Working With Affect: Love (Mixed With Intuition) Is All You Need

By Candyce Ossefort-Russell, M.A., LPC

Why Affect?

Never apologize for showing feeling. When you do so, you apologize for the truth.

— Benjamin Disraeli

An abundance of neuroscience research has been coalescing over the last couple of decades to tell us that we should pay attention to the difference between *talking about* affect in the therapy room vs. actually helping patients to *feel*. Allan Schore, a clinician/researcher who synthesizes neuroscience and psychotherapy research, says that

> [t]he ongoing paradigm shift across all sciences is from conscious, explicit, analytical, verbal, and rational left brain to unconscious, integrative, nonverbal, bodily-based emotional processes of the right brain. . . . [I]n general, the paradigm shift is from conscious cognition to unconscious emotion. (Schore, 2008, p. 21)

That's a very heady way of saying that, as therapists, we need to move out of our heads and into our hearts and bodies in order to help our patients learn to recognize and regulate the emotions they feel in their hearts and bodies. We need to attend to the emotions that our patients express directly, and, *even more importantly,* to the unconscious emotions our patients express without words.

Affective neuroscience also reinforces attachment research showing that it is in our attachment to a bigger, stronger, wiser, kind caregiver (Fosha, 2000), who is attuned to our emotional states, that we learn to regulate our own emotions. Our human evolutionary wiring for learning to manage emotions within the context of an attuned relationship continues throughout the lifespan. Thus deficits and wounds that emerge out of the parent/child relationship can be healed within the context of a *safe and caring* therapeutic relationship with a therapist who attends to and helps to regulate the recognition and expression of emotional states (Schore, 2008). That is, we therapists need to show up as attachment figures for our patients in an empathic, connected way, directly helping them with their emotions. If we show up in this way, our patients will have a new *lived* experience of being cared about and helped.

Diana Fosha, the founder of Accelerated Experiential Dynamic Psychotherapy (AEDP), describes how we end up developing difficulties in regulating our affect when we experience attachment failures (2008). We all experience intense emotions, experiences of being ourselves, experiences of being with others, and spontaneous bodily feelings, as we grow from infancy onward. And, because of our hard-wired attachment needs, we know we need to be close to our attachment figure to survive. If our attachment figure responds to our emotional experiences with withdrawal, avoidance, criticism, punishment, etc., we are left not only feeling afraid or ashamed of our experiences, but also alone with the big emotions that set the whole cycle in motion. Overwhelmed, we learn to defensively exclude these emotional experiences from our repertoire, and we develop problems as a result of chronic reliance on defenses against relatedness and emotion. Basically, being left alone with unregulated emotion is what generates psychopathology. Being left alone with intense emotion is unbearable, so we learn to avoid those emotions and self-experiences at all costs, in order to stay close to our attachment figures. So healing takes place when we can experience warded-off emotions in the presence of a caring other who will not leave us alone no matter what.

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Overall, modern research shows that helping our patients learn to effectively express and manage their affect is the number one therapeutic goal, and to reach that goal we need to show up in the consulting room in three key ways: We need to move beyond left-brained, "neutral," cognitive interpretations and into empathic explorations of bodily-based, nonverbal aspects of our patients' emotions. We need to own our attachment figure status, creating a caring, safe environment in which our patients can trust us to delight in them and to actively help them with their frightening, painful emotions. And we need to develop enough affective competence to stay with our patients' intense emotions in an empathic and joining way, and not leave them alone with their big emotions, no matter what.

Working With Affect

The roots of resilience and the capacity to withstand emotionally aversive situations without resorting to defensive exclusion are to be found in the sense of being understood by and existing in the mind and heart of a loving, attuned, and self-possessed other.

— Diana Fosha,
The Transforming Power of Affect

How does this kind of affect work translate into practice? By integrating the above described gifts of neuroscience, attachment, and emotion theory into my natural way of

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working with affect, my practice has deepened and become much more identifiably helpful to people. I've intensively trained in and studied AEDP, and I've studied AEDP's foundational literature by authors such as John Bowlby, Les Greenberg, Jude Cassidy, Daniel Siegel, Stephen Porges, Pat Ogden, Susan Johnson, Allan Schore, Louis Cozolino and many others. Rather than outlining a specific theoretical orientation in dry, left-brained way, I honor the more right-brained, experiential way of working that all of these authors and theorists strive to elaborate. So, below I explore how these theories have informed the way I work with affect, all of which are grounded in the literature mentioned above, (though the direct references aren't credited, as what I present is a conglomeration). AEDP is the core that ties them together. Some of these ways of working may seem obvious, but I'm amazed at how articulating even the obvious can make important ways of being in the room more embedded into the process.

Establish Safety and Undo Aloneness

Though I've always worked in an empathic way, AEDP and the literature of attachment have helped me to define the first step in any therapy—to truly value the patient, and make sure that's known. Diana Fosha once said, "You need to find something, no matter how small, to fall in love with in each patient." I really let myself care about each patient, and I express that caring through affirmation and validation of their defenses as best efforts they've made to survive in the environments they've been cast into, through a readiness to help, through a willingness to bear and share emotion with them, to a delight and pleasure in who they are that is apparent from the first time I meet with them.

Reverse Foreground and Background.

I've learned that consciously leaning into my intuition is the strongest, most reliable way into the "unconscious, nonverbal, bodily-based emotional processes of the right brain" (Schore, 2008, p. 21). One of the most basic tools I've learned from focusing on right-brained processes is to reverse the foreground and the background of what I attend to and comment on in session. In the past, my intuitive tracking of facial expression, bodily tone, breathing, tension level, tone of voice, etc. (whether in my patient or myself) would run in the background, giving me unconscious information that informed some of what I was doing, but not in a conscious way. In the foreground were my thoughts, tracking content, tying the present back to childhood, sleuthing through stories for connections and traces of feelings. After learning about right-brain importance, I consciously switched these two ways of being.

Now I let the left-brained mind-work run in the background, trusting that any important connections will be made and will come forward when needed. And instead I consciously focus on what I intuitively notice. AEDP calls this process moment-to-moment tracking. I comment on a slowing of breathing. I name a shift in eye contact. I notice if I feel like crying or if I can't breathe. I return to a subject skipped over. No matter how subtle the shifts may be, I no longer let the unconscious "nonverbal communication of emotional states" go by unexplored. Attending to this communication opens the door to depth of feeling and to sincere connection. Healing becomes palpable, reliable, and awe-inspiring as we make these implicit communications explicit.

Create Visceral, In-The-Moment Experiences and Name Them.

As all the literature indicates, patients need to have a lived, visceral experience of feeling their emotions in the presence of an empathic other, rather than just talking about emotions, in order to truly learn to regulate their emotions. When they have a new experience of feeling what was previously unshareable, and of not being rejected or turned away from, they are having the experience in their bodies, of a new way of living, and no one can take that experience away once it's happened. Whenever a patient is talking about a particular emotional issue, I ask for a vivid example of when this has happened to them, bringing the issue alive in the room. Then we can track the breathing changes, the voice-tone changes, the shaky hands, etc. that accompany the story they're telling. Then we can trust any primary process information that emerges (such as memories, spontaneous thoughts, feelings, images, sensations). Then the emotion lives and I can be there with them in it. Then we can name what just happened—that they felt the feelings while I was there with them—and they can memorize what that feels like so they can refer back to it again and again.

Focus On The Body.

I am continually amazed at how much emotional information the body carries. Whenever there's a crossroads moment, I ask the patient to check in with her body. Even if she says she doesn't notice anything, if I help her scan her body, she can usually do it. "What do you notice in your neck?" "What's your heart rate like?" "What's that hand doing?" Even if nothing emerges, that's important information. But more often than not, when I notice that someone isn't breathing, and I ask them to focus on their breath, not to change it or push past where it's getting stuck, but just to notice where it's getting stuck and "what comes" if they focus on the stuck place, huge pieces of critical information emerge. Likewise with a tight muscle or a lack of muscle tone. The body knows things and will offer up the information most of the time, if simply asked.

Leading Vs. Following (Or Going Beyond Mirroring).

I used to think that being attuned was the same thing as following. I could follow patients' stories and feelings all over the map in a very empathic way and believe I was attun-

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ing to them. But I learned a huge lesson as I watched a videotape of Diana's work. Diana interrupted a patient, not acknowledging the new subject but asking her to return to what she was saying earlier because she had grimaced and skipped right over it. I was aghast that she had interrupted the patient in that way. However, upon replaying the tape we saw that the patient very clearly gave Diana a "green light" when she interrupted her. She paused and grinned as if to say, "I was hiding and you found me!" And when they went back to what the patient had skipped over, a door opened into profoundly important feelings. These kinds of interventions are where the attachment-oriented therapist can directly help with emotional regulation and encouragement, and in fact, this kind of help is more attuned than just following the patient around all day.

In short, to be attuned, mothers (and therapists) need to lead and follow. Imagine a baby learning to sit up if a mother never pulled him up. Imagine a baby learning to play if a mother never initiated a game. The key to attunement is to watch for the signals you get in response to your leading or following. Sometimes I need to list some feelings the patient might be feeling. Sometimes I need to slow them down. Sometimes I need to help them disregard something that seems to be interrupting their flow. But always, always, always, when I make an active intervention, I need to track their response. When you're really attuning to the patient's subtle signals, they will let you know in no uncertain terms whether the leading is intrusive or helpful. Then, if you're experienced as intrusive and you observe that and make a repair, that's healing in and of itself.

Make The Attachment Relationship Explicit.

This quintessential AEDP technique is one of the most profound ways to bring healing affects into the room. After the patient has had an experience of feeling deep feelings in my presence, I ask something like, "What is it like to have this experience with me?" Many times patients have difficulty expressing this vulnerable experience, but with help and tenderness and encouragement, very often another big round of emotion ensues. Deep feelings of gratitude, or of mourning for the self or of coherent narrative often emerge. Much tender feeling comes up and intensifies when the relationship is explored directly, rather than having its value assumed.

Rewards for Patient and Therapist

There is ecstasy in paying attention. You can get into a kind of Wordsworthian openness to the world, where you see in everything the essence of holiness.

— Anne Lamott, Bird by Bird

The rewards are profound for working in the unconscious right-brain realm, for tuning in to deep, unconscious communications of emotion, and for relying on the healing and resilience inherent in an attachment system that functions in a healthy way. The more I work in this way the more I reliably help people, and the more I myself am healed.

The more I bring the depths of my heart to care for each and every patient, the more I am tuned in to the healing force that every person possesses, the more closely I attend to the unconscious, then the more I can see that the unconscious wants to be healed, wants to be heard, and the work flows. By paying deep and caring attention to every unconscious emotional detail, by feeling with instead of talking about, therapy becomes a meditation, an offering. The consulting room becomes sacred ground. Love (an affect, in my opinion) really is all we need.

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