is a load/ You have to bear/ That you can't carry
I'm right up the road/ I'll share your load/ If you just call me
(Withers, 1972).

The shared experience of listening to a song such as this, that speaks to *and normalizes* human experiences of vulnerability, of pain and sorrow, of being in need, of turning to a caring and reliable other for support, has the potential in and of itself to begin to undo the patient's heretofore unbearable aloneness in the face of suffering, *provided the patient is able to take in the presence and compassion of the other*. Importantly, when James remained slumped over on the floor after listening to the song, Blimling reached out to make connection (again, to metaphorically extend his hand), to further undo James' solitude and isolation in his emotional experience, by *gently* asking what the song meant to James.⁸ Here we have an example of moment-to-moment tracking and dyadic affect regulation, as well as an important instance of right-brain to right-brain communication. *How* the therapist engaged in this moment was as important, if not more so, than *what* he said. As I read this passage of the case study, I imagine Blimling's tone of voice, his gentle presence, the soft slow way he engaged James. These qualities of therapeutic presence and attunement are of paramount importance in a moment such as this. James responded in a heretofore novel and uncharacteristically unguarded way, sharing with his therapist affect-laden memories from childhood of his attachment relationship with his sister, which were evoked by the music. Thus, the collaborative music listening, in combination with the therapist's moment-to-moment tracking and attuned sensitive use of self, helped bypass some of James' strong defenses and played a key role in accessing some of James' inner world, and dyadically regulating the patient's affective experience.

In AEDP, the unit of intervention is what the therapist does and how the patient responds, which can then inform and guide our next intervention. In this case, very much in keeping with the ethos and stance of an AEDP therapist, Blimling shared his response to the therapeutic

⁸ Here, the therapist asked a "head-question"—what listening to the music *meant* to the patient. Whereas, because AEDP is an experiential and body-based treatment, I might have chosen to ask a question about James' physical, somatic experience in the moment, e.g., "What's happening inside just now, James?" or "What are you aware of physically, in your body?" However, sometimes asking a more cognitive question can be regulating of affective experience, and in this instance, Blimling's intervention was extremely effective!

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moment: "That's a very moving story... I can tell how important your sister was to you." And James responded defensively and sarcastically. Blimling recounts: "James' face tightened. 'You wanna make some big deal outta this now, right?', James said, his defensive mechanisms triggered by this brief moment of vulnerability" (Blimling, 2019, p. 131). The collaborative music listening had evoked previously unshared memories and feelings, and when the therapist shared his empathic response, the patient experienced signal anxiety and his defenses were triggered. This is often what happens when very defended people get closer to core affect. It is not surprising nor an indication of a therapeutic misstep! The feared emotions cue the anxiety, and the patient responds by becoming defensive, as a means of managing the anxiety (signal affect) and warding off the feared emotional (or relational) experience. Blimling states: "We spent the remainder of the session in the usual back-and-forth, with James asserting that he needed no treatment and me being cautious not to confront him in any way that may cause him to shut me out completely and flee from treatment" (Blimling, 2019, p. 131).

While the dilemma here for the therapist, with regard to how to best titrate affective experience in order to work at the growing edge of the patient's capacity for connection (to self and to other), is very valid, this juncture may again have offered an opportunity to attempt to bypass the patient's defenses, rather than spending the rest of the session in "the usual back and forth." One possible response might have been for the therapist to say something along the lines of: "James, I'm wondering if we could ask the part of you that gets so sceptical and critical of feelings if it would be willing to step aside for a few moments, so we could just make a little more room for what it was like to listen to that song and share memories of Janice with me? Because in some ways that was a big deal." This is an example of an AEDP attempt at defense bypass in order to stay with emergent core affective experience and/or metaprocess an important therapeutic moment. Although such an attempt might again have been met with further defensiveness, there is also the possibility that it could have opened up space for something new to transpire. Alternatively, if the therapist noticed visible signs of anxious activation in the patient, s/he might choose to co-regulate the anxiety, e.g., by slowing down and inviting the patient to breathe/and or ground, which might facilitate a drop down into the underlying core affect.

When James arrived on time for the next session, for the first time, this was another "green light" signal that the collaborative music listening was working in the service of transformance. The patient reported that he had been thinking a lot about his relationship with his sister, since the previous session. James said: "I hadn't listened to that song in a long time." Blimling responded by asking, "What was it like for you to hear it again?" (p. 131). This is an AEDP metaprocessing question, par excellence: an invitation to explore and experientially process an important moment in the therapy.⁹ The shared experience of music listening in the

⁹ In AEDP we metaprocess along the way, and also purposefully structure sessions to leave some time at the end for "Big M" Metaprocessing of the session as a whole. For example, near the end of a session, we might ask, "What was it like to have this experience today? What was meaningful or stands out for you from our time together? ...". And also, "What was it like to have the experience with me?" In this way, we metaprocess both affective and relational experience. We also can metaprocess retroactively- exploring an important moment of change from a previous session, as in the example above when Blimling asks James what it was like to have heard American Pie again.

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previous session deserves attention; we would not want an experience of potential therapeutic change to go unnoticed. Rather, we want to focus on experiences that are new and preferred, in order to engage positive neuroplasticity (Fosha 2018; Hanson, 2009).

When the patient again responded defensively, with sarcasm and scorn for his therapist's inquiries about his feelings, Blimling melted his patient's defenses by going beneath them and addressing the underlying feelings: "I would imagine it made you feel something. It certainly did for me when I listened to it and heard your story" (p. 131). This was a titrated version of an intervention that Eileen Russell calls "pressuring with empathy" (2015, p. 44). Russell and Fosha (2008) describe how this therapeutic strategy involves "the explicit use of the therapist's emotional reaction, more specifically, the explicit self-disclosure of her own feelings of compassion, warmth, or appreciation, to help the patient feel at a deeper level" (p. 181). Following his judicious and empathic self-disclosure, Blimling stays with James' emergent affective experience:

James was silent for a long period, looking at me as if he were sizing me up. "I mean, I didn't have like, a breakdown or anything", he said. "So what, then?", I asked. "I mean, I had forgotten how important my sister was to me then. It was like she was the one who was gonna save me, look after me or something, I dunno...". James trailed off. I waited several moments before responding, "Like I said last time, it's clear how important your sister was to you. I'm so sorry for your loss". James, again looking down, began to wipe his eyes. We sat in silence for a long time before he said anything. "I can't believe she's gone. Just like that, gone." I nodded as James continued to cry quietly. Again, James was allowing himself to experience the painful core affect he had worked so hard to avoid, but we were running out of time (Blimling, 2019, p. 132).

In the exchange above, Blimling's self-disclosure of how he was moved by his patient's experience, and his heartfelt "I'm so sorry for your loss," are further examples of an important underlying tenet of AEDP – that the therapist must be an active member of the dyad, one who is emotionally engaged and appropriately self-revealing. As AEDP practitioners, we bring our humanity with us into our professional role. Rather than attempting to be "neutral" or trying to bracket our personal responses to our patients, we share these, when appropriate, because judicious self-disclosure of this kind is often facilitative of the patient's growth and healing. This requires courage on the part of the therapist:

The patient cannot be expected to rapidly open up to a therapist who remains hidden and shielded. The emotional atmosphere should be one in which the patient feels safe and the therapist brave. The patient's sense of safety within the therapeutic relationship is enhanced in part by the therapist's risk taking (Fosha, 2000, p. 13).

Blimling's judicious self-disclosure here paved the way for James to experience his feelings *in connection*. He captures much of the essence of AEDP when he writes of this juncture:

Guided by Fosha's AEDP model, I saw my objective as being to make the space safe enough for James to experience his core affect (Fosha, 2010) without manipulation or distortion from his defensive structures, thus allowing for a new interpersonal experience and his

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innate "self-righting tendencies" (Fosha 2010) to take hold... As therapy progressed, it was hoped that James could continue to have contact with his difficult core affect such that he could meaningfully process his grief while gaining a new interpersonal experience of trust (Blimling, 2015, p. 132).

In AEDP, we help our patients develop their affective capacity, which is comprised of two aspects: expressive and receptive. Within a security engendering therapeutic relationship, patients develop their ability to feel and express their emotions, as well as their capacity to *receive* care and the emotional response from another. Fosha calls the latter "receptive affective capacity" (Fosha, 2018, p. 6).

This objective of fostering development of the patients' affective capacity provides another reason to metaprocess any and all therapy experiences in which the patient feels, expresses, and shares feared emotions, rather than defensively avoiding these. Predictably, patients experience an affective shift—and feel *relief*, or *lighter*, or some version of "good" or *better*—in the wake of a wave of adaptive core affect. We do not want this "post-breakthrough affect" (Fosha, 2007, p. 3) to go unnoticed. Rather, we want our patients to attend to any and all experiences that are disconfirming of the expectation that their emotions will be too much for them to bear! Or that an attachment figure will be indifferent or rejecting in response to their affect. We can think of metaprocessing as a way of accessing the innate, endogenous positive reinforcement that comes from allowing oneself to experience *emotion in connection*, and reap the benefits that come when one feels *safe enough to feel* (Fosha, 2000; 2009; 2018).

In the vignette described above, Blimling wrote: "Again, James was allowing himself to experience the painful core affect he had worked so hard to avoid, *but we were running out of time*" (Blimling, 2019, p. 132, italics are mine). Blimling's sessions in the composite case of "James" often run out of time at just the moment when I would have wanted to metaprocess the powerful change events that had occurred, in order to help them become more fully integrated in the moment. Doing so might have deepened the change process and rendered the treatment more quintessentially AEDP. In his case study, Blimling described several times when he metaprocessed powerful therapeutic moments from a previous session, retroactively. However, metaprocessing at a later time may not have the same power as having done so immediately on the heels of an emotionally charged moment, when the new experience of emotion-in-connection is more fresh and alive for the patient. For this reason, AEDP therapists intentionally structure their sessions to allow for metaprocessing near the end of each session, whenever possible.

The next breakthrough in treatment occurred in session 7, after a period in which the patient had become increasingly belligerent and aggressive in his personal life and in therapy. Importantly, Blimling had further embodied the AEDP therapist stance of *actively extending a helping hand* by persistently reaching out by phone to his patient (whom he feared might be at risk for suicide), after James had stormed out of session early in response to Blimling's suggestion that he again bring in music that was meaningful to him. At their next session, James recounted a painful interpersonal event and spontaneously described how he had been deeply moved by the music in the movie he'd watched the previous night:

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I was so fucking angry all weekend, but when that scene came on, I just, I dunno, I started crying. I cried and cried, the music was like a punch in the stomach (Blimling, 2019, p. 133).

Blimling, who was familiar with the movie score, again creatively, and this time spontaneously, incorporated music listening into the therapy to powerful effect, by asking James if they could listen to the piece together:

We sat and listened together, James with his head in his hands. James soon began to sob uncontrollably, his tears dotting the linoleum floor. This was the first time I had gotten a glimpse of the depth of James' true sadness, of his desperation. The music was the conduit by which his defenses had been bypassed, and instead of rage and condescension, he finally was able to feel what lay beneath, his core affect. It had returned him to that moment of despair he had felt while alone in his apartment, but this time he was able to let me see it. We sat in silence for several minutes following the conclusion of the movement. As James wiped his eyes, he quietly uttered just two words, "I'm alone".

I sat quietly and looked at James, but he did not raise his eyes from the floor. I said nothing for fear of disrupting this fragile moment, his experience of his core affect. Worse yet, I risked saying something that would cause him to return to his rageful, defended state. "There's nobody left – my sister is gone, her family wants nothing to do with me, not even an old friend wants anything to do with me." "I'm glad you came back", I said. James lifted his head and looked at me directly for the first time in the session. (Blimling, 2011, p. 134).

This vignette, in which James allows his therapist to see the depth of his sadness and to hold his experience of "I'm alone," was very touching to read. It provides a lovely example of the therapist: a) making space; and b) using affirmation and appropriate and necessary self-disclosure ("I'm glad you came back") to help undo a patient's aloneness with unwilled and unwanted, emotional experience (Fosha, 2003, 2009, 2018). There may also have been an opportunity here for Blimling to use *dyadic affect regulation*, at the very moment when he feared disrupting the "fragile moment" of James' experience of his core affect, by gently asking, "Do you have a sense of me here with you?" Or "what is your sense of me here with you?" This kind of relational intervention might have helped co-regulate the patient's affect in the moment and help him from sinking into shame. As AEDP therapists, we often have to navigate these choice points between allowing space for unfolding affective experience versus intervening in a way to facilitate the affective flow. Moment-to-moment tracking of phenomenological markers guide the therapist in these decisions, and without having been in the room (or viewing video of the session) it is impossible for me to know whether my suggestion above would have helped or interfered with the process.

The vignette from session 16, in which James *initiated* music listening with his therapist (another signal that the music listening is working in the service of transference), is also touching and evocative. The patient arrived looking "particularly chipper" and announced upon arrival, "I have something to play for you." He had brought in the Don McLean song, American Pie, which his sister had given him years ago along with a note that said "I hope this music can save your mortal soul" (Blimling, 2019, p. 135). Listening to the song with his therapist, James experienced sadness about his sister's death (and presumably for himself during his difficult

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childhood), as well as gratitude for his sister (who was his most consistent and attuned attachment figure). Significantly, he tells Blimling:

She gave me so much, I don't think she even knew," James said, his eyes again becoming glassy. We sat in silence for several moments. "You know, I realize I avoided music for so long because of this feeling", he said. "What's the feeling?", I asked. "I can't really describe it. The song seems both happy and sad at the same time, and I don't know whether to smile or cry". I paused for a moment. "Janice did give you a lot. I'm glad you had someone to give that to you". James began to cry, this time without reservation. "I miss her so much", he said. Little was said for the rest of the session, I simply sat with James while he cried (Blimling, 2019, 135).

Here, as Blimling sat in silence with his patient while he cried, the therapist was accompanying the patient in the processing of core affect, which is exactly what we want to do in AEDP when defenses have been bypassed and patients have dropped down into deeper and more vulnerable, authentic and unguarded affective or relational experience (i.e., State 2 of AEDP). When a wave of emotion has crested, an AEDP therapist might also gently ask, "Is there more?", in order to facilitate processing to completion and the release of the associated adaptive action tendencies. Then, we would typically then metaprocess the experience, for example: "Wow. That was a big wave. What's that like to experience?"

While processing affective experience to completion in this way is a key component of AEDP and typically yields an experience of the patient feeling lighter or better, Fosha writes: "what is usually the endpoint of the therapeutic road" in other therapeutic modalities "is [a] starting point" in AEDP (2000, p. 72). In AEDP we also want to process the *experience of change* that comes in the wake of experiencing core affect in a security-engendering attachment relationship. There is tremendous therapeutic potential in doing so.

THE SECOND AVATAR OF AEDP

Before commenting further on this moving vignette or the case study as a whole, it will helpful to discuss how AEDP has evolved as a model since the publication of Fosha's book, *The Transforming Power of Affect* (2000). The expansion and evolution of AEDP itself, as a theory, treatment model, and clinical roadmap has been informed by twenty years of patient change as witnessed, co-experienced, and co-engendered by an ever-widening community of clinician practitioners. That AEDP -- an experiential model based on the phenomenology of change as brought about through experiences of attachment and the processing of emotion in connection -- has evolved and expanded via therapeutic experiences of change, is deeply congruent with the theoretical underpinnings of this phenomenology-based transformational model. Over the past decade, the abovementioned "starting point" in AEDP (that follows change-for-the-better that is the usual "endpoint of the therapeutic road") has become an increasingly important focus of the model. Fosha (2018) refers to the period from 2000-2008 as the "First Avatar" of AEDP and describes how AEDP has since evolved from "an attachment- and emotion-focused model (First Avatar) to becoming more solidly and increasingly explicitly an attachment-, emotion- AND transformation-focused model (Second Avatar)." (Fosha, 2018, p. 7).

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Blimling's case study of James is informed primarily by the first avatar of AEDP. Whereas, in AEDP's Second Avatar (2008/9 to present), the *experience of transformation* itself is now seen as a change factor equal in importance to the experiential processing of emotion in a security engendering relationship. Hence, the *phenomena* that arise on the heels of moments of positive change and the experiential processing of transformational experience, have become increasingly important foci of the work:

We experientially process transformational experiences as assiduously as traumatizing experiences. And, countering the bias toward negative emotions both in our brains (Hanson, 2017) and in our field (Frederickson, 2013), the positive affects that accompany transformational experiences are attended to as carefully as the negative affects of trauma (Fosha, 2018, p. 4).

In 2009, Fosha expanded her model, originally comprised of three distinct phenomenological states (anxiety and defense; core affect; and core state) to a four state model. And it is to the more recently identified additional state of AEDP's phenomenological map that I wish to direct our attention now. In the wake of processing core affective experience to completion, people feel a change. The phenomenology that emerges subsequent to having experienced this change constitutes what we now call State 3 of AEDP. The primary, *de rigueur* AEDP intervention in State 3 is metaprocessing. And when we metaprocess in State 3, patients predictably experience and describe distinct and distinguishable affective and transformational phenomena. These are the emotions that come on heels of change, which result "from systematic experiential processing of transformational experiences, i.e., from successive rounds of metaprocessing." (Fosha 2018, p. 8). To date, Fosha (2018) has identified six distinct transformational processes and their related *transformational affects*, which include:

- *Mastery Affects* of pride and joy, pleasure, curiosity, and confidence that emerge when shame and fear abate and the self is newly resourced
- *Mourning- the-Self*: the painful yet liberating emotional experience of grief and compassion for one's own experiences of suffering and loss.
- *Tremulous Affects* of fear/excitement and positive vulnerability associated with new and unsettling, even if preferred, experiences of rapid change and "traversing the crisis of healing change" (Fosha, 2018, p. 9)
- *Healing Affects* of gratitude and tenderness towards the other (e.g., therapist) and/or feeling moved and touched or poignantly emotional within the self
- *Realization Affects* of wonder, amazement, and awe associated with taking in new emergent understanding and grasping the magnitude of changes within the self taking place.
- *Enlivenment Affects* (Iwakabe & Conceição, 2015) of exuberance and inspiration, excitement and motivation that accompany the emergent new sense of self as unbroken.

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AEDP's increased focus on the transformational potential of experiences of transformation¹⁰ is of great importance, because metaprocessing transformational experience simultaneously *expands* and consolidates experiences of change-for-the-better. Therefore, we want to attend to and explore transformational affects and positive therapeutic experiences as systematically as we would negative experiences. Remarkably, the thorough experiential exploration of moments of positive change in therapy frequently results in an upward and expansive spiral of positive affective experience. As the therapist resonates and responds to the patient's evolving transformational experience, the therapy pair engage in and co-create the kind of recursive and expansive, often joy-filled interpersonal exchange that Tronick (1998) called dyadic expansion of consciousness (Fosha, 2009, 2018; Russell, 2015). Moreover, this kind of mindful attention to preferred experience is facilitative of positive neuroplasticity (Hanson, 2009) that helps redress our species' survival-based bias to attend to that which is feared (i.e., to be anxious); and is consonant with Frederickson's (2001) broaden and build evolutionary theory of positive emotion (Fosha, 2018; Westwood, 2016).

Fosha (2018, p. 4-5) describes how this is a vitality generating and appetitive process:

We have discovered over many clinical encounters that focusing on the experience of transformation itself unleashes further rounds of transformation, through which positive changes can be powerfully consolidated, deepened, and expanded in a momentum-generating spiral of healing. Progressive rounds of metatherapeutic processing lead to a nonlinear, nonfinite transformational spiral, an ever emergent upward movement (Frederickson, 2009, 2013) that fuels the system with more and more energy and vitality (Fosha, 2009a, 2009b). Each new experience, once explored in the context of safe attachment, becomes the platform for the next round of exploration. Each new reaching becomes a platform for the next reaching.

When new pursuits and experiences are accompanied by positive affect, they bring more energy into the system and recharge the spiral yet again. As we exercise our new capacities, they become part and parcel of who we are, new platforms on which to stand and reach for the next level. As I have written before, "These positive emotion transformational processes are by their very nature recursive processes, where more begets more. This is not a satiation model or a tension reduction model, but rather an appetitive model. Desire comes in the doing. The more we do something that feels good, the more we want to do more of it" (Fosha, 2009a, pp. 202).

Returning to Blimling's case study, I wonder how things might have gone if the therapist and patient had metaprocessed James' experience of listening to American Pie and crying silently with his therapist witnessing and holding this deeply moving experience? I'm curious what it was like for James to have shared the poignant, bittersweet gratitude about having had his sister in his life and sadness for having lost her? Or his feelings of grief and compassion towards himself at an earlier time in his life? I can imagine that had the therapy pair experientially explored these important therapeutic moments, the patient might have felt a sense of relief and lightness, in the wake of the affective processing, and that it would have felt "right" and "true", and in this sense "positive", to have expressed these feelings and to have shared them with his

¹⁰ To illustrate this recursive and self-reinforcing concept, I use the image of M.C. Escher's lithograph "Drawing Hands" in which two hands come off the page to paradoxically draw each other into existence).

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therapist. Attending to this positive affective shift might have led to the kind of State 3 transformational affects described above (more below).

Moreover, AEDP has taught me (or perhaps more accurately, given me permission) to let myself feel deeply in relationship to my patients, and when appropriate, to judiciously self-disclose my feelings about the patient and/or our therapeutic process. In addition to metaprocessing (as suggested above), I might have let James see and know how his emotional experience affected me, and then asked him how it was for him to know he had so impacted me (i.e., metaprocessed my self-disclosure of his effect on me). People need to know they affect and have an impact on others, and it is often very powerful for patients to see and feel how they have impacted their therapist. Often these types of self-disclosures on the part of the therapist, in response to the patient's experience, and/or self-disclosures about the therapist's experience of the therapeutic process, deepen a patient's affective and transformational experience. Thus, making explicit to James how he impacted me might have deepened the unfolding and powerful change process facilitated by Blimling's incorporation of music listening into his treatment of James.¹¹

After the powerful session in which James and Blimling listened to American Pie,¹² the patient subsequently began to make healthier choices and positively engage more with others (e.g., joining a book club, casual dating). James also stopped drinking alcohol, experienced fewer depressive symptoms, and his awareness of his emotions and ability to regulate them also increased. James also began to reengage with his painful past in therapy, where his focus shifted from recent loss to childhood losses including his father's absence and failure to protect him from his mother's abuse. Again, music listening helped the therapy process, when James brought in the French language song, "Papaoutai":

...it means 'where are you dad? Roughly, anyway. The French is kind of slangy.'", James said. "Sounds relevant", I replied. "I asked myself that question every day as a kid...", James trailed off. "I just wanted my dad to come and get me, to take me away from my mother". James became somber. "I hate her. She ruined our family", he said, looking at the floor. I reflected that those were strong words, and that I imagined there were strong emotions underneath them as well (Blimling, 2019, p. 136).

Blimling's response here impressed me as sensitive and truly skillful, a gentle yet probing invitation for James to drop into and process deeper affective experience. James went on to recount deeply disturbing childhood experiences of abuse, about which he had never before

¹¹ Part of the beauty of metaprocessing is that it also lets us know if there is a rupture to attend to in the therapy and if there is a need for repair. For example, if I share with a patient how I am deeply moved by their experience and this somehow inadvertently impinges upon or takes the patient out of their experience and makes the moment more about me and my experience, then metaprocessing can help bring this to the fore so we can address the rupture and I can instigate a repair and adapt accordingly.

¹² Playfully, here, I suggest that James' sister's wish came true—the song did help free his mortal soul, metaphorically, by giving him access to long defended feelings, in relation to which the consequences of his defenses had become life-threatening.

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spoken to anyone.¹³ At this important juncture, Blimling asked two key metaprocessing questions:

I asked James what it was like to finally speak about it, and to speak about it with me. James paused for several moments. "Good actually," he said, "I know it sounds weird, but I feel like a weight is being lifted from me. I don't feel so angry, and the sadness feels different". In order to more fully explore how his experience had changed in therapy, I asked him to speak more about the sadness. James said that he had always felt alone, and that his sadness was irrelevant and a sign of weakness. Further, he had always felt that he was on his own in most aspects of his life, and that his emotional problems were his alone to bear as both a child and as an adult. "It's like I was drowning before," he said, "and I didn't even know it. Now I still have to swim, and that's hard work, but there's not the same desperation in it, you know?"

I was impressed with James' metaphor, and more importantly was struck by his increased ability to tolerate his affect without becoming totally dysregulated or relying on defenses that distanced him from people. He was, at this moment, experiencing a sadness which was neither disavowed nor incapacitating. Further, his characteristic anger and primitive devaluation were conspicuously absent. With respect to Fosha's model, James was now able to experience distressing emotion without becoming overly defended in the presence of another person with whom he felt secure, respected, and safe. This was an experience that he had only previously had with his sister, and his ability to maintain his secure attachment to me while still effectively processing so much traumatic material was a tremendous prognostic indicator (137).

Importantly, the patient had chosen the song, "Papaoutai," hoping the more contemporary style of music would appeal to his younger therapist, who had become a valued other. Blimling writes:

I was struck by James' assertion; he had chosen a song because he thought it would be something I liked, as well as something that was relevant for him. This demonstrated a willingness to connect that I found to be in stark contrast from James' initial presentation and overt disdain for me. His choice of music had become representative of his feelings of safety and attachment, and of wanting to relate and maintain proximity with me (Blimling, 2019, p. 140).

Here we see how the shared ritual of music listening in the therapy had become a manifestation of and conduit for the attachment relationship between patient and therapist. This is further apparent in James' request that Blimling bring *him* some music of the therapist's choosing, before leaving. Moreover, James' ability to tolerate rupture and navigate repair in his relationship with Blimling had also grown, as evidenced in how he responded to learning Blimling would be leaving the clinic. Clearly, the therapy described in the case study, skillfully

¹³ In AEDP, we might also work imaginatively to help a patient process emotion to completion, by inviting the patient to do a "portrayal" in which the adaptive action tendency related to the core affect is expressed through a fantasized scene (e.g., a rescue portrayal in which James' father—or adult James and his therapist—come and take him out of his mother's home, or an anger portrayal in relationship to his father for his failure to have done so, or to his mother for abusing him). See Fosha, 2000, for more information on this intervention.

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and sensitively executed by Blimling, as well as his creative incorporation of music listening in the treatment, had a powerful impact on the patient and led to important experiences of positive change, notably the above described marked growth in James' affective and relational capacity.

ENVISIONING POTENTIAL EXPANSION AND CONSOLIDATION OF THE TRANSFORMATIONAL PROCESS

Blimling writes about his experience of hearing that James had chosen "Papaoutai" with him in mind:

James' words were impactful for me, as they were personal on many levels. His exclamation that he had brought music that he genuinely hoped I would like seemed to be an affirmation of the strength of our relationship, and James' efforts to reach me as a person. (Blimling, 2019, p. 138).

Again, I am very curious what might have happened had the therapist shared with his patient *how* he was impacted by James' efforts to reach him as a person through his choice of music — what this meant to Blimling and, perhaps more importantly, how the therapist *felt* knowing this. I imagine that expressing this might have deepened James' sense of connection to Blimling and confirmed for James that he had indeed succeeded in his efforts to reach his therapist as a person. Based on my personal experiences as an AEDP therapist, as well as my theoretical understanding of the model, I would predict that the metaprocessing of this kind of judicious self-disclosure, at a moment such as this, could have yielded powerful transformational affects.

Similarly, when Blimling told James that he "saw a different James from the one who had initially walked into my office" (2015, p. 137) and affirmed the many significant changes James had made over the course of therapy, I believe this exchange could have been an important and powerful launching point for the therapy pair to explore James' feelings about the important work he had done and how much more connected he was now to his feelings and to other people. I can imagine how, had they metaprocessed the therapist's affirmation of his patient's changes, James might have experienced a sense of mastery and joy (State 3 *Mastery affects*) at being able to feel his emotions and share them. He might have experienced some of the tremulous affects, the positive fear associated with inhabiting a new way of being, and/or the deep emotional pain (*Mourning the self*) for all the times in his life when he had suffered alone, disconnected from others and from himself. Furthermore, James might have experienced a click of recognition with regard to the magnitude of changes he had made (State 3 *Realization affect*).

Often, as patients come to experience more of their inner world and allow themselves to do so, they express feelings of *gratitude* (State 3 *Healing affect*) towards the therapist for accompanying them on the journey and helping them come more alive-- not that we are looking for this kind of acknowledgement. If we were, this would be a narcissistic reversal and not in the interest or service of the patient's needs but rather of our own. However, State 3 expressions of gratitude on the part of the patient are indeed of value because this expression feels good and right and true to the patient, and *it needs to be received by the therapist*. The AEDP therapist and patient can together explore this positive feeling, and again, recursively the therapist can let the patient know how they feel upon receiving the patient's gratitude and inquire how it is for the

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patient to know and see how they have affected their therapist? Frequently, the patient's affective experience deepens in response, and they also have a sense of *exuberance* and *motivation*, fueled by their new and emergent sense of self as more whole and alive (State 3 *Enlivenment affects*).

Moreover, the therapist might express delight or joy in response to seeing the patient flourishing, or feeling deeply touched within her/himself by the scope of the change and the courage it took for the patient to shed defenses and engage in these new ways. Again, this self-disclosure can be metaprocessed and doing so often further deepens the patient's experience of transformational affects and sense of well-being. This is the stuff of the non-finite, non-linear transformational spiral Fosha describes. I have seen it over and over again in my work. While it is difficult to convey in writing the power of these affective phenomena, they are viscerally very compelling when experienced, both by the patient and, in resonance, by the therapist.

Subsequent to repeated rounds of State 3 metaprocessing, patients often experience a highly integrative state of calm, openness, clarity, coherence, acceptance, and compassion. Fosha (2000, 2009, 2018) calls this core state (the fourth state in AEDP's non-linear phenomenological map). Core state is characterized by ease, vitality, flow, and what Fosha (2009) calls the "truth sense...a subjective sense of 'truth' and heightened sense of authenticity" (p. 188). Almost always, the therapist simultaneously experiences a similar state, in resonance and harmony with the patient (Fosha, 2009).¹⁴ Fosha writes: "the defining qualities of core state overlap with qualities characteristic of resilient individuals and also with those cultivated by contemplative and spiritual practices..." (2009, p. 188). Perhaps James touched into core state near the end of the "Papatouai" session, when he said of his parents that "he finally realized he had to 'let them go'" (Blimling, 2109, p. 137).

SUMMARY AND CONCLUSION

In summary, Blimling's engaging case study clearly demonstrated how music listening can creatively and effectively be integrated into AEDP therapy to foster the healing power of attachment and emotion. The introduction and incorporation of collaborative music listening in the treatment helped Blimling: 1) build a relational bridge between himself and James; 2) soften and bypass the patient's formidable defenses; and 3) undo the patient's aloneness with

¹⁴ This is presumably a consequence of right-brain to right-brain communication, which creates a field of resonance between patient and therapist. Russell and Fosha (2008) "hypothesize that the shift from core affective processing" [and state 3 metaprocessing of transformational affects] to core state is a shift from sympathetic nervous system dominated high arousal states to parasympathetic nervous system low arousal states." As AEDP therapists, we are always seeking to attune with our patient's experiences and affective state, and we use our embodied experience to help guide us in doing so. In core state there is no need for dyadic affect regulation, because the patient is in a highly regulated, open state of calm. Rather than the therapist entraining the patient into a deeper state of affective processing (as happens when patient is in State 1 anxiety and defense) or co-regulating the patient's affect (as happens in State 2 processing of core affect), in core state, therapist and patient co-engage and co-entrain each other into the deep integrative state of calm and flow.

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overwhelming emotional experiences, thereby 4) facilitating the processing of core affective experience within a security engendering therapy relationship.

Thus, in combination with Blimling's sensitive and skillful work as a therapist, the evocative nature of music chosen by the patient as important to him allowed James to access his emotional world and aspects of his traumatic history, rather than warding these off defensively. Music helped the patient relate to his therapist and be known and felt by him. Throughout the treatment, collaborative music listening evoked and helped titrate and dyadically regulate the patient's powerful emotions, in the present moment, so he could feel, share, and process these. In doing so James grew significantly in his ability to regulate his emotions and to trust others, i.e., to "feel and deal while relating" (Fosha, 2000), and he began to make healthier life choices. No longer a feared realm to be avoided at all costs, the patient's affective experience could now help him adaptively navigate the world. Moreover, the shared music listening in the therapy helped James integrate his painful history into his self-story and sense of identity. The integration of traumatic experience and the articulation of a coherent and cohesive autobiographical narrative are hallmarks of trauma recovery (Bowlby, 1988; Herman, 1997).

Perhaps the therapeutic gains described in the Case of James could have been enhanced and further reinforced had the therapist allowed more time to experientially explore the patient's embodied, physical experience of moments intrapsychic and interpersonal contact—important moments in connection to his emotions and with his therapist. Having done so might well have deepened the change process and rendered the therapy more quintessentially AEDP. Furthermore, had Blimling and James assiduously and experientially explored the patient's *experience of therapeutic change*, through meta-therapeutic processing of moments of change for the better, this likely could have yielded further expansion and consolidation of the transformational process (via the unleashing of transformational affects and processes), thus augmenting the significant positive outcomes in the case.

This commentary also addressed AEDP's evolution over the past twenty years. AEDP is first and foremost an experiential model based on the phenomenology of change brought about through experiences of attachment and of emotion in connection. Consequently, the expansion and evolution of AEDP itself, as a theory, treatment model, and clinical roadmap, informed now by two decades of patient change as witnessed and co-engendered by a growing community of AEDP practitioners, is deeply congruent with the theoretical underpinnings and development of this phenomenology-based transformational model (Fosha, 2018). And now, Blimling's exploration of the incorporation of music into an AEDP therapy may further contribute to the evolution and expansion of AEDP, which is itself in consonance with Fosha's image of a non-finite transformational spiral of positive change.

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