TRUE SELF, TRUE OTHER AND CORE STATE:

Toward a Clinical Theory of Affective Change Process

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PART I: AFFECTIVE CHANGE PROCESSES

"*There is a distinct physical sensation of change, which you recognize once you experienced it. We call it a body shift. When people have this even once, they no longer helplessly wonder for years whether they are changing or not. Now they can be their own judges of that*" (Gendlin, 1981, p. 7)

A Metapsychology of Therapeutics. A model of therapy needs at its essence to be a model of change (Fosha, 2000, 2002). My goal here is to begin to articulate the metapsychology of therapeutics. This metapsychology of the therapeutic process should not be derivative --a poor cousin-- of the theory of psychopathology, but function as a strong explanatory framework in its own right.

Traditional psychoanalytic theory has been unequaled in the depth of understanding it provides into the phenomena, processes and mechanisms by which psychopathology develops and is maintained. However, the depth of understanding of pathology has not been matched by a depth of understanding of the phenomena of healing. The psychoanalytic metapsychology of therapeutic change, such as it is, as well as the psychoanalytic theory of optimal development for that matter, remain wedded to processes of pathology. Not surprisingly, a model of change rooted in pathology is better at explaining how and why people don't change (or get worse), than it is at explaining how and why people get better.

In contradistinction, AEDP (Accelerated Experiential Dynamic Psychotherapy) derives its understanding of how therapy works from an examination of different areas

where transformation operates powerfully, often rapidly and dramatically. AEDP, a model that integrates experiential and relational elements within an affect-centered psychodynamic framework, places the experience of affect in relationship at the center of how it clinically aims to bring change about (Fosha, 2000). Though its clinical method is experiential , fundamentally AEDP is a psychodynamic model. However, the inspiration for precisely those aspects which distinguish it from other psychodynamic approaches (both short- and long-term) comes from the rootedness of AEDP in natural affective change processes, and their characteristic phenomena.

Several bodies of theory and research have proved useful in helping restructure traditional psychodynamics into an affect-centered model that can account for the therapeutic phenomena that emerge upon the application of the techniques of the experiential STDPs.

---- Emotion theory and **affective neuroscience** (Damasio, 1994, 1999; Darwin, 1872; LeDoux, 1996; Panksepp, 1998; Siegel, 1999; Tomkins 1962, 1963) offer an account of change intrinsic to the experience of the *categorical emotions*, universal phenomena characterized by specific neurophysiological and body signatures, and by the state transformations and adaptive action tendencies released upon their experience and expression;

----- Attachment theory (Bowlby, 1988, 1991; Fonagy et al. 1995; Hesse & Main, 1999, 2000; Main 1995) and **the work of clinical developmentalists on moment-to-moment mother-infant interaction** (Beebe & Lachmann, 1994; Emde, 1988; Stern, 1985; Trevarthen & Aiken, 1994; Tronick, 1989, 1998) document how optimal

development and life-long resilient functioning have their roots in child-caregiver dyadic processes, highlighting the processes by which infants and caregivers moment-to-moment mutually regulate affective states and achieve safety and resonance despite the vicissitudes of attachment, self states and relatedness (Schore, 1994, 1996);

-----The somatic focusing experiential tradition (Gendlin, 1981, 1996; Levine, 1997) has documented how the psyche is transformed through the simple shifting of focus *away from* in-the-head cognition and *toward* moment-to-moment in-the-body sensing and feeling, a process which restores access to natural healing processes rooted in the body's basic adaptive mechanisms.

------ The exploration of **profound change experiences in adults around experiences of peak affect** (Beebe & Lachmann, 1994; Cooper, 1992) in the contexts of romantic love (Person, 1988), religious conversion (William James, 1902) and moments of meeting through authentic dialogues (Buber, 1965) has revealed processes by which intense and sudden undefended emotional experiences can lead to lasting, even life-long, transformations.

Affective Change Processes. These fields offer ample empirical evidence of some of the mechanisms through which naturally-occurring affective change processes involving emotion, relatedness and the body lead to rapid, deep and long-lasting change. These changes processes (1) operate moment-to-moment; (2) have clear-cut affective markers; (3) operate through transformations of state, in which the new state is characterized by greater access to emotional resources to promote higher adaptive

functioning; and (4) thus, operate in quantum leaps, rather than in a gradual and cumulative fashion..

In AEDP, we seek to harness the power of these natural change processes to effect therapeutic results (Fosha, 2002).

The notion of a *state transformation* is fundamental to AEDP. A particular emotional state has a characteristic organization of arousal, attention, motivation, affect, cognition, and communication; the principles by which these psychological functions operate differ from one state to another. For instance, different principles underlie the neurophysiological and psychological functions characteristic of sleeping and waking states, or of states of relaxation or trauma-induced shock. A "state transformation" refers to a change which is neither gradual nor graded, but rather involves a quantum leap; there is a qualitative change to an altogether different organization which is discontinuous with the one that preceded it. Deep and direct emotional experiencing activates a *state transformation*, in which the body landscape and the concomitant psychic functions are organized according to a different principle. It is not just that the individual is feeling more or less: in this new state, body physiology, information-processing, affect, memory, cognition and communication, as well as subjective self-experience, are organized in a fashion that is optimally conducive to effective therapeutic work. The work proceeds differently, and better, than it does in states in which emotional experiencing is not in the visceral foreground or is actively blocked off.

AEDP (Fosha, 2000) is rooted in the tradition of the experiential short-term dynamic psychotherapies. The experiential STDPs (e.g., Davanloo, 1990; McCullough Vaillant,

1997) have been distinguished by innovations in stance and technique to rapidly overcome defenses, minimize the impact of anxiety, and facilitate direct and visceral access to the experience of previously defended-against feelings and impulses in the here-and-now relationship with the therapist. Accelerated change results from the deep and rapid transformations that occur in the wake of affective breakthroughs, and the full processing of viscerally experienced emotion.

The key mutative agent in AEDP is the state transformation leading to the visceral experience of core affective phenomena within an emotionally engaged dyad (Fosha, 2000; Fosha & Slowiaczek, 1997). This involves bypassing defenses and neutralizing and alleviating the inhibiting impact of functionally pathogenic affects such as fear and shame. When defensiveness, fear and shame have been neutralized and cleared away, we gain access to the processes of change.

They all share a three stage process, involving **two state transformations**. It is these state transformations the AEDP therapist seeks to bring about from the initial moments of the first therapeutic encounter and, from then on, moment-to-moment throughout the entire course of the therapy.

1. When interventions aimed to counteract defenses, anxiety and shame are effective, there is a breakthrough of core affect. The full visceral experience of a specific core affective phenomenon constitutes the first state transformation. The state that occurs under the aegis of direct and visceral core affective experience is discontinuous with the defense-dominated state that precedes it. There is deep access to experiences that are crucial to adaptation and the characteristic processing is right-brain mediated

(i.e., largely sensorimotor, image-dominated, visceral, non-linear, etc., Siegel, 1999). There is also much greater access to previously unconscious material, a phenomenon referred to in the experiential STDP literature as "unlocking the unconscious" (Davanloo, 1990). The full visceral experience of each core affective experience results in the activation of adaptive action tendencies specific to each process. The affective markers associated with these adaptive action tendencies are invariably positive. By positive, I do not mean that the individual is necessarily happy; he may or may not be. What I do mean is that he feels good.

2. In turn, the completion of the full wave of visceral experience of core affects, unhampered by defense, sets the stage for the activation of yet another state, the **core state**. Sometimes this happens spontaneously; at other times it happens as a result of the therapist's asking the patient to focus in on how he feels now, in the wake of the completion of a cycle of core affective experiencing. The shift from core affect to core state represents the second state transformation. In the new state, referred to as the *core state*, intense, rapid, and mutative work readily takes place. The therapy goes faster, deeper, better; the patient has a subjective sense of "truth" and a heightened sense of authenticity and vitality; very often, so does the therapist. In the core state, relaxation, vitality, ease, clarity and well-being predominate. Therapeutic activities aim to make the most of the healing, transformational opportunities inherent within core state (Fosha, 2002).

The following image might help elucidate the difference between core affect and core state. Core affect is like a spotlight, intensely illuminating a previously obscured

segment of the emotional landscape that requires our attention; once we attend to that segment, we gain a new perspective on our emotional life. In core state, the entirety of the emotional landscape is visible, and it is evenly illuminated.

The following example illustrates the difference between core affect and core state: In working with a patient's whose presenting problem involved anxiety-driven inhibitions in major areas of her life, experientially focusing on some current inhibitions led to memories, visual and somatic, of an earlier trauma. The patient became deeply immersed in the terror and grief associated with an accident she had been involved in when she was a teenager. The full experience of terror and grief (core affects) associated with the accident was followed by the visceral experience of rage (core affect) at her parents for dismissing her distress in their eagerness to restore the appearance of normality. Through completing the full experience of grief, terror, and rage together with a supportive other (the therapist), the patient accessed a core state, in which --with feeling and emotional conviction-- she articulated her newly emergent understanding: the events that led to the accident, the accident itself, and its aftermath, were a microcosm of a lifetime of parental neglect and a childhood where a "road map" was always lacking. Freely and meaningfully roaming between the past and the present, the patient was able to articulate with startling clarity her life-long emotional experience, making sense of her current difficulties and putting them in perspective (core state). Furthermore, she was able to do so with greater self-empathy than she had ever been able to muster toward herself prior to this work.

Access to core affective phenomena provides the conditions necessary for thorough therapeutic exploration and working through, and leads to the release of the enormous healing potential residing within these experiences. The core state which follows the experience of core affect is optimally suited for the therapeutic integration and consolidation that translate deep in-session changes into lasting therapeutic results.

A direct consequence of the focus on change and the study of change processes is the appreciation of the crucial role of positive emotional experiences in therapy, an area of experience often neglected or only minimally discussed. Since much of what has to be renegotiated in the course of treatment are difficult, painful experiences, at times of unbearable proportions, therapy is commonly assumed to, of necessity, focus on the bad stuff; positive affective experiences are seen as the outcome of therapy, but not inherent in and integral to the processes of therapy. While there is no denying that the in-depth exploration of painful overwhelming matters is often excruciating, the study of the features of processes of change has alerted us to previously ignored or misinterpreted phenomena: positive affective experiences are part and parcel of the *moment-to-moment process* of transforming the suffering associated with pathological conditions. Positive affects are the invariant markers of core state.

The focus of clinical presentations, particularly those from the experiential STDP world, usually address the facilitation of first state transformation. That has been the real area of contribution of the experiential STDPs: how to systematically bypass defenses and alleviate anxiety so as to as rapidly as possible get access to core affective experience and, once access is gained, how to deepen the visceral experience of the

core affect so as to enhance the depth and thoroughness of the working through. However, what **I** am interested in today's presentation is first, exploring the nature of the transformation core affect leads to, and then, exploring and conceptualizing core state and its characteristic therapeutic phenomena.

PART II: THREE AFFECTIVE CHANGE PROCESSES AND THEIR AFFECTIVE MARKERS

Jean Genet said, and I couldn't agree more: "Acts must be carried through to their completion. Whatever their point of departure, the end will be beautiful. It is (only) because an action has not been completed that it is vile." (quoted in Levine, 1997). Let's look at what happens in the wake of fully accesses visceral experiencing of two of the affective change processes, the experience and expression of core emotion and the dyadic regulation of affective states.

Emotion and Adaptive Action Tendencies.

Emotion theory and now affective neuroscience teach us that emotions are crucial vehicles for adaptation (Damasio, 1994, 1999; Darwin, 1872; LeDoux, 1996; Panksepp, 1998; Siegel, 1999; Tomkins 1962, 1963). Categorical, or core, emotions include fear, anger, sadness, joy, or disgust. They are deep-rooted bodily responses with their own specific physiology and arousal pattern. All core affective phenomena, each is characterized by a "*distinctive biological signature*". Anger or rage, for instance, goes with the physiological profile preparing one for fight; "[b]lood flows to the hands, making it

easier to grasp a weapon or strike at a foe; heart rate increases, and a rush of hormones such as adrenaline generates a pulse of energy strong enough for vigorous action" (Goleman, 1995, p. 6).

The full visceral experience of core emotion in the absence of defenses and anxiety or shame, reflects a state transformation in which the individual has visceral access to precisely that which defenses had previously rendered off limits, that is, (1) previously unconscious material and (2) previously unavailable emotional resources. Core emotion can be regarded as the royal road to the unconscious, unlocking unconscious and previously inaccessible feelings, thoughts, memories, and fantasies related to the very roots of the patient's pathology. Core affective experience is crucial to the actualization of the core psychoanalytic agenda of uncovering the unconscious, i.e., it gives us --patient and therapist-- direct access to the raw materials required for a thorough working through.

In addition, the patient's full absorption in a highly precise and specific experience of a particular core emotion releases the *adaptive action tendencies* associated with that emotion. "Each emotion offers a distinctive readiness to act; each points us in a direction that has worked well to handle the recurrent challenges of human life" (Goleman, 1995, p. 4).

The adaptive action tendencies released by the visceral experience of categorical emotion give the individual access to new resources, renewed energy and an adaptive repertoire of behaviors, thus enhancing his functioning. The individual's new responses

reflect her/his access to new emotional information—about the self, the other, and the situation—that was not accessible to her/him prior to the full experience of the emotion.

Even when the categorical emotion is itself negative and/or painful, as in the case of anger or grief, the core state in which the adaptive action tendencies come to the fore is experientially highly positive. For instance, the adaptive action tendencies released by fully experienced anger often include a sense of empowerment and an assertiveness rooted in the rediscovery of psychic strength, self-worth, and affective competence.

By focusing on the sensations of the body, and doing so with no agenda, a positive transformational process is activated. "The irony is that the life-threatening events prehistoric people routinely faced molded our modern nervous system to respond powerfully and fully when we perceive our survival threatened. To this day, when we exercise this natural capacity, we feel exhilarated and alive, powerful, expanded, full of energy and ready to take on any challenge. Being threatened engages our deepest resources and allows us to experience our fullest potential as human beings. In turn, our emotional and physical well-being is enhanced" (Levine, 1997, pp. 42-43).

The Dyadic Regulation of Affective States.

As with emotion, adaptation is a central concept in understanding the function of the dyadic relational experience and its crucial role in affective regulation. The research on attachment powerfully shows that secure attachment is at the foundation of psychic health and that the mechanism by which attachment is formed involves the dyadic coordination of affective states (Schore, 1996; Trevarthen & Aiken, 1994). Secure

attachment emerges from a relationship within which the child's emotional experiences are met by the caregiver's openness, responsiveness and willingness to help (Cassidy, 1994). Optimally adapted individuals emerge from dyads in which affects do not disrupt the basic relational bond; quite the opposite, they deepen and enhance it. Most importantly, in such dyads, the inevitable disruptions in mutuality are short-lasting, and the disruptions themselves become powerful motivators of reparative efforts (Gianino & Tronick, 1988; Tronick, 1989).

The dyadic relatedness involved in maintaining the flow of emotional communication involves a moment-to-moment psychobiological process of *attunement* (i.e., mutual coordination of affective states), *disruption* (i.e., a lapse of mutual coordination) and *repair*, leading to the restoration of attunement (i.e., the reestablishment of mutual coordination) (Schore, 1996; Tronick, 1988). What emerges out of this process of attunement, disruption and repair is *affective competence*, i.e., emotional security, trust, self-confidence, and a sense of the self as effective in its capacity to regulate stress-producing emotional ups and downs (Fosha, 2001).

The achievement and/or restoration of coordination engenders a state transformation: it is marked by positive affects which are pleasurable to *both* members of the dyad. This is true even of the coordination the dyad needs to reach around negative affects. Whether the dyad is regulating joy, excitement, exuberance and playfulness or distress, anger, fear or frustration, 'getting in sync' is always accompanied by shared positive relational affect.

The rise and fall of coordination is a natural process. Optimally functioning dyads, i.e., those that give rise to securely attached and thus resilient children, are not characterized by longer periods of uninterrupted attunement. Rather, these optimally functioning dyads are characterized by the effectiveness of their reparative efforts: they are excellent at collaboratively metabolizing the negative affects associated with the disruption of coordination and regaining mutual coordination and the positive affects that accompany it (Tronick, 1989, 1998).

The maintenance of positive affective states associated with dyadic experiences of affective resonance has been shown to be crucial to optimal neurobiological development. "The baby's brain is not only affected by these interactions, its growth literally requires brain-brain interactions and occurs in the context of a positive relationship between mother and infant" (Schore, 1996, p. 62). These positive affects of resonance create a neurochemical environment highly conducive to new learning in which optimal brain development occurs: "The mother's face is triggering high levels of endogenous opiates in the child's growing brain. These endorphins … act directly on subcortical reward centers of the infant's brain" (Schore, 1996, p. 63).

The child is motivated to enter into such a "reciprocal reward system" because "euphoric states are perhaps the most appetitively compelling experiences available to life forms as so far evolved" (Schwartz, 1990, p. 125, quoted in Schore, 1996, p. 62). Euphoria has been here co-opted to serve the organism's adaptive aims.

Thus optimal attunement and the positive affects accompanying metabolized affective experience produce optimal brain growth, whereas chronic misattunement and

unmetabolized negative affect damage the brain. The dyadic regulation of affective experiences produces the changes that are the stuff of optimal development. This has uncannily precise parallels in treatment. Research shows that the therapist's attunement to the patient's affective state and the patient's experience of feeling safe and understood, i.e., affectively resonated with, is probably the most powerful contributor to the achievement of positive therapeutic outcome (see also Rogers, 1957).

Detour: The True Other

Before I discuss the fifth affective change process (for those interested in the discussion of the not included affective change processes, empathic reflection of the self, and somatic experiencing, see Fosha, 2002), the affirmation of the transformation of the self, I wish to take a detour and introduce the concept of the True Other, an experiential concept crucial to the experience of that process.

Winnicott's (1960) notion of the True Self captures an essential quality of experience rarely encountered in pure form; nevertheless, it does exist experientially at those times we call peak moments. It is an experience-near construct and a deeply meaningful one for the experiencing self. The True Other is the relational counterpart of the True Self, and similarly describes a subjective experience, with experiential validity.

An other becomes a True Other when she is so experienced by the individual, i.e., when the experiencer deems her to be so. The True Other, as I am using it here, has nothing to do with perfection: it has to do with responsiveness to need. On those occasions, when one person can respond to another in just the right way, that person

becomes experienced *for that moment* as a True Other. The action of an other which is "true" to what is necessary in the situation is defined in the terms of the individual experiencer. It captures an experientially accurate assessment at a given moment in the particular emotional predicament. And it is important that that experience be validated. The phenomenon refers to an essential experience of responsiveness, a deep way of feeling known and understood, seen or helped, which is meaningful, attuned, appreciative, and enlivening (Fosha, 2000, chapter 8).

It is important to localize the True Other experience *in the moment* and not mistake it for idealization. The True Other is a real, actual, deeply felt, experience. Idealization would occur only if the patient went on to assume trueness as an invariant feature of the other—that is, assumed the other to be always-and-across-the-board true, rather than a human being with frailties and faults. Like its counterpart, True Self experiencing, True Other experiencing takes place in a state of deep affective contact; unlike idealization, it is contingent, not rigidly fixed.

A perfect example of how the sense of the True Other captures an experientially accurate assessment that bears no relation to idealization occurs in the movie *Scent of a Woman*. Colonel Slade could not be a more frayed and contaminated individual. Narcissistic, arrogant, alcoholic, and abusive, his blindness, isolation, and alienation are the tragic consequences of a severe, lifelong character disorder. Charlie Simms, the other lead character, is a young prep school boy with an endearing mixture of innocence and integrity. A bond grows between the two, though Charlie has no illusions about Slade. There is a moment when Charlie faces a situation with a potentially disastrous

outcome. At this precise moment Slade comes forward for Charlie, and does so very effectively. Deeply understanding what Charlie needs, he provides it: he is there, he is effective when it counts and completely counteracts Charlie's excruciating and poignant aloneness. In that moment, a lifetime of narcissistic pathology notwithstanding, Colonel Slade is a True Other for Charlie Simms.

The True Other is an external presence who facilitates our being who we believe ourselves to be, who we are meant to be, someone who is instrumental in helping to actualize a sense of True self.

"I had opened a door to a secret vault. Its treasures were immense… Did I always know this room? Was my sin basically one of untruthfulness? Or more likely one of cowardice? But the liar knows the truth. The coward knows his fear and runs away. What if I had not met Anna? … But I did meet Anna. And I had to, and I did open the door, and enter my own secret vault. I wanted my time on earth, now that I had heard the song that sings from head to toe; had known the wildness that whirls the dancers past the gaze of shocked onlookers; had fallen deeper and deeper and had soared higher and higher, into a single reality – the dazzling explosion into self.

To be brought into being by another, as I was by Anna…." (Hart, 1991, p. 41- 42).

Indeed. The True Other is the midwife of the True Self.

The patient's experience of the therapist as a *true other* often emerges in exploring the completion of all five affective change processes. However, in the process of affirming-the-transformation-of-the-self, we find it front and center.

Affirming the Transformation of the Self and the Healing Affects.

In the last change process to be examined, it is precisely the experience of healing and therapeutic success that becomes the experiential focus of the work. What is usually the end point of the therapeutic road is the starting point of this investigation.

The systematic exploration of the patient's experience of having a therapeutic experience activates the highly reparative *metatherapeutic process* of *affirming-the-self-and-its-transformations* and the transformational affects that it gives rise to, the *healing affects.* Once these experiences emerge, they are privileged, focused on, enlarged, and explored with the same thoroughness and intensity as any of the other core affective experiences.

Unlike the role of mourning in the consolidation of therapeutic results which has been widely written about, little has been written about the affirming process. However, it too can make a vital contribution to the patient's well-being. It requires the processing of the good which one has and has had. The other side of the coin of the mourning process, it requires dealing with "having" (as opposed to "not having').

The label *healing affects* seems apt for these affective markers of therapeutic experiences. They arise when we feel that our emotional suffering is being alleviated, they arise when we feel seen or responded to as we have always wished, and they arise in moments when we have a sense of ourselves as being, in that moment, authentic and true. Change and furthermore, change for the better, is an essential aspect intrinsic to these experiences. The well-known "Amazing Grace" captures the essence of the

healing affects: “Amazing Grace/ How sweet the sound/ That saved a wretch like me/ I once was lost/ but now I’m found/ Was blind, but now I see.”

There are two types of types of healing affects, the affective markers of the affirming-the-transformation-of-the-self process: feeling moved, touched, and strongly “emotional”, within oneself; and feeling love, gratitude, and tenderness towards the other (Fosha, 2000, Chapter 8; James, 1902). What patients describe as feeling *moved*, *emotional*, or *touched* within oneself are feelings that arise in response receptive affective experiences of the self (i.e., feeling seen, understood, loved, empathized with, and affected by). Such experiences are perceived to be intimately involved with the process of the self’s striving toward greater authenticity. Just like in Grotstein’s writing (2002), shame is the experience of failing to be that which we know ourselves to be, pride and the other healing affects are the experience –for a moment- of being precisely what we knew we had within us to be. For those fortunate to have these moments, they become the guideposts of authenticity, concrete calipers of experience. The self’s response to the fostering role played by the Other in the transformation of the self gives rise to the second type of healing affects: feelings of gratitude, tenderness, love, and appreciation toward the affirming other.

I personally think the healing affects represent another categorical emotion and I would like to describe their phenomenology. The physical, physiological manifestations of the healing affects include a trembling, shaking voice associated with trying to contain emotion and hold back tears. The eyes are clear, light-filled, and usually moist with gentle tears. The gaze tends to be uplifted. There appear to be internal state changes

related to gaze direction. It is my sense that gaze up and gaze down are linked to internal state transformations of an affective nature: gaze down seems to be the affective marker for grief and experiences of loss, while gaze up is the affective marker for the healing affects and experiences of affirmation. The experiential correlate of the uplifted gaze is often a sense of "something rising," a "welling up," " a surge," or feeling "uplifted." Whatever the words used by a given individual, there is an upward direction to the sense experience.

Though the expression of feeling moved, touched or emotional, as well as that of deep love or gratitude is usually accompanied by tears, patients make it very clear that neither are they *primarily* sad, nor *primarily* in pain; at times, they actually report feeling happy or joyful. Even when, at other times, the reaction is mixed with sadness or emotional pain, the individual embraces and accepts the pain as one that is well worth feeling, welcoming the feeling, without being frightened and trying to avoid it. The healing affects possess simplicity, clarity, innocence, freshness, sweetness, and poignancy. The individual is in a state of openness and vulnerability, but a shimmering vulnerability without anxiety and without the need to be defended. The mood (or primary affective state) surrounding healing affects can be either solemn, poignant, and tender, or else joyous and filled with wonder, often accompanied by a gentle, almost shy smile. William James referred to healing affects with characteristic eloquence and phenomenological precision as "the melting emotions and the tumultuous affections connected with the crisis of change" (James, 1902, p. 238).

Contrast is an integral aspect of healing affects. This is the joy experienced by someone who has known pain, the light experienced after years of darkness, the experience of feeling understood after having felt misunderstood. Darwin (1872) speaks of the tears that accompany healing affects as tears of joy that gain their emotional charge by virtue of contrast with the emotional pain that preceded them. This is the essence of crying at the happy ending, of reunion triumphing over the grim specter of loss and its attendant grief. Comparison and contrast also reside in the paradoxical recognition with which these new experiences are met: encountering for the first time what one has always known.

Dynamic Issues That Make Dealing with the Affirming Process Difficult for Therapists. In general, difficulties in receiving love and emotionally recognizing experiences of being understood or of being empathized with are not as well known and understood as difficulties resulting from not having the love desired. In part, this has been an artifact of the neutrality of traditional therapists. It is only with a loving therapist who can initiate a loving exchange (Coen, 1996) that the patient's difficulties accepting and receiving that love --much as it is craved and yearned for when it is not available-- can come into view. Similarly, difficulties in owning emotional competence, resourcefulness and the resulting pride are not evident unless there is an explicit focus on the patient's strengths. These profound affective/relational experiences have received relatively little if any formal attention in the literature. Psychodynamic practitioners, trained in a tradition of plumbing the depths of the patient-therapist relationship, are

much more comfortable focusing on and working through negative experiences, frustrations and disappointments. As Adam Phillips says,

> Development in psychoanalytic theory is always described as a process in which, at each stage, the child is encouraged to relinquish something with no guarantee that what he or she is going to get instead will be better. *This is a hard school and we might wonder what it is in us that is drawn to stories of renunciation, to ideologies of deprivation*, whether they are called the symbolic, the depressive position, or Freud's description of the resolution of the Oedipus complex. (Phillips, 1997, p. 744, italics added).

Another major impediment is the phenomenon of the therapist's false modesty that covers up difficulties we have with being acknowledged and thanked for being exactly what we most value being. Wishing to help and to have a beneficial impact on a suffering other is exactly what propelled so many of us into the field. And yet, often, when patients who are genuinely helped, are full of gratitude and directly acknowledge us, our defenses kick up: we shy away, protest and deflect the patient's generous and truthful affirmation. Aside from being a huge loss for the therapist, it is a huge loss for the patient.

Our difficulties in this area interfere with our patients' progress. The therapist's receiving the patient's affirmation allows patients to acknowledge and validate their own resources and emotional capacities. In the deepest way, the therapist's capacity to accept the gift of the patient's gratitude allows the patient to have an experience of his own generativity, generosity and ability to have a positive and deep impact on the other, a process Winnicott (1963) recognized as fundamental to a rich inner living.

In looking at these three affective change processes, we have three examples of the intrinsic tendency of affective processes to move toward healing changes, and the association of such transformational processes with positive affective markers. in the absence of defenses and inhibiting affects, the very process of change, *and not only its*

outcome, feels good. We need to keep this in mind in each moment of each session and be mindful of Gendlin's radical point, all the more profound for its simplicity: "Nothing that feels bad is ever the last step." (Gendlin, 1981, p. 25-26.)

Thus, an experiential focus on transformation can be the catalyst for further transformations: experientially focusing on change that has already occurred activates further powerful changes. The achievement of resolution at one level establishes a new plateau, which rapidly becomes the baseline from which the next cycle of transformation proceeds. And in the wake of the completion of the full visceral experience of core affect characterizing each of the affective change processes, there is another state transformation. From core affect we proceed to core state. Figure and ground shift: solidly in experiential grasp, experiences of Self and Other recede and become the holding environment: What is in the experiential foreground is the *experience* of *emotional truth*.

PART III: CORE STATE AND THE TRUTH SENSE

"Out beyond ideas of 'being right' and 'being wrong,' there is a field.

I'll meet you there." Rumi

Like with core affect, in the core state, there is also no anxiety or defensiveness; but unlike core affect, neither is the body rocked by any particular distinct, specific emotion. Instead, there is calm, flow, openness, vitality, relaxation, ease, and clarity. Core state refers to an altered state of openness and contact, where the individual is deeply in touch with essential aspects of his own experience; he is in touch with his emotional truth. In

this state, experience is intense, deeply felt, unequivocal, and declarative; sensation is heightened, imagery is vivid, pressure of speech is absent, and the material moves easily. Effortless focus and concentration also are features of the core state. Relating is deep and clear, as self-attunement and other-receptivity easily coexist. *Core state phenomena* include, but are not limited to: (1) the sense of strength, clarity, and resourcefulness that emerges in the wake of, adaptive action tendencies; (2) core relational experiences of love, tenderness, compassion, and closeness, relational experiences emergent from a position of mindfulness and *self*-possession; (3) core self experiences of what individuals subjectively consider to be their "true self"; (4) core bodily states of relaxation, openness and vitality that emerge in the wake of the *body shift*; and (5) states of clear and authentic knowing and communication about one's subjective "truth" with resultant generosity, empathy, self-empathy, and wisdom. *It is in the core state that the reflective self function can operate at its fullest potency*. Working through, integration and therapeutic consolidation optimally occur in the core state; here, therapeutic changes take root.

Once core state is achieved, the therapy runs itself. With patients in core state, the therapist's activities can be reflective, collaborative, experiential, mirroring, or witnessing. The therapist can validate and receive, and participate in deep collaborative dialogue that is simple, essential and "true." Just being present and listening deeply is sometimes precisely what is needed. Often, the most powerful work can be done when both patient and therapist are in core state (which is not unusual). At those peak moments,

characterized as I-Thou relating (Buber, 1965) or true-self/true-other relating (Fosha, 2002), some of the deepest therapeutic work can take place.

Out There Musings. From the point of view of an experiential therapy, side by side with the historical/developmental model that is to be modified, a model that is not developmental in its origins is being articulated. This is a work in progress, a new working model forged of new corrective and reparative experiences. We are working here, as a patient of mine dubbed it, "on the other side of history." "Each encounter has the possibility of being a "moment of meeting," an opening for the core state/ innate wisdom and authenticity of the self to be experienced and expressed. We are making new procedural knowledge" (Hoffman, 2001). But what are we activating?

When core state is activated, a particular brain state and body landscape come to the fore. How do we conceptualize how such states are neurophysiologically represented, side by side with our knowledge of how emotional procedural knowledge -- all the bad stuff that went down -- is encoded in the right hemisphere? It takes us right into the neurobiology of plasticity and the neurobiology of the change and healing processes (Fosha, *in press*). What do we, and affective neuroscience, make of the potential for true self living inherent in us all that can be activated almost regardless of severity of psychopathology? What do we, and affective neuroscience, do with the fact that oodles of bad news procedural knowledge wired into our right brains, there remains this capacity to respond fully to conditions that invite I/thou relating, core state, true self being, authenticity, genuineness, and wisdom?

My out-there proposal is that the core state is a wired-in feature of the organism, the same as the categorical emotions, a wired in capacity to respond in this fashion under particular conditions. The capacity to experience the categorical emotion of anger or fear or joy does not depend on procedural knowledge. It's been there all along. Of course, procedural experience is codified in how, let's say anger, is regulated and expressed. However, the capacity to respond to intrusions, boundary violations and assault (of self and territory) with the emotion of anger is in the nature of the organism.

Similarly, the capacity for core state. It has been there all along. It is a capacity we have. The conditions for its activation have to do with a variety of things, and what those things are needs to occupy us as therapists, as interventionists, as researchers; but the capacity to experience core state is as wired in as is the capacity to respond with anger or joy or fear or disgust.

Viewed in this fashion, like Bion's "O," the core state predates the dynamic specificity of the individual. Through this way of construing the construct of core state, in one fell swoop, we join biology (the biology of emotion, adaptation) with the highest/deepest aspects of emotional/spiritual quests. In devoting oneself to the search for the emotional truth of the moment, of the session, in getting past defenses a la STDP, or past repressed unconscious phantasies, a la Bion/Grotstein, there is a force of experience to which one surrenders. In striving to fulfill one's deepest self, one encounters the biology of human emotion.

Clinical experience suggests that the activation of core state has to do with conditions of true self/true other relating. Core state activation is facilitated by being with a True

Other, whom my colleague Kent Hoffman (2001) characterized as someone with “the gravitas, the depth of comprehension required to allow the risk and the surrender into that state.” He continues: “I believe that this core state is our deepest identity (our original nature). I believe that we are all awaiting a moment of its first awakening and I believe that in therapy this often happens precisely because of the recognition that someone finally "gets it" enough for "me to enter into my deepest self." Usually that is followed by emotion (often tears of gratitude, just as often by tears of rage about not having been able to experience this before). Of importance … is not how we get there, but that we can get there - to this place of finally coming home - to ourselves and to a new sense of relatedness (true self/true other).”

While being with a True Other is one kind of condition that can activate the core state, other conditions that conditions that activate core state include, for example, the full experiential processing of any of the five affective change processes. For example, completing the full cycle of a core emotion such as grief can also activate it. Here is a patient, someone in the field and thus familiar with my ideas on core state, who wrote me the following e-mail about what he experienced after hours of grieving the death of his favorite aunt (who, incidentally or not so incidentally, was a True Other):

“Just wanted to be in touch with you.....we got back into NYC Monday around 2 pm. Aunt's memorial service was Sat. morning; I gave the eulogy, then we all traveled 3 hours to Raleigh to bury her ashes next to her husband. A very long, sad day.

An amazing thing happened when I climbed into that pulpit on Sat morning.....I was totally calm, voice seemed to be in a lower register in my sadness (I think you could say I

was in a "core state"!!!!). I talked my way thru it (I didn't read it, only the passages from letters from my aunt to me that I had worked into the eulogy). The eulogy seemed to really lead the family through a healing process. Bob had never seen me that way and he was amazed. A cousin told me later I was a "born preacher." (Of course I had cried my eyes out hours before I had to give it and told Bob to be prepared that he might have to come up and finish it, I didn't know what might happen.) … Family was very grateful to me, and I really did enjoy the connecting time with my cousins especially those whom I don't see all that often. All that was very positive for me. Saturday after both services we got back to my cousins, drank good Scotch, and told funny stories about her."

In his next e-mail, in which he gives me permission to quote him, he suggests that voice quality might be one of the places where to investigate the phenomenology of core state as a wired-in state within a distinct and specific phenomenology:

"Of course you can read from my email if you think it helps illustrate your point.... I am curious about what state I was actually in when giving the eulogy. It was very different from anything I have ever experienced, frankly.....not even when I was in one of those deeper places with you in our work. It was profoundly deep and utterly, utterly calm and peaceful. The most tangible and describable thing about it to me was my voice....as I said, it seemed to be in a lower register. The rest of the experience is more difficult to describe..... I am assuming based on what you tell me that this is core state or something very close.....and although I was not crying when it was happening, I was crying hours before..... "

As I was preparing this talk, I had the pleasure of hearing James Grotstein speak about the truth instinct in Bion's and in his work (Grotstein, 2002). It gave me the missing piece to describe core state, of course, the missing piece that was there –for the noticing—all along. It allowed me to articulate the affective marker for core state. I am calling it the *truth sense*. This affective marker is an aesthetic experience of rightness. It is what the individual has at those unusual moments of actually having an experience of emotional truth, a moment of touching O. It is the sense that comes with righting oneself, with things being right. It is the sense that comes with righting oneself, of things being right.

The healing affects mark change and transformation, capturing the astonishment and gratitude that our expectations constructed on procedural knowledge are, against all odds, being disconfirmed. By contrast, the truth sense is the sense of coming home (regardless of whether one has been, in procedural fact, emotionally homeless). It is right. It is. That's all. The truth sense is the internal experience of core state, of relief at correctness. It is the relief and calm that settles in when a picture that's been crooked comes into alignment. There is an internal experience of coherence, of cohesion, of completion. It is an affective experience that is as much aesthetic as anything else. Something inside clicks into place. The athlete who performs as he is capable of performing says "yes!" Grotstein's (2002) patient says "exactly."

"There is an internal landscape, a geography of the soul; we search for its outlines all our lives." Thus begins Josephine Hart's novel Damage. She continues: " We may go through our lives happy or unhappy, successful or unfulfilled, loved or unloved, without

ever standing cold with the shock of recognition, without ever feeling the agony as the twisted iron in our soul unlocks itself and we slip at last into place."

Then later: "A stillness descended upon me. I sighed a deep sigh, as if I had slipped suddenly out of a skin. I felt old, and content. The shock of recognition had passed through my body like a powerful current. …. I had been home. For a moment, but longer than most people." (p. 26-27).

Implicit in the truth sense is the idea of phenomena having a mind of their own, so to speak. Like Eigen says: "One cannot regulate the movement of truth. Rather one seeks to modulate oneself in relation to requirements that truth discloses" Ultimately, what we are after, moment-to-moment, is "the emotional truth of a session," and the patient's greatest degree of experiential contact with it.

A Coda of Sorts. To return to the theme of attunement, disruption, and repair. And with repair, the return of dyadic coordination. Core affective experiences, good or bad, in essence represent disruptions of our going on being. However highly valuable, they are disruptions as they constitute the process though which growth takes place. Core affective experience enlarges the self, takes us outside of ourselves and makes us struggle with something disruptive, uneasy, difficult, stressful, what have you (Fosha, *in press*). When the affective intensity is spent, the calm of the core state comes to the fore. We can integrate the fruits of the affective intensity into our ongoing sense of being. Core state signals that we have basically integrated back into the self, and made our own,

what was foreign and disruptive and challenging, though also enlivening, during the core affect. And thus we emerge enlarged, changed, transformed, bigger than before. But in a funny paradoxical way, evolution aside, bigger and better is not accurate. In essence, through the process of transformation, for better and worse, we become increasingly ourselves. In the language of core state, cascading transformations lead us toward becoming "clearer and simpler" (Ondaatje, 2000) to ourselves.

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