HOW IS ATTUNEMENT, DISRUPTION, AND REPAIR EXPERIENCED BY THE THERAPIST IN AN ATTACHMENT-FOCUSED APPROACH TO PSYCHOTHERAPY?

by

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Abstract

This study explored the question: How is attunement, disruption and repair (ADR) experienced by the therapist in an attachment-focused approach to psychotherapy? The prevailing conception of ADR has emerged from a confluence of domains of inquiry: infant development research, psychotherapy, and affective neuroscience. However, it was not until recently that insights from these three areas of study converged. This convergence has created a flood of theoretical literature that conceptualizes ADR as a fundamental vehicle for change in the therapeutic relationship. However, two principal issues have been eluded: 1) there has been a lack of consensus on what constitutes attunement, disruption and repair and, 2) while ADR has been investigated extensively in infant development research and has been theorized to occur in the therapeutic relationship, there is a dearth of empirical demonstrations examining attunement, disrupton and repair as experienced by the therapist in the therapeutic process.

The current research comprised a qualitative micro-analysis of the moment to moment shifts in the interactive process of ADR as experienced by the therapist. By investigating the question, "How is attunement, disruption and repair experienced by the therapist in an attachment-focused approach to psychotherapy?" the present qualitative study filled in a significant gap in the literature, contributed to our knowledge of the construct and the role of attunement, disruption and repair in the therapeutic process, informed existing theory on affect regulation and attachment repair, and informed the change process in therapy.

Lay Summary

The current research comprised a qualitative micro-analysis of the moment to moment shifts in the interactive process of attunement, disruption and repair (ADR) in the therapist/client dyad. A key goal of this dissertation was to investigate a phenomenon (i.e., attunement, disruption and repair) that had been theorized to occur in the therapist/client dyad but that had not been hitherto empirically studied. The findings within this research addressed a significant gap in the existing literature on ADR; contributed to our knowledge of ADR in the therapeutic process; informed the process of change within psychotherapy; informed existing theory on attachment processes in the therapist/client dyad; and added to the body of research on Accelerated Experiential Dynamic Psychotherapy (AEDP), an attachment-infused experiential model of therapy.

Preface

This research was conducted with the approval of the University of British Columbia (UBC) Office of Research Services Ethics Behavioural Research Ethics Board (BREB), certificate number H12-00365. This dissertation is the original work of Enzula Tavormina, the author, and all participant interviews and data analysis were undertaken by the author.

Table of Contents

Glossary

Affect: Affect is a "superordinate category for valenced states" (Gross, 1998, p. 273) including emotion episodes, moods, and dispositional states.

Attunement: Attunement is the act of focusing on another person (or ourselves) to bring into awareness the internal state of the other in interpersonal attunement (or the self, in intrapersonal attunement). Attunement is matching a feeling or quality of the internal state of another. Attunement, Stern conveys, "permits one human to 'be with' another" by "sharing likely inner experiences" (Stern, 1985, p.157).

Coping: Coping refers to "the organism's efforts to manage its relations with an environment that taxes its ability to respond" (Rottenberg & Gross, 2007, p. 325).

Psychological defense: Psychological defense refers to "relatively stable characteristics of an individual that operate outside of awareness to decrease the subjective experience of anxiety and other negative affects" (Rottenberg & Gross, 2007, p. 325).

Dyadic Affect Regulation: A process involving dyadic states of attunement, disruption, repair and the restoration of coordination at a new level (Fosha, 2000).

Dyadic Attunement: Dyadic attunement in the client/therapist dyad is the process through which the client is assisted to re-experience and regulate his/her affect in the context of a safe and trusting relationship with a therapist. This occurs through "the moment-to-moment affective communication between dyadic partners that occurs through non-verbal, right-brain-mediated processes involving gaze, tone of voice, rhythm, touch, and other vitality affects" (Fosha, 2008, p. 8). This affective communication facilitates the establishment of coordinated states.

Emotion Episode: Emotions are brief and short-lived and have specific objects that give rise to emotional response tendencies while emotion episodes unfold over a longer period of time and include the ongoing interaction of the instigator and social context (Gross, 1998).

Emotion: Emotions are "adaptive behavioral and physiological response tendencies" (Gross, 1998, p. 272). Emotions comprise emotional cues, evaluation of those cues, behavioural, experiential and physiological emotional response tendencies, and modulation of these tendencies determining a final emotional response.

Emotional Regulation: Emotional regulation regards the "attempts individuals make to influence which emotions they have, when they have them, and how these emotions are experienced and expressed" (Rottenberg & Gross, 2007, p. 325). Emotional regulation is a

process that can occur deliberately or automatically. Emotional regulation is one aspect of affect regulation. Affect regulation also includes forms of coping, mood regulation, and psychological defense.

Feeling: Physiological sensation of emotions.

Mood: Moods are the "pervasive and sustained 'emotional climate'" (Gross, 1998, p. 273) that distort cognitions more than they do action tendencies.

Presence: Presence is our openness to the unfolding of possibilities. Presence permits us to be open to others, and to ourselves,

Resonance: "Resonance is the coupling of two autonomous entities into a functional whole. A and B are in resonance as each attunes to the other, and both are changed as they take the internal state of one another into themselves. When such resonance is enacted with positive regard, a deep feeling of coherence emerges with the subjective sensation of harmony" (Siegel, 2007, p. 4).

Vitality affects: Vitality affects are the dynamic, kinetic qualities of feelings that are composed of qualities such as intensity, shape and time.

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Above all, I dedicate this dissertation to my incredible mom, Angelina, who passed away in 2013 and who by example, taught me about courage, perserverance, selflessness and wisdom who has always had tenacious belief in her children. I am the first in generations of women in my extended family to earn a PhD and among a handful to even attend University, none of which would ever have been possible without my *mamma*. She was my root, my foundation. She taught me the strength, struggle, joys and pride of Sicilian womanhood. *Da sempre, per sempre, Mamma, ti amo con tutto il cuore.*

Chapter 1: Introduction

Statement of the Problem

This study investigated the experience of attunement, disruption and repair (ADR) as experienced by the therapist in an attachment-focused approach to psychotherapy.[1] "Attunement" has been a term in contemporary parlance in psychotherapy. It was frequently understood as a construct intertwined in some way with empathy. A therapist was viewed as empathic if s/he is attuned to the client; that is, engaged with the client in a particular manner. But what is attunement? The concept of attunement has not been easily articulated. Its referent seems ephemeral but not so ephemeral as to escape attention or interpretation, or efforts to teach it. Yet, there have not existed any manualized instructions for learning attunement nor workbook practice exercises as there have been, for example, with empathy. And, even when one can reveal what appeared as a mechanics of attunement (e.g., open body posture, eye contact, leaning in at appropriate moments), it has remained elusive nonetheless. It has been the *je ne sais quoi* that some people seemed to demonstrate intuitively and others have struggled to embody. Nevertheless, in the last few decades, research in several domains of inquiry have significantly advanced our comprehension of attunement in psychotherapy and have conceptualized attunement alongside disruption and repair as an interrelated process.

Our contemporary understanding of attunement, disruption and repair as an interrelated process and as a psychotherapeutic intervention has resulted from the confluence of three areas of inquiry: infant development research, theories of psychotherapy, and affective neuroscience. In particular, our current understanding of ADR has been the result of significant historical changes in paradigms in these three areas. These shifts in paradigms were: (a) infant development theory moved from viewing the infant as a blank slate to focusing on intersubjectivity as constituting the psychical world of the infant (e.g., Bateson, 1971, 1975, 1979; Murray, 1980; Trevarthen, 1979; Tronick, Als, & Adamson, 1979; Tronick & Cohn, 1989; Stern, 1985); (b) the phenomena of psychotherapeutic change were transposed from the intrapsychic experience of the individual to the relational context of the therapist/client dyad

[1] This study involved clinicians employing Accelerated Experiential Psychodynamic Psychotherapy (AEDP) in sessions with their clients. AEDP is an attachment-infused experiential model of therapy and will be further explicated in Chapter Two.

(Mitchell & Black, 1995); and (c) research in affective neuroscience prompted a movement away from cognitive models of psychotherapy to affective models (Fosha, Siegel, & Soloman, 2009).

Recently insights from these three areas of inquiry have begun to converge (e.g., Fosha, 2000; Fosha, Siegel, & Soloman, 2009; Lipton & Fosha, 2011; Schore, 2001; Siegel, 1999). Two principal concerns have emerged from these attempts at convergence: (1) there has been a lack of consensus on what dyadic attunement actually is and, (2) while attunement, disruption and repair has been investigated extensively in infant development research (e.g., Trevarthen, 1998; Tronick, 1989; Stern, 1985), and has been theorized to occur in the therapeutic relationship, there has yet to be any study that has examined this phenomenon in the therapeutic process. In fact, the research on attunement, disruption and repair in the therapeutic context has been scant. Only two studies have applied Stern's (1985) concept of affect attunement to psychotherapy: Davis and Hadiks (1994) and McCluskey (2005). Additionally, while several studies on ruptures and resolutions abound (Coutinho, Ribeiro, & Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Norcross & Wampold, 2011), such investigations have been predominately quantitative. Further, there have not been any existing studies to date that have investigated attunement, disruption and repair as an interrelated phenomena in the therapeutic dyad. In light of the theoretical literature (e.g., Fosha, 2000; Safran & Muran, 2000; Schore, 1994; Siegal, 1999) that postulates attunement, disruption and repair as a central process within the therapeutic relationship, there has been a significant absence of empirical literature investigating the construct and the role of ADR in the therapeutic process.

Purpose of the Study

Coutinho, Ribeiro, and Safran (2009) in their review of ruptures and their resolution in the therapeutic alliance asserted that researchers needed to investigate, among other issues, "the way in which the mutual regulation between therapist and patient in rupture episodes leads to change" (p. 488). They affirmed that this would require a shift in the approach to research away from quantitative methods to qualitative methods so that we can better understand the "micro-analysis of moment to moment shifts in the interactive process of the therapeutic dyad" (p. 488). In line with this assertion by Coutinho et al., the current research project investigated the micro-process of attunement, disruption and repair and shed light on nuances of ADR in the therapeutic dyad. By investigating the question, "How is attunement, disruption and repair experienced by the therapist in an attachment-focused approach to psychotherapy?" the present qualitative study

addressed a notable gap in the literature, contributed to our knowledge of the construct and the role of ADR in the therapeutic process, informed existing theory on affect regulation and attachment repair, as well as the process of change in therapy.

Theoretical Underpinnings

As stated, our current understanding of attunement, disruption and repair within the theoretical and empirical literature has been distributed, for the most part, across three diverse domains of inquiry: infant development theory, psychotherapy, and affective neuroscience. The conceptualization of dyadic attunement within each of these three areas of inquiry and the converging insights from these areas of inquiry conjectured that a co-constitutive process of attunement, disruption and repair occurred between therapist and client and has been the mechanism by which affect regulation occurs (Fosha, 2000; Safran & Muran, 2000; Schore, 1994; Siegal, 1999; Stern, 1985). However, while ADR as an inter-related co-constitutive process has been theorized to occur in the therapeutic relationship, there had yet to be any study that has examined this phenomenon in the therapeutic process until the present research project.

The following section will provide a rationale for the current study by summarizing the theoretical underpinnings of ADR. I will outline central notions of how ADR has been conceptualized within infant development theory, psychotherapy and affective neuroscience. Building on my rationale, I will then discuss how these concepts of ADR have been applied to the therapist/ client dyad through emotion theory. I will affirm the need for empirical qualitative research on ADR within the therapeutic process, and state the significance of the present research project. The key theoretical underpinnings succinctly discussed in this section will be elucidated in greater detail in Chapter Two.

Infant development research. ADR has been construed as foundational to attachment development in the infant/ caregiver dyad (Schore, 1994; Siegal, 1999; Stern, 1985). It is imperative to discuss ADR in infant development research when investigating this phenomena within adult psychotherapy, because ADR has been applied to explicate attachment processes in the adult therapist/ client dyad (e.g., Fosha, 2000; Safran & Muran, 2000; Schore, 1994; Siegal, 1999). Within the domain of infant development, research on intersubjectivity (e.g., Bateson, 1971, 1975, 1979; Murray, 1980; Trevarthen, 1979; Tronick, Als, & Adamson, 1979; Tronick & Cohn, 1989; Stern, 1985) spearheaded conceptualizations of ADR in the infant/ caregiver relationship. This vein of research on intersubjectivity demonstrated that infant/caregiver

interaction was bi-directional and mutually influenced. At the core of these investigations on the intersubjective world of the infant was both a focus on the infant's attunement to the movements, sounds and emotive expression of others, and a focus on how infant/ caregiver attunement helped a child regulate affect and develop secure attachment. Stern (1985) was paramount in both elaborating the features of mutually regulated infant/ caregiver interactions and creating a bridge between developmental psychology and clinical disciplines of psychology. Affect attunement, Stern affirmed, was a crucial aspect of intersubjectivity both within the infant/caregiver dyad and within the therapist/client relationship. Stern defined affect attunement as matching the feeling or quality of the internal state of another. Further, Stern maintained that this matching was manifested by behaviours that are not a replication of another's behaviour, but rather "recast the event and shift the focus of attention to what is behind the behavior, to the quality of feeling that is being shared" (p. 142). Attunement, Stern conveyed, not only entailed the matching of experiences, but also insinuated a kind of sharing of them such that attunement "permits one human to 'be with' another" by "sharing likely inner experiences" (p. 157). Research on affect attunement in the infant/ caregiver dyad was pivotal because it demonstrated both the bi-directionality of infant/caregiver interactions and most significantly, evinced how a child learned to regulate affect through a caregiver's attunement to affect (Stern, 1985). These notions of attunement in infant development literature inspired assertions within psychology that a similar interaction of affect attunement and affect regulation occurred in the therapeutic process (e.g., Fosha, 2000; Lipton & Fosha, 2011; Schore, 1994; Siegal, 1999). Such theoretical assertions emerged because psychotherapy itself had undergone a paradigm shift to a relational two-person intersubjectivity (Mitchell & Black, 1995). Significantly, this move to a relational psychology created conditions from which constructs of dyadic attunement could advance.

Psychotherapy. The paradigm shift in psychotherapy to a relational two-person intersubjectivity was historically initiated by object relation theorists (e.g., Bion, 1962; Fairburn, 1952; Klein, 1975; Winnicot, 1965) who held that individuals intrapsychically sorted life experiences into internal representations of object relationships. In this new paradigm, the therapist was viewed in terms of his/her primary object relations, and the therapist's affective experience was comprehended as more centrally involved in the client's struggles (Mitchell & Black, 1995). These notions shifted psychotherapy from a one-person psychology founded on the intrapsychic experience of the individual to a two-person, interactive and relational psychology.

Foundational to this move to a relational psychology was the application of infant/ caregiver interactions to elucidate processes in the adult therapist/ client dyad. For example, Bion (1962) deciphered that affective attunement between infant and caregiver was an intrinsic feature of human intimacy, that affective attunement was a key aspect of projective identification, and a highly adaptive survival strategy. Bion conjectured that in projective identification, an infant projected unbearable experiences onto his/her "attuned" caregiver, who then organized these experiences in more manageable form so that it was bearable to the infant. Because infants lacked the capacity to speak, Bion posited that without affective attunement the infant would be left at the mercy of terrifying experiences. Bion asserted that a similar process of projection, organization, and introjection occurs in the therapist/ client dyad where the therapist functions as a "container" for mental concepts originally located in the client's experience. In a related manner, Winnicot (1965) drew from his observations of mother/infant engagements as a model for what transpired within psychotherapy. Referring to the sense of maternal care a mother expresses with her infant, Winnicot believed that the therapist similarly provides a "holding environment" for the client so that he/she can feel safe to "reveal himself to himself" (Philips, 1988, p. 11). Bowlby's (1973, 1980) attachment theory enhanced relational theory by alleging that a fundamental instinctual behavioural system of bonding occurs between infants and their caregivers and that the infant's relational environment activated and shaped this behavioral system. Bowlby asserted that the role of the therapist is akin to the role of a caring and responsive caregiver. He developed the notion that the therapist provided corrective emotional attachment related experience by virtue of providing a safe haven and secure base for the client to explore both past relationships with attachment figures and current relationships, including the relationship with the therapist. Similarly, Carl Rogers' (1965) person-centered therapy was pivotal because it brought about the idea of the therapeutic relationship as "curative." Finally, research in the therapeutic alliance (e.g., Coutinho, Ribeiro, and Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Norcross & Wampold, 2011) highlighted the relationship between client and therapist and explored the impact of ruptures and their resolutions (i.e., repair) in the therapeutic dyad.

Although psychoanalytic theory, attachment theory, person-centered therapy, or theories of the therapeutic alliance did not explicitly distinguish dyadic attunement as a discrete process, several clinicians, as explicated above, drew on the infant/ caregiver relationship to elucidate key

interactions in the therapist/ client dyad. Most importantly, these clinicians characterized the therapeutic relationship as relational and formed by mutual influence (Mitchell & Black, 1995). This move to a mutually influenced relational psychology set the conditions for dyadic attunement as a therapeutic process to emerge.

Affective neuroscience. Affective neuroscience advanced notions from infant development research and relational psychology on dyadic attunement by hypothesizing that attachment developed in the infant/caregiver dyad through right-brain to right-brain communication of affective states (Schore, 1994; Siegal, 1999). According to Schore (2001), dyadic attunement occurred when a caregiver who was sensitive to the feelings of a child, was able to tolerate negative affective states and comfort the child before such states became overwhelming. The caregiver in this situation mirrored the child's distress and regulated the child's shifting arousal levels. This communication between caregiver and infant, when synchronized (i.e., attuned), was referred to as a coordinated state. A coordinated state was the synchronization of the neural circuits of two individuals such that the individuals were in biological rhythm with each other (Schore, 2001). Researchers in affective neuroscience purported that it was through this coordinated affective state that a caregiver assisted an infant to soothe his/her negative affect and by which the infant learned to self-regulate negative affect. However, Schore observed that the caregiver was not always attuned to the infant. Significantly, Schore affirmed that it was with the multiple occurring misattunements that interactive repair transpired:

> In this essential regulatory pattern of "disruption and repair" (Beebe & Lachmann, 1994; Schore, 1994) the "good-enough" caregiver who induces a stress response in her infant through a misattunement, reinvokes in a timely fashion her psychobiologically attuned regulation of the infant's negative affect state that she has triggered. The reattuning, comforting mother and infant thus dyadically negotiate a stressful state transition of affect, cognition, and behaviour. (p. 20)

This process of disruption and repair from negative affect followed by positive affect was paramount for the development of resiliency by teaching a child that negative affect could be "endured and conquered" (Schore, 2001, p. 21). Hence, affective neuroscience conceptualized dyadic attunement as an interrelated and interactive process inclusive of attunement, disruption, and repair and one that was foundational to resiliency and to affect regulation.

The aforementioned conceptualizations and converging insights of ADR within infant development theory, psychotherapy, and affective neuroscience led clinicians (e.g., Schore, 2003; Siegel, 1999) to propose that a similar process of attunement, disruption and repair occurred in the therapeutic dyad and was the mechanism by which mutual affective regulation transpired in the therapeutic process.

Emotion theory. To further elucidate how ADR transpired within the therapeutic process, clinicians turned to emotion theory. Emotion theory illuminated the significance of affect regulation in the therapist/client dyad and contributed to our understanding of attunement, disruption and repair. This theory held that "emotions are biologically wired into the human organism through an evolutionary process and that they play an adaptive role in the survival of the species" (Safran & Muran, 2000, p. 43). Emotions provide us with immediate appraisals of what interpersonal situations mean to us. Such appraisals, which can be present in awareness and out of awareness, were part of "one's ecological attunement to the unfolding dynamic aspects of the situation" (Parkinson, 1995 as cited in Safran & Muran, 2000, p. 47). Safran and Muran delineated some of the implications of emotion theory in psychotherapy. Emotions can be construed as embodied knowledge such that therapists and clients were always "resonating with one another at bodily-felt levels" (p. 47). To the extent that a therapist can attune to the client's felt-sense and expression of affect, a therapist can assist a client in articulating his/her affect, manage dysregulated emotions, and create meaning out of his/her embodied affect (Fosha, 2000). As well, the therapist's ability to attune to a client's affect during disruptions in the dyad and to tolerate this affect, can assist the client toward repair and transformation (Fosha, 2000; Safran & Muran, 2000; Schore, 1994; Siegal, 1999).

Significance of this study. In sum, various realms of inquiry such as infant development theory, relational psychology, affective neuroscience and emotion theory have conceptualized ADR as a key process of mutual affect regulation that occurs in the therapist/client dyad. These conceptualizations have raised queries about how ADR transpires and has been experienced within the therapeutic process, queries that have not been robustly investigated in the empirical literature. As encapsulated in the previous pages, while there have been several theoretical suppositions on ADR within the therapeutic dyad, there has been scant empirical investigations of ADR within the therapeutic process. The extant research on ADR has investigated attunement (e.g., Davis & Hadiks, 1994; McCluskey, 2005), disruption and repair (e.g., Coutinho, Ribeiro,

& Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Norcross & Wampold, 2011) as discrete processes with the large majority of these studies employing a methodology of task analytic paradigm or randomized control. The lack of empirical qualitative research about a phenomenon that is theorized to be fundamental to affect regulation within the therapist/client dyad has been concerning and has left a significant gap in our comprehension of ADR in the therapeutic process. The present research project was the first qualitative study that investigated ADR as a co-constitutive interrelated process in the therapeutic relationship and has addressed this gap in the literature.

ADR Defined

Recently, there has been a surge of therapeutic models that focused on emotions and attachment in counselling with a particular eye to how affect regulation occurred within the therapist/client dyad (e.g., Elliot et al., 2009; Fosha, 2000; Johnson, 2009). In Accelerated Experiential Dynamic Psychotherapy (AEDP), Fosha (2008) drew from research in affective neuroscience to prioritize the processing of emotions and the therapist/client attachment relationship. According to Fosha, attunement, disruption and repair in the client/therapist dyad is the process in which the client is accompanied and assisted to re-experience and regulate his/her affect in the context of a safe and trusting relationship:

> Through the moment-to-moment affective communication between dyadic partners that occurs through non-verbal, right-brain-mediated processes involving gaze, tone of voice, rhythm, touch, and other vitality affects, members of the dyad establish coordinated states. The process of dyadic affect regulation proceeds through countless iterations of cycles of attunement, disruption, and then, through repair, the re-establishment of coordination at a higher level. Though invariably accompanied by negative affects, the disruption of coordination, if repaired, is a major source of transformation. (p. 8)

Fosha's description of ADR was reflective of the confluence of affective neuroscience, infant development research and psychotherapy.

Akin to Fosha (2008), and particularly helpful in understanding therapeutic process, McCluskey's (2005) conceptualization of dyadic attunement echoed the convergence of theories from affective neuroscience, infant development research and psychotherapy. McCluskey proposed a complex understanding of "empathic attunement" based on "the activation and deactivation of a process" (p. 161). This fourfold process involved (1) the activation of

careseeking from a client through the expression of affect that is met by (2) cross-modal attunement and empathic input by the therapist such that it (3) assuages the client and enables him/her to self-regulate and (4) engage in exploration of his/her concern.

For the purposes of this dissertation, I conceptualized dyadic attunement in accordance with McCluskey's (2005) fourfold process as described above. In agreeing with Fosha (2008), I held that dyadic attunement involved the "moment-to-moment affective communication between dyadic partners that occurs through non-verbal, right-brain-mediated processes involving gaze, tone of voice, rhythm, touch, and other vitality affects" (p. 8). I distinguished disruption from attunement and defined disruption as an experience "accompanied by negative affect" (p. 8) that occurred when the dyad is no longer in a coordinated (i.e., attuned) state (e.g., careseeking was not met by cross-modal attunement and empathic input or there was a misattunement). The repair process occurred when the client was met by an attuned other, re-established a coordinated state with the other, and was subsequently able to self-regulate and engage in exploration. While recognizing that attunement, disruption, and repair are discrete constructs, I viewed them as aspects of an interrelated process that is co-constitutive. As Ham and Tronick (2009) underscored, the ideal interaction of attunement was not of "absolute synchrony and coordination" (p. 620), but one that also involved both "mismatches of affective states, miscoordination of responses, and misapprehensions of relational intentions," (p. 620) as well as the reparation of mismatches.

To investigate ADR in the therapeutic process, the present research project employed the aforementioned conceptualization of ADR as an interrelated process that is co-constitutive. By investigating the micro-processes of moment to moment shifts of ADR in the therapeutic process as experienced by the therapist, the phenomenological qualitative study herein addressed a significant gap in the literature, contributed to our knowledge of the construct and the role of ADR in the therapeutic process, informed existing theory on affect regulation and attachment repair, as well as the process of change in therapy.

Chapter 2: Literature Review

The following chapter will provide an overview of the ideas, theories and significant literature currently published on attunement, disruption, and repair. This chapter will expand the rationale on investigating the therapist's experience of ADR by discussing the ideas that have informed the research question and by providing a critical eye to the relevant literature. The literature review comprises two sections: a) the theoretical literature on ADR, and b) extant empirical research. The theoretical literature summarizes key notions of affect attunement in infant development research, discusses how attunement, disruption and repair has developed within diverse orientations of psychotherapy, delineates the central ideas of ADR within affective neuroscience, and explicates the key tenets of AEDP, the attachment focused approach to psychotherapy utilized in the current project. A review of the empirical literature revealed that there were only two existing studies on affect attunement in psychotherapy. Because of this, the empirical literature review will appraise studies in adjunct and related topics such as alliance rupture and repair, therapeutic presence and resonance, mirror neurons, and affect attunement.

Theoretical Literature

As introduced in chapter one, our current understanding of attunement, disruption and repair as a discrete process and as a psychotherapeutic intervention has resulted from the confluence of three areas of inquiry: infant development research, theories of psychotherapy, and affective neuroscience. In the following sections, I explicate in greater detail the theoretical literature in each of these three areas of inquiry.

I begin by identifying the relevant infant development research that has investigated the notion of intersubjectivity between infant and caregiver and that provided the backdrop for Stern's (1985) widely adopted theory of affect attunement. An initial overview of these child development theories is essential in comprehending the current research topic of ADR in the therapeutic relationship because these child development theories have been used to explain adult attachments in the therapeutic relationship (e.g., Bowlby, 1973, 1980; Winnicot, 1965). While clinicians such as Bowlby (1973, 1980) and Winnicot (1965) have long asserted that the role of the therapist is similar to the role of a caring and responsive caregiver, more recently, the attachment and affective regulatory relationship between infant/caregiver has been applied with augmented clarity to explicate similar attachment processes within the adult therapist/client dyad (e.g., Fosha, 2000; Lipton & Fosha, 2011; Schore, 1994; Siegal, 1999).

The initial review of infant development research is followed by an overview of ADR within various lineages of psychotherapy. I delineate the origins of dyadic attunement in object relations theory, attachment theory, human experiential psychotherapy, and the therapeutic alliance. Subsequently, I discuss the influence of affective neuroscience in the development of ADR and its application to the contemporary psychotherapy of Fosha (2000).

Infant development research. The concept of attunement in infant development research can be traced to the early 1970s. There began a shift in studies of child development from viewing the infant as a blank slate upon whom knowledge was imparted to a focus on intersubjectivity as underlying the activity of infants with their caregivers. This change was prompted by infant development research that employed film to investigate the moment by moment interactions between infants and their caregivers (e.g., Bateson, 1971, 1975, 1979; Murray, 1980; Trevarthen, 1979; Tronick, Als, & Adamson, 1979; Tronick & Cohn, 1989; Stern, 1985). This vein of research demonstrated the possibility of an underlying intersubjectivity in infants' interactions with their caregivers, and in children's understanding of the thoughts and emotions of others. The infant's development no longer was interpreted simply as a consequence of his/her parents' influence. Infants and caregivers existed in relation and the infant/caregiver interaction was interpreted as bi-directional and mutually influenced. At the core of the newly emerging research on the intersubjective world of the infant was a focus on the infant's attunement to the movements, sounds and emotive expression of others.

Trevarthen (1998) was among a handful of infant developmentalists who began using film in the late 1960s to investigate infant behaviour. It appeared to Trevarthen that there was a coherency to the communication-like behaviour of a newborn in relation to his/her mother and that this communication-like behaviour preceded the mastery of objects. This had not been hitherto observed in infants so young. Trevarthen's research prompted him to depart from the conventional view of the infant as a newborn in need of socialization to become a person. Instead, his research focused on the responses of healthy newborns to "people who take them as persons with intentions and feelings of companionship, and who feel pleasure when an infant responds" (Trevarthen, 1998, p.16). Reflecting on the plethora of studies in infant development over the last few decades, Trevarthen contended that "human sympathetic consciousness" (p. 15) was not solely an acquired skill, as was conventionally believed, but rather, that an infant innately possessed effective interpersonal intelligence at birth. While recognizing that infant

development involved learning, Trevarthen also asserted "the child is born with motives to find and use the motives of other persons in 'conversational' negotiations of purposes, emotions, experiences and meanings" (p.16). This occurred through sympathetic engagement between persons that signaled "the ability of each to 'model' or 'mirror' the motivations and purposes of companions immediately" (p. 16). Trevarthen's observations paralleled research in infant development conducted by Bateson (1971, 1975, 1979), Murray (1996), and Stern (1971) that also explored the communication-like behaviour of infants and mothers.

Bateson (1971, 1975, 1979) analyzed vocal, facial and gestural expressions in films of the infant and his/her mother. She noted a spontaneous face-to-face interaction between infant and mother and discovered that mother and infant were collaborating in a pattern of alternating, non-overlapping vocalizations. The patterned vocal, facial and gestural expressions of infants came to be termed by infant developmentalists as "protoconversation." Research in protoconversation called attention to the rhythmic interaction and coordination between infants and adults. It underscored the importance of timing and synchronization of gestures to syllables of adult speech in the communication of infants (e.g., Beebe, Stern, and Jaffe, 1979; Beebe, Jeff, Feldstein, Mays & Alson, 1985; Jaffe, Stern, & Peery, 1973; Stern, 1971). Moreover, this interactional pattern of protoconversation between infants and caregivers appeared to be common across cultures. Trevarthen (1988) conducted a study of protoconversation with mothers and infants from three socioeconomic groups in Scotland and an equal number of traditional urban mothers and infants in Lagos, Nigeria. While some differences existed, the study suggested that essential features of protoconversation were independent of cultural differences. These investigations contributed to the developing notion that infants were born with a predisposition to expect reciprocity in eye-to-eye contact, smiling, crying and vocalization and that features of protoconversation, such as mutual gazes and smiles, regulated interpersonal contact.

Most striking across the emerging currents of research at this time was research that came to be known as perturbation studies. Perturbation studies involved disruption to maternal communication during which the behaviour of the infants were compared with normal face-to-face engagements (e.g., Murray, 1980). Perturbation studies demonstrated the "dramatic impact on the infant when the mother's regulatory input is experimentally halted" (Ham & Tronick, 2009, p. 620). Although, Murray's research was among the first of the perturbation studies

investigating infant/caregiver interpersonal interaction, empirical investigations of face-to-face exchanges between mothers and infants emerged at about the same time from other laboratories:

> Stern (1971) working with Jaffe at Columbia University; Trevarthen (1974) working with Richards and Brunter's lab at Harvard as well as with Brazelton at Harvard; Catherine Bateson (1971) working with Bulows, and Brazelton (Brazelton, Kozlowski & Main, 1974) working with Tronick (Tronick, 1979; Tronick, Als & Brazelton, 1975; Tronick, Als, & Adamason, 1977). These researchers began the now rich tradition of documenting the minute details of the mother-infant face-to-face exchange, showing both partners to be active participants in the cocreation of many patterns of relatedness. (Beebe & Lachmann, 2003, p. 386)

Beebe and Lachmann (2003) reported that this research constituted a dramatic shift to understanding infant/caregiver interaction as bi-directional or mutually regulated.

Stern (1985) elaborated the features of mutually regulated infant/caregiver interactions. In his influential book, *The Interpersonal World of the Infant,* Stern heralded "a new dialogue between clinical disciplines and developmental psychology" (Trevarthen, 1988, p. 26) that "marked a major advance in clinical perceptions of the infant as a person" (p. 26). This seminal publication of the interpersonal world of the infant was a crucial bridge between research in infant development and theories of psychotherapy. In this publication, Stern (1985) challenged the psychoanalytic notion that "the infant was born with an undefined and ineffectual self" (p. 26). Conventional psychoanalytical theory promoted the view that physiological regulation predominated the early ontogeny of infants. The inner life of the preverbal infant was seen to be affected by changes in physiological states and the infant was depicted as "fairly asocial" (p. 44). By contrast, Stern asserted that infants have an active subjective life and that it is through intersubjectivity that a preverbal infant developed an emergent self. This perspective of an intersubjective emergent self in the preverbal infant diverged considerably from the psychoanalytic view. Although psychoanalytic object relations theorists recognized the active subjective life of the infant, as did Stern, Stern contended that they did not delineate the mental capacities that would lead the infant to distinguish a sense of self.[2] To draw attention to this

[2] Stern (1985) acknowledged that a handful of theorists have written historically about intersubjectivity. Examples included the concept of the "intermental" as described by Vygotsky

issue, Stern turned to the experimental research of infant developmentalists to articulate the nuances of the infant's social experience in the development of the emerging self.

Stern (1985) asserted that infants develop a sense of the self in a series of overlapping and interdependent layers and that these domains of self-experience remain influential throughout the child's life. Most notably, Stern purported that between the ages of seven and fifteen months, the experience of affect attunement developed between infants and their caregivers. Stern elucidated that several processes must occur for there to be an intersubjective exchange of affect between infants and their caregivers:

> First, the parent must be able to read the infant's feeling state from the infant's overt behavior. Second, the parent must perform some behavior that is not a strict imitation but nonetheless corresponds in some way to the infant's overt behavior. Third the infant must be able to read this corresponding parental response as having to do with the infant's own original feeling experience and not just imitating the infant's behavior. It is only in the presence of these three conditions that the feeling state within one person can be knowable to another and that they can both sense, without using language, that the transaction has occurred. (p. 139)

This pivotal shift to affect attunement occurred at about nine months. Prior to this, infants interacted with their caregivers primarily through imitation, a process where "caregivers and infants mutually create the chains and sequences of reciprocal behavior that make up social dialogues during the infant's first nine months" (Stern, 1985, p. 139).

What was essential about this early exchange prior to nine months is that the caregiver communicated within the same modality of the infant so that she/he was performing the approximate imitations of the infant's immediate behavior. At about nine months, however, the caregiver/infant interaction was modified so that matching was largely cross-modal. Stern described cross-modal matching as occurring when "the channel or modality of expression used by the mother to match the infant's behavior is different from the channel or modality used by the infant" (p. 141). For example, an infant's body movements were matched by the caregiver's voice, or inversely, the intensity of an infant's voice was matched by the caregiver's body movements. Most significantly, what was being matched was not the overt behavior of the

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(1965), "interpersonal relatedness" as articulated by Fairburn (1949), "the form of the personal" as elaborated by MacMurray (1961) and Sullivan's (1953) notion of "interpersonal field."

person but the feeling state or the quality of the internal state. Attunement behaviors, Stern evinced, "recast the event and shift the focus of attention to what is behind the behavior, to the quality of feeling that is being shared" (p. 142). In answer to the question of what inner state was being attuned to, Stern affirmed that both categorical affects such as joy or sadness as well as vitality affects were attuned to. Vitality affects were the dynamic, kinetic qualities of feelings that are composed of qualities such as intensity, shape and time and that we experience as "dynamic shifts or patterned changes within ourselves or others" (p. 156). As Stern described:

> Attunements can be made with the inner quality of feeling of how an infant reaches for a toy, holds a block, kicks a foot, or listens to a sound. Tracking and attuning with vitality affects permit one human to 'be with' another in the sense of sharing likely inner experiences on an almost continuous basis. This is exactly our experience of feeling-connectedness, of being in attunement with another. It feels like an unbroken line. (p. 157)

Stern's description of attunement as a "feeling of connection with an unbroken line" echoed the concept of communion and the I-thou relationship depicted by Buber (1958) and elaborated by Roger's (1965) person-centered counseling. It also paralleled Schore's (1994) concept of "affect synchrony" and Siegel's (1999) "mutual synchrony," notions that will be discussed in more detail in a subsequent section on affective neuroscience.

Stern (1985) further distinguished between affect attunement and intersubjectivity. He stated that intersubjectivity concerned "the mutual sharing of psychic states" (p. 144) through intentions and motives. However, affect attunement was concerned with qualities of feelings. In this respect, Stern noted that intersubjectivity was a broader process of which affect attunement was a particular aspect.

Additionally, Stern (1985) differentiated between empathy and affect attunement. Stern maintained that in expressing empathy, one took the experience of emotional resonance, abstracted empathic knowledge from the emotional resonance, and integrated this knowledge into a response that helped one identify with the experience of the other. Although empathy and affect attunement shared in the process of emotional resonance, Stern asserted that affect attunement "takes the experience of emotional resonance and automatically recasts that experience into another form of expression" (p. 145). This other form of expression into which emotional resonance was cast did not need to be an empathic response.

In clarifying this process, McCluskey (2005) stated that affect attunement was essentially the "giving of expression to the affect of the other in a way that the other can recognize as originating in and belonging in themselves" (p. 49). McCluskey gauged that affect attunement comprised a first stage of resonating with the feelings of another and a second stage of activating a desire to communicate those feelings so that the other person grasped that you have understood his/her experience. This communication occured through cross modal matching of the vitality affects described by Stern (1985). McCluskey (2005) further elucidated:

> What Stern shows conclusively is that we pick up the affect of other people; what we do with it, how we interpret it and how we respond to it is another matter and is largely dependent on our empathic capacity, how secure we feel and our level of arousal and well being. Empathy can be understood as our capacity to move away from ourselves as the locus of our reference for understanding emotion and sensation and see these phenomena as they might be experienced by another person, given their context and the information coming to them from their senses and cognition. It involves the capacity to read another's mind and put oneself in his or her shoes. (p. 50)

Stern and McCluskey clearly distinguished affect attunement which was "tuning in" through vitality affects and the picking up of the affect that other people feel as distinct from the cognitive process of empathic responses. It was through this process of affect attunement that a caregiver assisted a preverbal infant in regulating his/her affect. However, as the infant matured and became verbal, both affect attunement and empathy were necessary to assist a child in regulating his/her affect.

Stern's (1985) depiction of affect attunement and the significance of affect attunement in both communication and regulation were key to understanding the interactional processes that occurred in the infant/caregiver dyad and also in understanding the interactional processes that occurred in the therapeutic context. Stern's concept of affect attunement could not have transpired without the substantial body of research in infant intersubjectivity (e.g., Trevarthen, 1998), protoconversation (e.g., Bateson, , 1971, 1975, 1979) and perturbation (e.g., Murray, 1980). These researchers were but a handful of infant developmentalists that contributed to a paradigm shift that no longer interpreted infants as blank slates subject to their parents' influence. Instead, the behaviour of infants and caregivers was viewed as existing in mutual relation. Stern's seminal publication of the interpersonal world of the infant was a crucial bridge

between research in infant development and theories of psychotherapy. The subsequent section explores how attunement has been portrayed historically in psychotherapy.

The origins of attunement, disruption and repair in psychotherapy. The historical development of the construct of ADR has various lineages in psychotherapy: psychoanalytic influences, attachment theory, and humanistic experiential psychotherapy. Psychoanalytic theories and attachment theory did not directly illuminate the concepts of dyadic attunement. Instead, what they accomplished was to centralize the client/therapist relationship in the therapeutic dyad and conceptualize the dyad as mutually influenced. This laid the groundwork on which the constructs of attunement, disruption and repair could advance. In the subsequent sections, I summarize the theoretical influence of psychoanalysis, attachment theory, humanistic experiential therapies, and the working alliance in the historical development of the concept of ADR.

Psychoanalytical influences. In psychotherapy, a transformation in paradigms occurred that foddered the conditions for the constructs of attunement, disruption and repair to develop. Psychotherapy moved from a one-person psychology founded on the intrapsychic experience of the individual to a two-person, interactive and relational psychology. In psychoanalysis, this change was initiated by object relation theorists (e.g., Bion, 1962; Fairburn, 1952; Klein, 1975; Winnicot, 1965) who held that individuals intrapsychically sorted life experiences into internal representations of object relationships. In the new paradigm of a relational psychology, the therapist was no longer viewed as detached and calm, but rather, in terms of his/her primary object relations, and the therapist's affective experience was comprehended as more centrally involved in the client's struggles (Mitchell & Black, 1995). Two object relations theorists who were particularly salient to the historical development of a relational approach to psychoanalysis and to the development of the constructs of attunement, disruption and repair were Bion (1962) and Winnicott (1965).

Bion (1962) was interested in the concept of projective identification as developed by Klein (1975). More specifically, he was fascinated by what happens to the object onto whom the infant's feelings were projected. Bion viewed the infant as filled with disturbing sensations that she/he could not organize or control. He claimed that an infant projects this disorganized content onto the mother in order to escape unpleasant effects. The receptive mother organized the experience for the infant, who then introjected it in a form that was bearable. What Bion posited

was that if the mother was not attuned, the infant was left vulnerable to potentially terrifying experiences. He maintained that affective attunement as it transpired between an infant and caregiver was an intrinsic feature of human intimacy and he suggested that because infants cannot speak, affective attunement might be a highly adaptive survival mechanism (Bion, 1962; Mitchell & Black, 1995). Bion's notion of affective attunement as an intrinsic feature of human intimacy was very similar to the concept of affect attunement that Stern (1985) elucidated in infant development research decades later. Where Bion spoke of projection, organization and introjection that could only occur through affective attunement, Stern spoke of affect attunement being communicated and recast through vitality affects.

Bion (1962) purported that the process of projection, organization and introjection that occured between mothers and infants similarly transpired between therapist and client. Central to his premise was the notion of the therapist as a "container" for mental concepts that were located originally in the client's experience. The interpretation of the therapist as a container for a client's dysregulated affect is still common today, and used to describe aspects of the therapist/client interaction in a variety of therapeutic approaches. Bion's work was significant because he moved traditional psychoanalytic theory from being preoccupied with fantasy in the mind of the infant to concern with a complex relational event in the minds of two people. For Bion, the client experienced the analytic situation in terms of his/her primary object relations and the therapist's affective experience was more centrally involved in the client's struggles (Bion, 1962; Mitchell & Black, 1995).

Winnicott (1965), like Bion, was fascinated with the interaction between infant and mother and based his model of psychotherapy on the relationship the mother had with her infant. In a qualitative comparison between Winnicott and Kohut, DeRobertis (2010) explicated some of the more salient features of Winnicott's views on development. Winnicott asserted that the difference between healthy and unhealthy development of a child was due to the child's environment. In particular, Winnicott emphasized the quality of the infant/mother relationship as the key environmental influence in a child's development. The quality of the infant/mother relationship depended not on a perfect mother, but a "good-enough mother." A good-enough mother was one who met the needs of a highly dependent infant. Philips (1988) underlined the importance in Winnicott's view of how the mother approached the infant:

> The infant's earliest stages of development depend upon this notion of presentation, of the unimpinging attentive presence of the mother and the ways in which she makes herself available in her new state of being absorbed in her infant. (p. 101)

The good-enough mother attended to the needs of her child with a sense of presence and absorption. In this description, we can sense the experience of attunement or communion that Stern (1985) depicted in his observations of the infant/caregiver interaction (see p. 13).

Paramount to Winnicott's (1965) account, was the assertion that children had a natural tendency to learn, grow, and adapt to the environment and that in growth promoting environments, this innate tendency unfolded organically. A growth promoting environment, furnished by the good-enough mother, was achieved through a process Winnicott termed "holding." Holding referred to the actual physical holding of an infant that was intended to provide a sense of safety and protection from harm. Holding also denoted the mother's ability to attend both to the biological and psycho-emotional needs of the child throughout her daily routines. For Winnicott, DeRobertis noted, a reliable and consistent experience of holding provided a sense of sensorimotor unity and continuity over time. Holding along with a steadfast presentation of the world in manageable doses fostered both integration and the infant's nascent sense of identity.

Winnicott, as with Bion, did not abide a psychotherapy where the therapist was detached and calm and was restricted to providing interpretations of the client's intrapsychic experience. Winnicott drew from his observations of mother/infant engagements as a model for what transpired within psychotherapy. Referring to the sense of maternal care a mother had with her infant, Winnicott believed that the therapist similarly provided a "holding environment" for the client so that he/she could feel safe to "reveal himself to himself" (Philips, 1988, p. 11). Psychoanalysis was less about interpretation and more about the therapist creating a climate of trust and containment for the client's conflicts so that resolution arises from the client. The following quote captured the realm of reciprocity that underlined Winnicott's (1970) approach to therapy:

> A sign of health in the mind is the ability of one individual to enter imaginatively into the thoughts and feelings and hopes and fears of another person; also to allow the other person to do the same to us….When we are face to face with a man, woman or child in our specialty, we are reduced to two human beings of equal status. (p. 117)

Winnicott's depiction of "two human beings of equal status" who mutually grasp each other's hopes and fears was a striking departure from the psychoanalytic portrayal of the detached and calm therapist who interpreted the client's intrapsychic phenomena.

Such portrayals, by Bion and Winnicott, of the therapist/client relationship as one of "containment," "absorption," and "presence" in the context of a "holding environment" provided the backdrop for future investigations in contemporary psychotherapies for the development of attunement, disruption and repair. It is my contention, that without this historical turn to a developmentally informed conception of psychotherapy that was based on relationality and mutual influence, it was unlikely that notions of attunement would have received as much attention. The subsequent sections describe the influences of Bowlby's attachment theory, Roger's person-centered theory, and the therapeutic alliance on the constructs of attunement, disruption and repair.

Attachment theory. Attachment theory originated with John Bowlby (1973, 1980) and Mary Salter Ainsworth (1989). Bowlby was a child psychiatrist who was mentored in psychoanalysis by Melanie Klein. Although Bowlby considered himself a psychoanalyst, he was alienated by his psychoanalytic peers because of the significance Bowlby placed on relational experiences in human development and the therapeutic context. While psychoanalysis stressed the importance of early relationships with caregivers, this emphasis was on the intrapsychic experience of the child; that is, how the child dealt with painful experiences by defensively excluding them from conscious memory. Bowlby believed that a psychoanalyst should address the relational experiences that had caused and contributed to the child's defenses. He asserted that a child's emotional bond to his/her caregiver was the core relational experience, damage to which resulted in psychological distress. In this belief, Bowlby was motivated by ethological research that showed that an animal's bond to its mother was not simply a result of classical conditioning from feeding, but rather, a result of filial imprinting in which a young animal learns the characteristics of its parent. Bowlby alleged that a similar fundamental instinctual behavioural system occurred within the human infant and that the infant's relational environment activated and shaped this behavioural system. This view diverged significantly from Freud, who had hypothesized that the infant's fundamental instinctual system was sexual. Bowlby instead prioritized the relational needs of the child and underlined the importance of the child's emotional bond to his/her caregiver. More specifically, Bowlby asserted that children who

suffered caregiver deprivation not only experienced psychological and emotional wounds, but also, these wounds impacted communities and societies at large through intergenerational transmission. In short, children who suffer caregiver deprivation grew up to be parents who were unable to care for their children.

Bowlby's major collaborator, Mary Salter Ainsworth (1989), was a developmental psychologist whose research interests centered on child security and dependency. Her major contribution to attachment theory was the identification of differing patterns of infant attachment behaviour and how these patterns are associated with caregiver behaviour in the home. Ainsworth (1989) initially conceptualized three types of attachment that occurred in clinical observations of children: secure, anxious/ambivalent, and avoidant. Main and Soloman (1990) later developed a fourth category they termed "disorganized/disoriented" attachment behaviour.

Bowlby (1973) and Ainsworth (1989) underscored that repeated failure of a child to find comfort from an attachment figure not only influenced the development of insecure attachment styles, but it also impaired affect regulation and led to anxiety, agitation, and anger. Affective self-regulation was the ability of an individual to modulate affective states in order to maintain homeostasis. For example, one's ability to quell anger in order to communicate effectively, or calm one's fear and ease one's anxiety when agitated, was dependent on the ability to regulate emotions. It was presumed that the development of capacities for the regulation of emotion was crucial for healthy interpersonal relationships, socioemotional adjustment, and behavioral self-control (Siegel, 1999). According to attachment theory, the capacity to regulate affect did not unfold organically, but rather, developed as a result of the infant's temperament and the caregiving style to which the infant was exposed (Main & Weston, 1982). In optimal environments, a caregiver's emotionally sensitive responses to an infant's signals served to amplify a child's positive affect and modulate negative affect (Main & Soloman, 1986). An emotionally responsive caregiver reduced feelings of infant distress such as fear, anxiety, or sadness. Bowlby (1980) proffered that repeated experiences of responsive caregiving become encoded in the infant's implicit memory as mental models or schemata. He suggested that experiences of responsive caregiving, once internalized through mental schemata, enabled infants to self-regulate their responses to emotionally stressful stimuli. By comparison, disruptions in early attachment perturbed a child's ability to self-regulate affect and contributed to the development of psychological distress in childhood, adolescence, and adulthood (Bowlby,

1980; Siegal, 1999). Although Bowlby recognized that an emotionally responsive caregiver reduced feelings of infant distress, he conceptualized this process through cognitive psychology and that of the development of mental schemata. He did not elaborate on the notion of affect attunement as a discrete process. His contribution to psychotherapy and to the development of attunement, disruption and repair was most evident in the concept of the therapist as a secure base.

In *A Secure Base*, Bowlby (1988) asserted that the role of the therapist is similar to the role of a caring and responsive caregiver. Just as the caregiver provided a secure and protective environment so that a child can feel safe enough to explore his/her environment and develop knowledge about the self and the world, the therapist provided a secure base so that the client can explore unexpressed feelings, gain a better understanding of self, and revise dysfunctional internal working models.

The concept of the therapist as a surrogate caregiver was appropriated from Winnicott (1965) who believed that the therapist recreated a holding environment that resembled the psychic space between mother and infant, a space that was neither wholly psychological nor physical but which allowed for the child's transition to being an autonomous individual. Similarly, the holding environment or secure base in psychotherapy was one in which a client had the opportunity to meet neglected attachment needs in the presence of a caring and skilled therapist. In Bowlby's psychodynamic model of psychotherapy, this entailed uncovering deep-rooted fears, challenging defenses, and understanding distorted perceptions that interfered with healthy intrapersonal and interpersonal functioning. Bowlby avowed that the therapist provided corrective emotional attachment related experience by virtue of becoming a safe haven and secure base for the client to explore past relationships with attachment figures and current relationships including the relationship with the therapist. A corrective emotional experience was "an experiential relearning through which the client can safely alter his or her rigid relational patterns by being exposed to new interpersonal experiences with the therapist" (Bernier & Dozier, 2002, p. 32).

Although Bowlby alleged that the therapist provided corrective attachment related experience by virtue of becoming a safe haven and secure base for the client, he never addressed how this played out inter-relationally. McCluskey (2005) described this short-coming in attachment theory as follows:

> Attachment theory proposes that exploratory behaviour in individuals is dependent on the accessibility of a safe base, one that can be relied on to be supportive and educative in times of crisis or threat. . . . The other building block for the concept under discussion is empathy. For the operation of therapeutic work, attachment theory on its own is insufficient as it fails to address the nature of the support offered back at the base. The instinct to survive can a get a child or adult to return to a safe place when necessary. However, the reception one gets at the base will determine whether one actually gathers further resources or simply recovers and resuscitates the ones one already has. (p. 76)

McCluskey affirmed that what constituted support in a safe haven was an attuned and empathic response to one's internal state of arousal from someone who could sustain that response long enough for that internal state of arousal to be assuaged and who could assist with accessing one's own skills and resources.

Humanistic experiential psychotherapy. The influence of human experiential psychotherapy on the historical development of the construct of empathic attunement can be traced initially to the work of Carl Rogers (1965). Rogers grounded his theory in a humanistic person-centered approach. He prioritized the therapeutic relationship and characterized the therapist/client dyad as one that conveyed empathy, positive regard, and genuineness. Although both relational psychoanalytical theory and attachment theory also emphasized the therapeutic relationship, Rogers' person-centered therapy underscored an authentic, accepting, and empathic relationship as inherently curative.

The notion of empathy in person-centered therapy was closely associated with the construct of attunement. According to Bohart & Greenberg (1997), Rogers conceptualized empathy as an ability to "perceive the internal frame of reference of another with accuracy and with the emotional components and meanings as if one were the person, but without ever losing the 'as if' condition" (p. 6). Rogers (1965) departed from the psychoanalytic perspective that focused on the unconscious experience of the client as the root of his/her problems. Instead, Roger's concept of empathy, largely influenced by Gendlin (1968), involved focusing on the client's meaning of their moment-to-moment experiencing:

> The therapist tries to nonjudgmentally understand the client's immediate frame of reference in the moment and to communicate that understanding back to the client. In essence, empathy in practice is careful "communicative attunement" (to borrow a term

> from Orlinsky, Grawe, & Parks, 1994). The therapist attempts to imaginatively enter the client's experience of struggling to articulate, share, and dialogue with the therapist, as well as to try to grasp the content of what the client is striving to communicate. (Bohart & Greenberg, 1997, p. 7)

Notably, in the above description, the concepts of empathy and attunement have become enmeshed and there was little attempt to discriminate them. For my purposes, it is important to note that Stern (1985) sharply distinguished attunement from empathy. As discussed on pages 15-16 of this research, Stern claimed that affect attunement was a distinct form of expression that did not necessarily progress to empathic knowledge or empathic response. Moreover, while empathy involved the mediation of cognitive processes, Stern maintained that attunement occurred largely out of awareness.

Similarly to Bowlby, Rogers (1965) never conceptualized attunement as a discrete process. Nevertheless, Roger's person-centered therapy was pivotal because it brought into focus the curative capacity of the therapeutic relationship itself.

The working alliance. The therapeutic relationship has been studied extensively in the literature on working alliance. The working alliance is seen as pivotal to the constructs of attunement, disruption and repair because the working alliance is the context within which ADR transpires. The body of literature on the working alliance has been additionally significant because it has shed light on the processes of rupture and repair within the therapeutic dyad.

In psychoanalytic theory, the concept of the working alliance can be traced to Sandor Ferenczi and ego psychological theory (Safran & Muran, 2000). Ego psychological theory cultivated the idea of the working alliance by directing their focus on the "real" (Safran & Muran, 2000, p. 7) therapeutic relationship, a notion that stemmed from Greenson (1967, 1971) and that extended ego psychological theory. The real therapeutic relationship was defined as a "mutual human response of the patient and therapist to each other, including undistorted perceptions and authentic liking, trust, and respect for each other" (Safran & Muran, 2000, p. 9). In its inception, the working alliance was conceived as the ability of the therapist and client to work purposefully together in treatment. According to Safran and Muran, some authors (e.g., Elizabeth Zetzel, Lawrence Friedman) viewed the alliance through a maternal model where the therapist provided a supportive relationship similar to the maternal environment. The centrality of the therapeutic alliance, Safran and Muran noted, was later advanced in other therapeutic

traditions (e.g., Greenberg, Rice, Elliot, 1993; Rogers, 1965) and even cognitive behavioral therapy (e.g., Acceptance and Commitment Therapy). These therapeutic traditions generally defined the therapeutic alliance as the emotional alignment of the client and therapist based on trust, mutual regard, respect and agreement about the goals of therapy (Gelso & Carter, 1985). Safran and Muran, however, advocated for Bordin's (1979) formulation of the alliance. Bordin viewed the alliance as essential for therapeutic change and defined the alliance as the "degree of agreement between patient and therapist about the tasks and goals for therapy, and on the quality of the relational bond between them" (Safran & Muran, 2000, p. 11). Each component (i.e., task, goals, bond) was interdependent such that one impacted the other (e.g., a poor bond will impact the quality of tasks and goals or strongly articulated goals will strengthen a bond). The therapeutic bond constituted the affective quality of the therapist/client relationship and was most relevant to the construct investigated in this dissertation, that of attunement, disruption, and repair. Safran and Muran depicted the bond as "the extent to which the patient feels understood, respected, valued" (p. 12). While a solid and stable working alliance was related to positive therapeutic outcomes (Horvath & Greenberg, 1994), a working alliance characterized by strain and impasses in the therapeutic relationship that remained unresolved was predictive of negative therapeutic outcomes (Sommerfeld, Orbach, Zim, & Mikulincer, 2008).

In their research on alliance ruptures, Safran and Muran (1996) recognized two types of alliance ruptures in the therapeutic dyad: confrontational and withdrawal. Confrontational ruptures occurred when clients expressed their dissatisfaction with either the therapist or some aspect of therapy. Withdrawal ruptures occurred when clients withdrew from the relationship. This withdrawal could occur emotionally or cognitively and could reflect the client's feeling of being misunderstood by the therapist or reflect a client's reaction to their needs not being met within therapy. From an attachment perspective, these ruptures were understood as the activation of the client's internal working model and projection of his/her insecure attachment patterns onto the therapist.[3] Safran (1993) asserted that if the therapist supported the client's exploration of negative feelings, resolved the rupture, and restored a solid working alliance, increased trust and potentially new ways of interacting emerged. In attachment terms, when a therapist successfully resolved an alliance rupture and a new interpersonal interaction with the client emerged, the

[3] These ruptures can also be understood as transference and countertransference within psychodynamic models of therapy.

client was provided with a corrective emotional experience that assisted him/her to unlearn previously unhelpful relational patterns and relearn positive relational patterns.

More recently, Safran and Muran (2006) considered whether the notion of the therapeutic alliance and its susceptibility to ruptures was still meaningful. They adduced that in the psychoanalytic tradition, the paradigm shift from a one-person psychology to a two-person relational psychology that emphasized mutual influence, authenticity in the dyad, and therapist flexibility, had rendered the concept of the alliance unnecessary. In considering the role of the alliance and rupture, the authors stated that:

> The alliance construct played an important role among psychotherapy researchers in bringing the therapeutic relationship back into focus at a time when the person-centered tradition with its emphasis on the core conditions had become marginalized by the mainstream, and the cognitive behavioral tradition was in the ascendance. (p. 289)

Currently, Safran and Muran (2006) were directing their research efforts to questions about the role of relational factors in the change process. Among other issues, they suggested investigating mutual regulation between therapist and client and its impact on client affect regulation. The research focus of this dissertation on attunement, disruption and repair explored mutual regulation in the therapeutic dyad and was representative of the direction of investigation proposed by Safran and Muran.

To recap, the move from an intrapsychic psychology to a relational psychology created the conditions from which the constructs of attunement, disruption and repair could advance. Bowlby's (1988) contribution to the historical development of attunement was evidenced in the notion of an attachment bond between infant and caregiver and in the idea of the therapist as a secure base. Rogers' (1965) contribution to the development of attunement was demonstrated by his emphasis on the therapist/client relationship as authentic, accepting, and empathic. However, neither Bowlby nor Rogers articulated the concept of attunement as a discrete process. Rogers conflated the concept of attunement with empathy, and Bowlby never elaborated the interactional means required for the therapist to provide a secure base for the client. The notion of the working alliance offered an account of ruptures and their resolution in terms of goals, tasks, and bond in the therapeutic relationship but had yet to investigate micro-processes such as that of attunement, disruption and repair in the therapist/client dyad. It was not until research in

affective neuroscience intersected with theories of psychotherapy and infant development that the construct of attunement, disruption and repair as a discrete therapeutic process emerged.

Affective Neuroscience. Fosha, Siegel, and Soloman (2009) purported that we are living in times of "shifting paradigms and emerging frontiers" (p. vii) as pertains to psychotherapy. The decades of an advancing cognitivism were giving way to a new era of affective and somatic models of psychotherapy. This paradigm shift has been instigated by developments in neuroscience that recognize "the primacy of affect in the human condition" (p. vii). In essence, affective neuroscience posited that emotions were fundamental capacities of the human brain, that we inherited a variety of emotional dispositions through our mammalian brains, and that these systems were essential to generating primary affective states that lied at the core of the plasticity of the human brain (Panksepp, 2009). Developments in affective neuroscience have inspired a synthesis of clinical and neuroscientific approaches. Siegel (as cited in Panksepp, 2009) underscored that although clinicians engage themselves with the life experiences and stories of people who come to therapy for assistance:

> Whatever the approach, lasting change in therapy occurs as a result of changes in the human mind . . . which involve changes in the functions of the brain. Exactly, how the mind changes during the therapeutic process is the fundamental puzzle that the synthesis of neuroscience and psychotherapy seeks to solve. (p. 4)

This merger of neuroscience with psychotherapy and infant development drew further attention to the process of dyadic attunement in the therapist/client relationship.

Dyadic attunement stemmed from research in affective neuroscience that hypothesized that attachment developed in the infant/caregiver dyad through right-brain to right-brain communication of affective states (Schore, 1994; Siegal, 1999). According to Schore (2001), dyadic attunement occurred when a caregiver who was sensitive to the feelings of a child, was able to tolerate negative affective states and comfort the child before such states became overwhelming. The caregiver in this situation mirrorred the child's distress and regulated the child's shifting arousal levels. This communication between caregiver and infant, when synchronized (i.e., attuned), was referred to as a coordinated state. A coordinated state was the synchronization of the neural circuits of two individuals such that the individuals were in biological rhythm with each other (Schore, 2001). Researchers in affective neuroscience conjectured that it was through this coordinated affective state that a caregiver assisted an infant

to soothe his/her negative affect and by which the infant learned to self-regulate negative affect. The ensuing pages will elaborate these psychoneurobiological concepts in more detail.

Schore (2001) had been key in positing that regulation of affect was a central organizing principle in the psychoneurobiological models of normal and abnormal development. One of his central premises was that the adaptive capacities of the early maturing right brain that dominated the first three years of life were experience dependent and embedded in the attachment relationship of the infant/caregiver dyad. The quality of the attachment experiences could influence positively or negatively the maturation of the brain structure and therefore infant psychological development. The right brain was involved chiefly in processing social-emotional information, regulating bodily and affective states, coping with stress, and non-verbal communication.

At about two months of infancy, the primary visual cortex developed enough so that the "visual stimuli emanating from the mother's emotionally expressive face becomes the most potent stimulus in the infant's social environment" (Schore, 2001, p. 18). According to Schore, the intense mutual gaze by infant and caregiver characterized by non-verbals such as gaze direction, facial expression, posture, and body movements indicated a process of "affect synchrony" (p. 18):

> Synchronicity is defined as a match between mother's and infant's activities that promotes positivity and mutuality in play. By synchronizing with the child's attentive states, mothers structure playful interactions, regulate infant attention, facilitate the development of verbal dialogue, and promote the infant's capacity for self-regulation . . . mutual synchrony exists when both partners simultaneously adjust their attention and stimulation in response to the partner's signals. (Feldman as cited by Schore, p. 349)

Affect synchrony or mutual synchrony provided an opportunity for the coordination of biological rhythms in the infant/caregiver dyad. Schore underlined that engagement through mutual synchrony, disengagement where both partners could be together "yet alone (autoregulating) in the presence of the other" (p. 18), and reengagement were essential to coordination of biological rhythms. During these moments of affect synchrony, infant and caregiver recreated "an inner psychophysiological state similar to the partner's" (p. 19) whereby they were sharing or experiencing the same feeling state. Schore discerned that theoreticians have employed the concept of "resonance" to signify the mutually attuned communication that occurred in the

infant/caregiver dyad. Resonance was the "energy-infused moments" (p. 19) where both partners "move together from low arousal to a heightened energetic state of high arousal, a shift from quiet alertness into an intensely positive affective state" (p. 19). These energy shifts were fundamental features of emotion, were heightened during resonance, and permitted a "coherence of organization in the infant" (p. 19).

Schore (2001) elucidated that dyadic resonance was the context for communication between infant and caregiver and that these "moment-to-moment expressions of the mother's regulatory functions occur at levels beneath awareness" (p. 20). To enter into this communication, the caregiver needed to attune not to the infant's overt behaviour, but rather, to the rhythms of the infant's internal state. Drawing from research in neuroscience and infant development, Schore purported that the attuned infant/caregiver communication occurred through right brain to right brain resonance:

> In affectively charged face-to-face transactions, the biologically significant information that emanates from the mothers' face is imprinted in the infant's developing right interior temporal areas that process familiar faces (Nakamura et al., 2000) and thereby take on a "special biological meaning." The right hemisphere is also dominant for the perception of "biological motion." These psychoneurological events of mother-infant play sequences drive the "affective bursts" embedded within moments of affective synchrony, in which positive states of interest and joy are dyadically amplified. (p. 25)

Although such "joining of two minds" (Siegel, 2003, p. 32) was critical to developing self-regulatory capacities in the infant/caregiver dyad, it was but one aspect of the process of attunement. Schore (2001) conveyed that the caregiver was not always attuned to the infant. Significantly, it was with the multiple occurring misattunements that interactive repair transpired:

> In this essential regulatory pattern of "disruption and repair" (Beebe & Lachmann, 1994; Schore, 1994) the "good-enough" caregiver who induces a stress response in her infant through a misattunement, reinvokes in a timely fashion her psychobiologically attuned regulation of the infant's negative affect state that she has triggered. The reattuning, comforting mother and infant thus dyadically negotiate a stressful state transition of affect, cognition, and behaviour. (p. 20)

This process of disruption and repair from negative affect followed by positive affect was paramount for the development of resiliency by teaching a child that negative affect could be "endured and conquered" (Schore, 2001, p. 21). Hence, affective neuroscience conceptualized dyadic attunement as an interrelated and interactive process inclusive of attunement, disruption, and repair and one that was foundational to resiliency and to affect regulation.

In sum, research in affective neuroscience hypothesized that attachment developed in the infant/caregiver dyad through right-brain to right-brain attuned communication of affective states (Schore, 1994; Siegal, 1999). This communication of affective states involved attuned coordinated states as well as multiple occurring misattunements and interactive repair. Researchers in affective neuroscience postulated that it was through this phenomena of attunement, disruption and repair that a child developed resiliency. What emerged within the literature of affective neuroscience was a conceptualization of attunement, disruption and repair as an interrelated and interactive process, a process foundational to affect regulation and the development of secure attachment. In contemporary models of psychotherapy such as AEDP (Fosha, 2000), it was this conceptualization of ADR that had been posited to transpire within the adult therapeutic relationship (Schore, 1994; Siegal, 1999) and that formed the topic of the current research project.

Accelerated experiential dynamic psychotherapy (AEDP). As stated above, the conceptualization of attunement, disruption and repair as an interrelated and interactive process has been reflected in AEDP, a contemporary and attachment-focused model of psychotherapy. Because AEDP clinicians have been trained to scan and track a client's moment to moment affective experience within the context of a dyadically attuned therapeutic relationship, AEDP therapists were selected as participants within the current research project. As such, it was important to include a description of AEDP in the theoretical literature.

Fosha (2000) conferred that AEDP is a healing oriented treatment approach which integrates experiential and relational elements within an affect-centred psychodynamic framework. Drawing from research in affective neuroscience, emotion theory, infant development research and interpersonal psychotherapy, AEDP centralizes the attachment relationship between the therapist and client as key to healing and transformation. Specifically, AEDP references the attachment relationship between caregiver and infant to underscore the emotionally dyadic regulatory processes that occur between therapist and client.

AEDP maintains that affect is experienced through four state transformations (see Appendix 7): (1) stress, distress and transformance; (2) the processing of emotional experience; (3) the metaprocessing of transformational experience, and (4) core state and the truth sense. State one involves both dysregulating or inhibiting affects that may present as defenses, anxiety or shame. State one also involves feelings of transformance. Transformance denotes an inner motivational force that is adaptive and self-righting and that strives for vitality, authenticity and genuine contact (Lipton & Fosha, 2011). From the inception of the therapeutic encounter and throughout the therapeutic process, the AEDP therapist recognizes and affirms transformance strivings in the client. The AEDP therapist provides a secure and trusting therapeutic relationship so that clients feels safe to explore difficult and challenging emotions that underlie defenses and dysregulation.

The second state transformation, processing emotional experience, refers to accessing and experiencing ones' underlying core affect in the presence of a caring other. AEDP underscores that emotions are centred in the body and that the experiencing of one's emotions "to completion" in the presence of a caring other assists clients to develop both intrapersonal and interpersonal emotional regulation. The notion of experiencing an "emotion to completion" is metaphorically akin to emotional waves that advance and recede within oneself. The therapeutic relationship in AEDP is characterized by "affective resonance, sharing, and empathy" (p. 29) and is akin to Winnicot's (1965) holding environment, a growth promoting environment intended to provide safety by attending to a client's psycho-emotional needs. Within this interaction, the attuned therapist guides the client "toward exploring emotional regions that might otherwise remain unchartered, allowing the unfolding of self experience" (Fosha, 2000, p. 38). Pathology, within AEDP, has been defined as unbearable aloneness in the face of overwhelming emotions. The client is guided to places where he/she has felt unbearably alone and to re-experience their affect in the context of a safe and caring other, i.e., the therapist. At all times, the therapist works within the client's "window of tolerance" (Siegel, 1999).

The third state transformation transpires with the metaprocessing of healing affects. When a client experiences core emotional process and has been held in the recognition and affirmation of the therapist, healing affects arise. Healing affects are the feelings of being moved and touched within the self, feelings of love and gratitude toward the other. Metaprocessing is the processing of what's therapeutic about therapy and about the therapeutic relationship. Within

AEDP, it's not enough to experience one's affect but more so, to experience one's affect to completion in the presence of a safe and caring other. When healing affects arise, the therapeutic focus moves to metaprocessing the healing affects, to metaprocessing how the client experiences these healing affects and additionally, how the client experiences affect in the context of the therapeutic dyad.

Finally, a fourth state transformation occurs with core state and truth sense. Core state and the truth sense is the experience of empathy, self-empathy, wisdom, generosity and clarity about one's subjective truth that occurs when previously warded off feelings, insights and associations have been integrated (Lipton & Fosha, 2011).

A foundational concept in AEDP is that the therapist and client are engaging in the therapeutic journey together where the therapist aims to foster a sense of "we-ness." Further, the therapist's feelings are central to the therapeutic relationship and are shared to both strengthen the dyadic relationship and to help the client explore and develop receptive affective capacity. Receptive affective capacity is the experience of feeling seen, felt, loved and understood by a caring other. An additional fundamental concept in AEDP has been the prioritizing of the attuned therapist/client dyad. As mentioned in Chapter One, Fosha (2008) underscored that the AEDP therapist accompanies and assists clients to re-experience and regulate their affect through countless iterations of cycles of attunement, disruption, and repair that transpire through right brain to right brain mediated processes of vitality affects such as gaze, tone of voice, touch and other non-verbals. In this respect, AEDP clinicians have been trained to actively attune to and engage dyadic affective processes within the therapeutic relationship so that they can recognize and assist clients in each of the aforementioned state transformations towards integration.

Summary of theoretical literature. The preceding theoretical literature summarized key concepts of affect attunement in infant development research, discussed how attunement, disruption and repair developed within diverse orientations of psychotherapy, delineated the central ideas of ADR within affective neuroscience, and outlined key tenets of AEDP, the attachment-focused model of psychotherapy that has been employed by clinicians in this research study.

A review of infant development theories and particularly the notion of intersubjectivity between infant and caregiver was essential in comprehending the current research topic of ADR in the therapeutic relationship because these child development theories had been used to explain

adult attachments, and specifically ADR, in the therapeutic relationship. Stern's seminal publication of the interpersonal world of the infant was a crucial bridge between research in infant development and theories of psychotherapy. Stern's (1985) depiction of affect attunement in both communication and emotional regulation in the infant/ caregiver dyad, when applied to adult attachment, was key to understanding the interactional and affective regulatory processes that occurred in the therapeutic context.

Within psychology, the move from an intrapsychic psychology to a relational psychology created the conditions from which the constructs of attunement, disruption and repair could advance. Object relation theorists (e.g., Bion, 1962; Fairburn, 1952; Klein, 1975; Winnicot, 1965) spearheaded this paradigm shift to a two-person psychology by holding that individuals intrapsychically sorted life experiences into internal representations of object relationships. These clinicians drew from their observations of mother/infant engagements as a model for what transpired within psychotherapy. The focus of therapy became less about the intrapsychic experience of the client but rather, on interpersonal relations within the therapeutic context. Bion (1962) spoke of the therapist as a "container" for mental concepts and dysregulated affect that were located originally in the client's experience. Winnicott (1965) referred to the sense of maternal care a mother has with her infant and believed that the therapist similarly provided a holding environment for the client. Bowlby (1988) conveyed the notion of an attachment bond between infant and caregiver and transposed this notion in the idea of the therapist as a secure base. Rogers' (1965) emphasized the curative nature of an authentic, accepting and empathic therapist/client relationship. While these clinicians drew from their observations of infant/ caregiver engagements to allude to dyadic attunement within the therapist/ client dyad, none of these clinicians articulated the concept of attunement as a discrete process. Similarly, the notion of the working alliance offered an account of ruptures and their resolution in the therapeutic relationship, but it had not investigated the micro-processes of attunement, disruption and repair in the therapist/client dyad. It was not until research in affective neuroscience intersected with theories of psychotherapy and infant development that the construct of attunement, disruption and repair as a discrete therapeutic process emerged.

Research in affective neuroscience hypothesized that attachment developed in the infant/caregiver dyad through right-brain to right-brain attuned communication of affective states (Schore, 1994; Siegal, 1999). Such investigations postulated that it was through this attuned

coordinated affective state that a caregiver assisted an infant to soothe his/her negative affect and by which the infant learned to self-regulate negative affect. Moreover, researchers noted that the caregiver was not always attuned to the infant and that significantly, it was with multiple occurring misattunements that interactive repair transpired, that is, that a child learned to regulate negative affect. What emerged within the literature of affective neuroscience was a conceptualization of attunement, disruption and repair as an interrelated and interactive process, a process foundational to affect regulation and the development of secure attachment. This conceptualization of ADR has been theoretically postulated to transpire within the adult therapeutic relationship (Schore, 1994; Siegal, 1999). However, there had not been any studies that actually investigated ADR within the therapeutic process. The research herein was the first qualitative investigation of ADR in the therapeutic relationship. The proceeding section will contextualize the current research by reviewing the extant empirical literature on attunement, disruption and repair.

Empirical Research on Attunement in Psychotherapy

As explicated in this chapter thus far, the conceptual development of attunement, disruption and repair emerged from a confluence of disciplines: infant development research, psychotherapy, and affective neuroscience. However, it was not until recently that insights from infant development research, psychotherapy, and affective neuroscience converged. The most noteworthy example of convergence of these three areas of inquiry integrated in a psychotherapeutic model is Fosha's (2000) Accelerated Experiential Dynamic Psychotherapy (AEDP). Because this convergence was a recent phenomenon, research on ADR in the therapeutic context has been scarce. There were only two studies that applied Stern's concept of affect attunement to psychotherapy: Davis and Hadiks (1994) and McCluskey (2005). Thus with only two studies in existence on affect attunement in psychotherapy, in order to situate the present study in the context of extant knowledge and research it was necessary to examine relevant and related, if somewhat adjunct, topics in conducting a literature review. The following literature review will appraise current studies in alliance rupture and repair, therapeutic presence and resonance, mirror neurons, and affect attunement.

Research on alliance rupture and repair. As stated, the notion of the working alliance (see p. 24), addressed ruptures and their resolution with respect to goals, tasks, and bond in the therapeutic relationship. The body of literature on alliance rupture and repair is substantive (e.g.,

Coutinho, Ribeiro, & Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Norcross & Wampold, 2011) and ranges in methodology from quantitative (e.g., randomized control studies) and task analytic paradigm, to qualitative methods (e.g., phenomenological, case study). This area of research has focused on the effectiveness of alliance rupture and repair, investigated the types of impasses and misunderstandings experienced by the therapist or client, and presented diverse rupture resolution models. While this research has been robust, there have not been any investigations on micro-processes such as that of ADR in the therapist/client dyad, nor have there been any investigations of ADR as an interrelated and co-constitutive phenomena. The literature on alliance rupture and repair with its focus on ruptures and their resolutions was nevertheless closely related to the topic of this dissertation and was reviewed subsequently. The proceeding section will discuss existing literature reviews and meta-analyses on alliance rupture and repair, qualitative phenomenological research on ruptures and resolutions, and studies employing task analytic paradigm.

Literature reviews and meta-analyses. A series of literature reviews and meta-analyses (Coutinho, Ribeiro, & Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Norcross & Wampold, 2011) have encapsulated the literature on alliance rupture and repair. These literature reviews investigated alliance rupture and repair in terms of its effectiveness. For example, Norcross and Wampold (2011) headed the interdivisional task force on evidence-based therapy relationships. They categorized findings resulting from their meta-analyses on the relationship elements that were effective in psychotherapeutic treatment into demonstrably effective, probably effective, and those that were promising but did not have substantial evidence as yet. The therapeutic alliance, empathy and collecting client feedback were shown to be demonstrably effective, and elements such as congruence/genuineness, repairing alliance ruptures, and managing countertransference were promising but lacking in research. Coutinho, Ribeiro, and Safran (2009) also reviewed the literature on the resolution of ruptures in the therapeutic alliance. They asserted that the main avenue of change in the therapeutic dyad was the process of going through impasses or ruptures and resolving them effectively. Indeed, repair of alliance ruptures has been correlated with positive outcomes (e.g., Foreman & Marmar, 1985; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Lansford, 1986; Muran, Safran, Samstag, & Winston, 2005; Safran & Muran, 1996; Weiss & Sampson, 1986). Specifically, the literature demonstrated that a high-low-high pattern of alliance development was related to good outcomes

(e.g., Kivilighan & Shaugnessy, 2000; Patton, Kivlighan, & Multon, 1997; Stiles et al. 2004). The high-low-high pattern referred to a strong working alliance (high) that then experienced a rupture (low) that was eventually resolved so that a strong working alliance was restored (high). Although this body of literature on the effectiveness of alliance ruptures and repairs was helpful in outcome research, the current research project differs in methodology and does not have outcome as its purpose. By employing a phenomenonlogical qualitative methodology, the present research project investigated the therapist's experience of attunement, disruption and repair and aimed to gain a richly woven comprehension of ADR as experienced by the therapist in an attachment-focused approach to psychotherapy.

Qualitative research. In Eubanks-Carter, Muran, and Safran's (2010) review of the existing body of research on alliance rupture and repair, they categorized the studies by their methodology: task analytic paradigm, randomized control studies (RCTs), qualitative methods, naturalistic observation paradigm. In the area of qualitative methods, Hill (2010) undertook three phenomenological studies in alliance ruptures and resolutions (i.e., Rhodes, Hill, Thompson & Elliot, 1994; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Hill, Kellems, Kolchakian, Wonnell, Davis, & Nakayama, 2003). These phenomenological qualitative studies along with those by Haskayne, Larken, and Hirschfeld (2014), and Soygüt and Gülüm (2016) will be subsequently reviewed.

The first study by Rhodes, Hill, Thompson, and Elliot (1994) investigated the experience of 19 cases where clients felt misunderstood by their therapists. Participants consisted of therapists or therapists-in-training who discussed their experiences of having had a misunderstanding with their own therapist when they were clients. Participants were asked to respond to a detailed questionnaire that described the event. In analyzing the data, Rhodes et al. employed a method of consensus coding in order to minimize potential bias and to derive a more complex conceptualization of the phenomenon. The authors initially coded the data as a resolved event (client felt able to continue therapy) or unresolved (unsatisfactory outcome). They then further broke the data down into thought units that expressed unique ideas. These thought units were then sorted into domains according to the sequential framework by Strauss and Corbin (1990). Eleven of the cases evinced misunderstandings that were resolved and eight cases were unresolved. Misunderstandings were described by clients as therapists being out of tune with or not responsive to their needs. Findings indicated that resolving a misunderstanding depended on

how the client felt about the therapeutic relationship. In a good therapeutic relationship, clients were more willing to express negative feelings about a misunderstanding. Additionally, therapists were more apt to demonstrate flexibility and acceptance of the client's misunderstanding, responses that led to resolution. A poor therapeutic relationship was characterized by the therapist's unwillingness to discuss or accept a client's perspective about a misunderstanding and a therapist's lack of awareness about how the client felt. These unresolved misunderstandings frequently led to clients quitting therapy. This study by Rhodes et al. defined ruptures as a misunderstanding in the therapeutic process and left the participant to determine the type of misunderstanding he/she shared for the study. This open-ended investigation of a rupture was akin to the approach within the present research project. In the present study, there were no restrictions placed on the types of disruptions investigated. Nevertheless, the present research differed from Rhodes et al. by interviewing the therapist instead of the client, by investigating ADR as an interrelated phenomenon, and by conducting in-person interviews rather than questionnaires. In person interviews have the advantage of capturing nonverbal nuances that are not present in questionnaires as well as the advantage of asking clarifying questions. The present study additionally differed from Rhodes et al. by utilizing video-recorded sessions to assist with recall of the phenomenon. As well, the video-recorded sessions and the Interpersonal Process Recall method (Larsen, Flesaker & Stege, 2008) employed in the research herein permitted an investigation of the micro-processes of ADR, micro-processes that were not captured in the study by Rhodes et al.

The second study by Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) employed both questionnaires and in-person meetings to interview 12 experienced therapists about cases where there was an impasse that led to the termination of therapy. Their study encompassed therapist cases from long-term therapy in private practice (i.e., median of 84 sessions over 18 months). As with the study by Rhodes et al. above, Hill et al. utilized a consensual qualitative method to analyze the transcribed interviews into domains and core ideas. They then sorted these ideas into categories according to general (all cases), typical (7 – 11 cases), variant (3 - 6 cases), and developed a narrative account of the therapist's perspective of the impasses. Their findings portrayed four types of impasses as characterized by the therapist: possible therapist mistakes, triangulation, therapist issues, and transference. Possible therapist mistakes involved the therapist being unsupportive, too cautious, being unclear (e.g., difficulty

with boundaries, losing neutrality or changing techniques), and misdiagnosing the client. Triangulation occurred when other people in clients' lives made them feel like they had to choose between the therapist and the other person(s) (e.g., family member, another therapist). Personal issues on the part of the therapist (e.g., difficulty dealing with strong negative affect, family of origin issues triggered by client's issues, rescuing client, life stressors) interfered with therapy. Transference included the client perceiving and reacting to the therapist as if the therapist was his/her parent. Therapists attempted to resolve the rupture by helping clients explore what had happened. This was achieved through re-engagement, insight, and re-conceptualizing the problem. Additionally, therapists sought out consultation and/ or employed positive self-talk to reframe the situation. Akin to the current research project, the study by Hill et al. investigated the therapist's perspective in retrospective client cases and employed a small sample of participants in a phenomenological qualitative analysis. However, unlike Hill et al., the present research project employed video recorded sessions both to assist with therapist recall and to investigate the moment-to-moment micro-processes of ADR. Additionally, while Hill et al. investigated impasses alone, the present research investigated attunement, disruption and repair as an interrelated process.

The third study by Hill, Kellems, Kolchakian, Wonnell, Davis, and Nakayama (2003) investigated the experiences of thirteen therapists who worked with both angry and hostile clients. As with Hill et al. (1996), the authors in this study employed consensual qualitative research to analyze the interviews. This involved analyzing the transcribed interviews into domains and core ideas and sorting the categories into general (applied to all), typical (more than half) and variant (applied to two to half of events). The findings discussed how therapists felt when addressing hostile anger, therapist attribution of client anger, and factors that influenced resolution. Therapists experienced feelings of anxiety, incompetence, annoyance and frustration when managing client anger and attributed client anger to doing something the client disliked (e.g., setting boundaries, ensuring client safety, challenging client's behaviour). They conveyed difficulty and struggle addressing client's hostile anger. On the other hand, therapists found ease with addressing unexpressed anger by clients. In these cases, they imparted care and encouraged clients to express their anger. The authors found that several factors influenced the resolution of anger. Hostile anger was more difficult to resolve when the therapist challenged problem behaviour (e.g., missed appointments, drug use). Therapists who allowed themselves to

experience their annoyance and frustration had an easier time resolving client anger. Client anger was more readily resolved when therapists attempted to connect with clients rather than simply acknowledging client anger. Additionally, unexpressed anger was more likely to be resolved if there was a strong therapeutic relationship and if the therapist raised the issue of anger and assisted the client to explore it. Notably, therapists attributed unresolved anger events to client personality problems but attributed resolved anger events to problems in the therapeutic relationship. As with the present research project, Hill et al.'s study investigated the therapist's perspective in retrospective client cases and employed a small sample of participants in a phenomenological qualitative analysis. However, the research herein differed by employing video recorded sessions to assist with recall and by investigating the moment-to-moment micro-processes of ADR. Moreover, this third study by Hill et al. focused solely on anger as an impasse while the present research project investigated attunement, disruption and repair as an interrelated process and did not place restrictions on the type of disruption investigated.

Haskayne, Larken, and Hirschfeld (2014) undertook a phenomenological qualitative study on rupture resolution during long-term psychodynamic therapy. Four client/ therapist dyads were interviewed and the findings were analyzed utilizing Interpretative Phenomenological Analysis. The data consisted of recorded interviews with clients and therapists. No therapy sessions were recorded. Haskayne et al. found four overarching themes with six sub-themes in their research: 1) negative emotions were experienced by clients as dangerous (e.g., like a bomb, collapsing, overwhelm, uncontained); 2) participants experienced therapy as a process of discovery (e.g., gradual, hard work with a back and forth progression); 3) struggle in dealing with tensions within the dyad (e.g., not knowing what the therapist's silence was about or unfinished business on behalf of the therapist; control and power in negotiation of roles), and 4) positive connection in the dyad once the struggle had been resolved (e.g., emotional sensitivity and shining a light on client's interactions). In the discussion of their findings, the authors conveyed several concepts: that the beginning of sessions entailed resistance by clients (e.g., fear of negative emotions as defense); transference and countertransference in the struggle in addressing tensions; and that attunement fluctuated throughout therapy "similar to a dance" (p. 82). The research demonstrated that "therapeutic ruptures or struggles and repairs were relational intersubjective experience between clients and therapists" (p. 83) and that participants experienced a mirroring process in the positive

connection post-repair. The authors linked this mirroring process to Winnicot's "notion of the maternal mirroring in which the attuned mother helps the infant identify feelings by mirroring their behaviour with marked exaggeration" (p. 83). They proposed that this mirroring process revealed in the theme of positive connection enhanced a "sense of intimacy . . . in which clients felt cared for" (p. 83). Haskayne et al. concluded by questioning the definition of therapeutic rupture by Safran et al. (2009) because it did not capture the "emotional struggle of the rupture experience during long-term psychodynamic therapy" (p. 83). They recommended exploring ruptures and repair within different therapeutic approaches. The study by Haskayne et al. was similar to the present research project in that it employed a qualitative interpretative phenomenology to analyze the data. Significantly Haskayne et al. interviewed both therapist and client allowing them to investigate the intersubjectivity of ruptures and their resolutions. Although the present research on ADR only focused on the therapist's experience of ADR, the Interpersonal Recall Method (Larsen et al., 2008) required a video-recorded session inclusive of both therapist and client and thus permitted a moment-to-moment investigation of the micro-processes involved in ADR that addressed the notion of intersubjectivity. As such, Haskayne et al.'s findings on intersubjectivity and maternal mirroring were especially relevant to the current research topic of ADR.

More recently, Soygüt and Gülüm (2016) conducted a phenomenological qualitative study on therapists' perspectives on ruptures. Therapeutic alliance ruptures were identified in 48 cases and 742 sessions by utilizing the Working Alliance Inventory-Client form. The sessions consisted of two therapeutic approaches, cognitive behavioural therapy and schema therapy. All segments were video-taped and transcribed. The transcription of the selected segments were then presented to twenty psychotherapy experts who were asked to analyze the segments and answer what they thought the cause of the struggle was and how they might solve the struggle. The authors employed thematic analysis to investigate the data. The study found that therapists were most likely to cite the client's contribution as the cause of the rupture than to attribute the cause to the therapists or the therapist-client relationship. In regards to recommended resolutions to the ruptures, therapists were more likely to suggest technical resolutions (e.g., using Socratic techniques) as opposed to relational resolutions. Soygüt and Gülüm attributed this to the psychotherapeutic orientation of the participants, that is, participants' therapeutic approach was not relationally oriented. The authors noted an increased "adherence to the therapy and use of

available resources" (p. 120) when there was a rupture and that there was a "lack of process oriented perspective" inclusive of client and therapist contributions in resolving the rupture. Soygüt and Gülüm's research employed thematic analysis to analyze the data akin to what was utilized in the present research project. However, rather than interview the therapists or clients who directly experienced the ruptures, Soygüt and Gülüm recruited therapists to analyze the transcribed segments and give their opinion about the struggle. The present research project directly interviewed therapists about their experiences of ADR in a session that was video recorded. In person interviews allowed for a recounting of firsthand experience and provided opportunity for elaboration, follow up and clarifying questions during the interviews.

Task analytic paradigm. In addition to the aforementioned qualitative studies on the therapeutic alliance, there was a body of research employing task analytic paradigms to develop models on rupture resolution. The task analytic paradigm was based on the notion that psychotherapy process could be viewed as a sequence of recurring states in identifiable patterns. The idea was that by observing and identifying these patterns, a road map or model could be developed to assist clinicians with interventions. Four studies were noteworthy: Aspland, Llewelyn, Hardy, Barkham and Stiles (2008), Bennett, Parry and Ryle (2006), Cash, Hardy, Kellett, and Parry (2014), and Safran and Muran (1996).

Bennett et al. (2006) employed task analysis to investigate how therapists resolved ruptures in the therapeutic alliance with clients with borderline personality disorders. They investigated 107 enactments from 66 sessions in four good outcome cases and compared this to 35 enactments from 16 sessions in two poor outcome cases. The therapeutic approach to therapy was cognitive analytic therapy, an approach where threats to the alliance are viewed relationally and dialogically and as "re-enactments of dysfunctional interpersonal patterns in which the therapist is as active as the client" (p. 397). The study's intention was to develop a model for resolution of ruptures. Sessions with clients were audiotaped and those sessions where there had been a deterioration in alliance were identified. The authors then compared how the therapists handled the rupture with a model developed by a panel of three psychotherapists, (i.e., how ruptures should be resolved was compared with how therapists actually resolved them in sessions). Bennett et al. then applied their finding to develop the "rational model" (p. 408), a model that involved five stages of resolution and an additional three stages of reflection on the rupture or "threat event" (p. 408). The five stages entailed: the marker of rupture;

acknowledgement of the rupture in the here-and-now by the therapist; an exploration and collaboration of what was felt; linking the client's feelings with previous experiences in earlier sessions or in the client's life, with relationships to others or to childhood memories; negotiation of the link and elaboration on understandings; and consensus of how the rupture was associated to other relationships or originated in the past. Three additional stages permitted for further exploration of the rupture, including a new way of relating and affirming the therapeutic relationship. Bennett et al. underscored that the model was not linear and that "cycling within and between stages will occur" (p. 408).

Aspland, Llewelyn, Hardy, Barkham and Stiles (2008) compared an initial rational model of rupture resolution in cognitive-behaviour therapy (CBT) with empirical observations in two cases of CBT with successful outcomes. The study utilized Greenberg's (1984) task analysis that involved "observational, inductive and iterative" strategies (p. 700) to analyze the data and develop their model. Their model involved six stages: (a) therapist internally recognizes an emerging problem; (b) therapist addresses empathic failure by attending to client experience through summarizing, exploring and validating; (c) restoration of collaborative relationship and (f) negotiating of new therapeutic task. At stage c (i.e., restoring collaboration) the therapist can begin to (d) make links to a broader pattern in the client's life and the process would then involve (e) responding to client's needs and (b) attending to client experience through summarizing, exploring and validating. Aspland et al.'s rupture repair model supported previous research that "ruptures result from therapists persisting with the application of technique irrespective of client concern." (p. 706). Resolution occurred when therapists shifted their approach to be more helpful and collaborative, a finding that supports Safran and Muran's assertion that a new interpersonal experience with a therapist can modify a client's "maladaptive interpersonal schema" (Safran & Muran, 1996 as cited by Aspland et al., p. 706). Notably, therapists did not overtly recognize or discuss the rupture. Several conjectures about this were proposed: that therapists possibly processed the rupture silently, that there was a predominance of withdrawal ruptures that were largely covert, that the CBT therapists were more behaviourally focused, or that covert management of ruptures was the norm. The study also found that the use of summarizing, exploring and validating the experience of the client toward resolution of rupture was in line with previous studies that recommended therapists need to "become more empathic and responsive,

use reflection, and encourage clients to express their concerns rather than continuing with technical intervention" (p. 708).

Cash, Hardy, Kellett, and Parry (2014) employed the task-analytic method to explore two good outcome cases with CBT therapists working with clients with borderline personality disorder. The rupture repair sequences investigated in this study were compared with Aspland et al.'s (2008) rupture resolution model. As with Aspland et al.'s model, the model derived in this study was not a linear process but one that involved "cycling between and within stages in a cumulative process that gradually moves toward resolution" (p. 141). Cash et al.'s rupture resolution model involved six stages: acknowledging interpersonal difficulties that the client experienced outside therapy; acknowledging the client's feelings, patterns, or problem that prevent progress in or out of therapy; changing therapeutic approach to explore interpersonal patterns (including therapeutic alliance, current and past relationships outside of therapy); clarifying, summarizing and making links to the client's formulation; restoring therapeutic alliance by affirming the client's role in therapy, encouraging client's contribution and responsibility of the client's role in therapy; negotiating therapeutic task and facilitating the client to explore core schema activated in the session; and therapist and client pursuing this task. Cash et al. identified "external observer" (p. 142) components that included a reflective component on the part of the therapist during the change in approach stage. This involved the therapist's reflective stance, empathy, validating affect, personal emotional disclosure, collaboration, acceptance of their role in the rupture, acknowledging therapist limitations and redirecting to the salient issues. The external observer component was unique to Cash et al.'s findings. In line with Aspland et al.'s study, this study found that the therapist did not explicitly acknowledge the alliance rupture. Therefore the ruptures in Cash et al.'s study were not explored with reference to the alliance, as supported in Bennett al.'s model. The analyses in the current study found that rupture resolution was a cumulative process with resolution attempts reflecting only part of the solution. The notion of the emotional disclosure on the part of the therapist was supported by Bennet et al.'s model and was linked to the corrective emotional experience, that is, when a therapist discloses their own feelings "to help the client understand and incorporate difficult emotions, which have been 'projected' into the therapist" (p. 143). The inclusion of emotional disclosure in this study as well as the emphasis on an affective component in Bennet et

al.'s model, lead Cash et al. to hypothesize that resolving ruptures necessitates a focus on affective experience.

Safran and Muran (1996) developed their seminal model of rupture resolution through a four stage process of analysis: developing the model, testing the model, developing a treatment and its evaluation. To begin, the authors utilized the task analytic paradigm and observed 15 psychotherapy sessions that had alliance ruptures that seemed to have been resolved. In accordance with the task analytic paradigm, Safran and Muran observed the transcribed sessions for sequences of recurring states and transitions in identifiable patterns. From these observations, the authors developed an initial model of rupture resolution that included four client states and three therapist interventions. Client states encompassed: a marker of withdrawal, exploring his/ her avoidance of the rupture, and exploring the interpersonal schema associated with the rupture. Therapist interventions to resolving ruptures involved: assisting a client to focus on immediate experience, empathizing or accepting responsibility, probing for fears. This initial rupture resolution model was then re-tested a second time on another seven sessions. Safran and Muran further refined their model based on the results of this second re-testing. Subsequently, the authors re-tested this refined and revised model for a third time in a new data set of sessions from three other therapists working in the same treatment modality. Re-testing entailed replicating findings in this new data set of sessions. From this third re-test, Safran and Muran derived a final rupture resolution model.

The final rupture resolution model involved four stages: 1) attending to the rupture marker; 2) exploration of avoidance; 3) exploration of rupture experience, and 4) self-assertion. In stage one, clients indicated a rupture through expression of anger, dissatisfaction or disengagement and the therapist responded by inviting attention to a client's immediate experience. Safran and Muran conveyed that stage two, exploration of avoidance, had two internal processes: response of self and expected response of other. In effect, exploration of avoidance referred to a client's defensive verbalization or coping strategies such as "changing the topic, speaking in a deadened voice tone, and speaking in general terms rather than here-and-now specifics of the therapeutic relationship" (p. 454). In this second stage, a therapist responded to a client's defensive verbalization by drawing the client's attention to the defense and by probing for "inner experience" (p. 454). This second stage led to stage three, i.e., the client disclosing his/her inner experience and further exploring the block. An example of this would be

a client disclosing that he/she felt afraid and engaging with the therapist to explore what underlied the fear and how it functioned as a block. The fourth stage, self-assertion, referred to clients becoming aware of their role in the rupture and transposing this to their own interpersonal relationships. As with the aforementioned rupture resolution models (i.e., Aspland et al., 2008; Bennett et al., 2006; Cash et al., 2014), Safran and Muran emphasized that their rupture resolution model was "circular, repetitive, and nonlinear" (p. 455). This research by Safran and Muran was significant in that it was among the first studies to employ a task analytic paradigm to investigate rupture and their resolutions in transcribed therapist/ client sessions. It affirmed that there were nonlinear stages in the resolution of ruptures that can be tracked in session transcripts.

In sum, the aforementioned literature that utilized a task analytic paradigm to develop rupture resolution models underscored three findings that were relevant to the present research project: 1) resolutions encompassed stages best understood as a process of therapist/client engagement; 2) resolutions were not a linear process but circular and repetitive, and 3) resolving ruptures most likely necessitates a focus on affective experience. The focus on affective experience to resolve ruptures supports the notion of ADR as conceptualized within the current research project, i.e., that ADR is an affective regulatory process. However, while the theoretical literature on attunement, disruption, and repair (e.g., Schore, 1994; Siegal, 1999; Fosha, 2000) has alluded to the nonlinearity of ADR, both the notion of nonlinearity and especially the idea that there may exist different stages of ADR has not been fully explored. Notably, none of these studies (i.e., Aspland et al., 2008; Bennett et al., 2006; Cash et al., 2014; Safran & Muran, 1996) utilized video recordings in their analysis as was employed in the current research. As mentioned, video recordings were important in the present study because it assisted with recall and assisted with moment-to-moment tracking of micro-processes in the interactions between therapist and client. Additionally, the literature on rupture resolution models differed from the current study in that its aim was to develop a model. The aim of the research herein was not to develop a model, but rather, to investigate the therapist's experience of attunement, ruptures and their resolutions (i.e., disruption and repair).

Summary of the alliance rupture and repair literature. The literature on alliance rupture and repair was relevant to the current study because it demonstrated how strains or deterioration in the quality of relatedness in the therapeutic dyad negatively impact treatment if they were not successfully resolved. However, it was clear from the literature on alliance ruptures and repairs

that ruptures were characterized by disagreements in the shared goals and tasks of therapy with little reliance on the attachment bond. The topic investigated in this dissertation (i.e., attunement, disruption and repair) was more finely nuanced than that simply required to maintain a relationship wherein the client feels he or she is working with the therapist on mutual goals or tasks. The study by Haskayne et al. most closely resembled the current research in that it was an interpretative phenomenological qualitative study of dyads employing thematic analysis. By interviewing both therapist and client, Haskayne et al. investigated the intersubjectivity of ruptures and their resolutions. As such, Haskayne et al.'s findings on intersubjectivity and maternal mirroring were especially relevant to the current research topic of ADR. Notably, none of the literature on alliance ruptures and repair seems to have used videotaped sessions as was employed in the current study. Videotaped sessions have the advantage of assisting with recall of events as well as the advantage of facilitating the investigation of moment-to-moment micro-processes, micro-processes that are lost in direct observation or audiotaped sessions. Finally, the literature on task analytic paradigms demonstrated diverse models of rupture resolution and is relevant to this study because it delineated the repair process as necessitating a focus on affective experience, as being nonlinear, and as encompassing stages.

Literature on therapeutic presence and resonance. A review of the literature on presence and resonance revealed how these concepts were entwined with notions of attunement. The literature reviewed in this section will help to differentiate these constructs.

Presence. Geller (2002) conducted a two-part investigation on therapeutic presence. In this phenomenological qualitative study, she first interviewed seven expert therapists on the quality of presence in psychotherapy. Six of the therapists were humanistic and experiential in therapeutic orientation and one was a CBT therapist. Geller employed a method combining condensation and categorization of meaning as outlined by Kvale (1996). Utilizing this method, Geller first derived key components of presence from the reading and re-reading of the transcripts and then compressed them into briefer statements of presence. A second component of the study was the development and administration of a self-report measure on the experience of presence. Her findings included three categories of therapeutic presence: preparing the ground for presence, process of presence, and the experience of presence. The third category, the experience of presence, encompassed descriptions such as absorption, awareness, focus, enhanced emotional experiencing, grounding, and being with and for the client (e.g., holding the

intention for client's healing). It is my view that this third category of the experience of presence moved beyond presence to describe the phenomenon of attunement. For example, Siegel (2010) distinguished between attunement and presence as follows:

> Presence is our openness to the unfolding of possibilities. Attunement is how we focus our attention on others. . . . the ways we take in the internal worlds of other people and allow them to shape how we are in that moment. The subjective side of attunement is the authentic sense of connection, of seeing someone deeply, of taking in the essence of another person in that moment. When others sense our attunement with them, they experience "feeling felt" by us. (p. 34)

The definition of attunement and presence distinguished by Siegel was collapsed under that of therapeutic presence in Geller's (2002) study.

McCollum and Gehart (2010) examined how mindfulness meditation can teach therapeutic presence to beginner therapists. They applied Geller and Greenberg's (2002) definition of therapeutic presence: "an availability and openness to all aspects of the clients' experience, openness to one's own experience in being with the client, and the capacity to respond to the client from this experience" (p. 72). It should be noted that this definition conceived therapeutic presence as a quality of being rather than a skill. Similarly, mindfulness meditation, according to McCollum and Gehart, entailed a practice of "bringing the practitioner's awareness fully into the present moment without judging or evaluating the experience" (p. 347). In this phenomenological qualitative study, McCollum and Gehart, taught mindfulness meditation as part of a practicum course at the master's level in counselling. They conducted a thematic analysis of the weekly journal entries of 13 participants that were students of the course. Within a social constructionist framework, the authors utilized Braun and Clarke's (2006) thematic analysis to analyze the data and derive common themes. They found that mindfulness helped students be present in their sessions. Specifically, being present involved attending to inner experience, awareness of client's experience, and interacting with clients from this place of awareness. In contrast to the study by Geller (2002), the participants in McCollum and Gehart's study did not describe presence as an experience of immersion or absorption in the client's world. Instead, the participants felt emotionally connected to their clients without a sense of merging with them. For the purposes of this dissertation, it is helpful to distinguish between awareness and openness to experience and "attending to" or "interacting" with clients. Openness

to experience refers to a phenomenon that reflects a quality of presence. "Attending to" or "interacting" with clients more aptly portrayed dyadic attunement.

Davis and Hayes (2011) conducted a review of the empirically supported advantages of mindfulness for psychotherapists in successful treatment. In particular, they reviewed research on therapists who meditate and client outcomes. The authors defined mindfulness as "moment-to-moment awareness of one's experience without judgement" (p. 198). Their review of the empirical literature found that mindfulness assisted with emotional regulation, helped clients respond with more flexibility and less reactivity, and enhanced interpersonal interactions (e.g., protected against stress in relationship conflicts, increased ability to respond to social situations, and predicted relationship satisfaction). However, there were conflicting results in research that investigated the relationship between therapist trainees' mindfulness and client outcomes. For example, a phenomenological qualitative study by Aiken (2006) of six therapists who were experienced meditators revealed that mindfulness can assist therapists to "develop their ability to experience and communicate a felt sense of client's inner experiences; be more present to client's suffering; and help clients express their body sensation and feelings" (Davis & Hayes, 2011, p. 202). By contrast, Davis and Hayes conveyed, that another three studies on mindfulness meditation with counsellor trainees and treatment outcomes (i.e., Bruce, 2006; Stanley et al., 2006; Vinca & Hayes, 2007) revealed no relationship between mindfulness meditation by counsellor trainees and treatment outcome. Davis and Hayes conclude that while the literature on the psychological benefits of mindfulness meditation is robust, the research on whether mindfulness practice by therapists or therapist trainees impacts treatment outcome is inconclusive. Regardless of the fact that the impact of mindfulness practice on treatment outcome is inconclusive, it appears from the literature that mindfulness can assist therapists to be more attentive to a client's suffering, experience a felt sense of client's inner experiences and assist clients to tune in to and express their bodily sensation and feelings; that is, mindfulness can assist therapists to develop presence and attunement. For the purposes of the current research project, it is important to distinguish mindfulness from attunement. A key distinction to be noted is that mindfulness can assist in the development of presence and attunement but that mindfulness is not attunement.

Resonance. As with the notion of presence, the concept of resonance also has been confounded with attunement in the literature. Larson (1987) conducted a phenomenological

qualitative study of the therapist's experience of resonance. To initiate this study, Larson sent questionnaires to therapists inquiring about their experience of resonance. The author sent 130 questionnaires to Santa Barbara marriage and family therapists and 20 questionnaires to Saybrook Institute-trained therapists in the San Francisco Bay area who held a Doctor of Philosophy degree and who practiced psychotherapy. From this initial pool, 31 therapists were interviewed about their experience of resonance. These 31 therapists were selected because they had indicated that they had experienced resonance more than once in sessions with clients and were willing to be interviewed. Larson thematically analyzed their responses to arrive at a descriptive definition of psychotherapeutic resonance comprising six aspects: (1) an altered state of consciousness through intense focus on inner experience; (2) the synchronizing of minute movement patterns in the dyad; (3) a palpable shift in the alignment of the dyad to similar frequency; (4) a sense of merging of the selves in the dyad; (5) nonverbal comprehension of the client's feelings, and (6) sensations and somatic feelings perceived by the therapist. Larson's multicomponent definition of therapeutic resonance was comparable to the definition of attunement espoused by Fosha (2008) (see p. 8) and Siegel (2010). However, it seems that the quality of resonance denoted an additional metaphysical aspect (i.e., an altered state of consciousness). In fact, Siegel (2010) distinguished between presence, attunement, and resonance as follows:

> Presence permits us to be open to others, and to ourselves. Attunement is the act of focusing on another person (or ourselves) to bring into awareness the internal state of the other in interpersonal attunement (or the self, in intrapersonal attunement). Resonance is the coupling of two autonomous entities into a functional whole. A and B are in resonance as each attunes to the other, and both are changed as they take the internal state of one another into themselves. When such resonance is enacted with positive regard, a deep feeling of coherence emerges with the subjective sensation of harmony. (p. 4)

It appears that resonance moves beyond presence and attunement. Resonance was the aspect of synchronizing with attunement so that "both are changed as they take the internal state of one another into themselves" (Siegel, 2010, p. 4). This description of resonance coupled with attunement captured the metaphysical aspect of resonance depicted in Larson's study. However, Larson lumped presence and attunement together under a description of resonance. In accordance with Siegel, I believe it is important to differentiate between these subtle processes.

In sum, the research on therapeutic presence and resonance underscored the need to differentiate these constructs more clearly. Much of the literature seemed to confound these concepts and fell short of differentiating presence and resonance from attunement. While there was overlap among the concepts and they often functioned in unison, they were not one and the same. For purposes of this dissertation, I utilized the definitions of therapeutic presence and resonance listed on p. x in this text.

Mirror neurons. The findings from empirical studies on mirror neurons have illuminated the concept of dyadic attunement as it has been identified in affective neuroscience literature. Gallese, Eagle, and Migone (2007) reviewed the literature on mirror neurons and discussed its applications to psychotherapy. Their premise was that one person's actions, intentions, emotions and sensations were automatically stimulated through neuronal mechanisms when observing the actions of another.

Mirror neurons first were discovered in macaque monkey brains in the early 1990s through a study by Rizzolatti, Gallese, and Fogassi (1996). They observed that premotor neurons in macaque monkey brains discharged when the monkey engaged in goal-related actions as well as when monkeys observed other individuals and/or monkeys engaging in similar actions. Gallese et al. underlined that mirror neurons were not duplicating the action but encoding the goal of the action independent of the movements required. Follow up studies led to support for, and advanced, the original findings (e.g., Kohler, Keysers, Umilta, Fogassi, Gallese, & Rizzolatti, 2002; Umilta, Kohler, Gallese, Fogassi, Fadiga, Keysers, & Rizzolatti, 2001).

The discovery of mirror neurons in monkeys motivated the investigation of similar capacities in humans (e.g., Iacoboni, Molnar-Szakacs, Gallese, Buccino, Mazziotta, 2005; Rizzolatti, Fogassi, & Gallese, 2001; Rizzolatti & Craighero, 2004). The studies cited showed that the experience of a given emotion in an individual was "underpinned by the activity of a shared neural substrate" (Gallese et al., 2007, p. 141), and that:

> being touched on one's body activates the same neural networks activated by observing the body of someone else being touched. . . . the same neural structures are activated both during the subjective experience of pain and in the direct observation or symbolically mediated knowledge of someone else's experience of the same painful sensation. (pp. 141-142)

Gallese et al. employed the term "embodied simulation" to refer to the automatic activation of a neural substrate in the observer of the same motor program of the perceived behaviour of another. Embodied simulation "constitutes a fundamental basis for an automatic, unconscious, and inferential understanding of another's actions, intentions, emotions, sensations, and perhaps even linguistic expressions" (p. 144). The authors underscored that embodied simulation created a phenomenal state in the observer called "intentional attunement." One was not simply observing the intentional behaviour of another, but also, was experiencing the emotions, sensations, or actions of another. Gallese et al. (2007) underlined that similar processes of embodied simulation and intentional attunement occurred in infant development, processes that constituted infant/caregiver intersubjectivity and that were reflected in concepts such as Stern's (1985) affect attunement:

> The mother's attuned or congruent response permit's the infant to find him- or herself in the eyes of the mother . . . The mother's ability to match the infant's mental states contributes to the infant's capacity to develop a concept of its own mind and the minds of others. . . . What makes active attunement possible and what constitutes the biological basis of such attunement, we propose, is the existence of the mirror neuronal system and automatic embodied simulation. (p. 152)

In Wolf, Gales, Shane, and Shane's (2001) review of the literature on mirror neurons in humans, they also examined the developmental role of mirror neurons from amodal perception to empathy and communication. In describing intersubjectivity, the authors stated:

> The reason this neurological capacity seems consistent with the recognition of "an other" as a subjective being comes back to the idea that, through the mirror neurons, the "observer" has an enhanced capacity to recognize the "intention in the actor" (p. 101).

Thus it appeared that from a neuroscientific perspective, empathy developed from both affective attunement in the infant/caregiver dyad and the infant's capacity to recognize the other as having a separate mind, processes in which mirror neurons were believed to play a pivotal role.

Applying the concept of mirror neurons to the therapist/client dyad, Gallese et al. (2007) suggested that the embodied simulations occur in the therapeutic dyad and serve a regulatory purpose. Through embodied simulation and intentional attunement, the therapist experienced the feelings of the client. What the therapist experienced however, was a modified version or simulation of the client's feelings, not a replica. The client then saw in the therapist a "more

manageable version of what the patient is experiencing" (p. 149). In this process, the authors distinguished between mirroring responses and congruent or attuned responses. Congruent or attuned responses to another's feelings were modulated or complementary simulations rather than replicas. The therapist experienced automatic simulation of the client's behaviour and derived empathic understanding from this simulation, eventually leading to a modulated empathic response. Furthermore, the authors speculated, a reparative process occurred when "the therapist's accurately attuned response to the patient is automatically simulated by the patient, enhances the patient's sense of 'we-ness' (a sense of connectedness to the other), and thereby contributes to a feeling of self-integrity" (p. 159).

In sum, the research on mirror neurons elucidated the neuropsychological processes by which dyadic attunement between therapist and client was believed to transpire. Gallese et al.'s (2007) theoretical conjecture regarding the function of mirror neurons within the psychotherapeutic dyad portrayed underlying neurophysiological processes of the corrective emotional experience (see p. 22). What was prominent in this was the reciprocal occurrence of both embodied simulation, the "automatic, unconscious, and inferential understanding of another's actions, intentions, emotions, sensations" (Gallese et al., 2007, p. 144), and intentional attunement, the experiencing of the emotions, sensations, or actions of another. Theoretically, this meant that in the therapeutic dyad, mirror neurons were resonating from client to therapist and from therapist to client reciprocally. This mutual synchrony centralized attunement as an interactive process occurring in the dyad and underscored the necessity to investigate this phenomenon in the dyad, as achieved in this dissertation.

Research on affect attunement. As noted earlier, the literature on attunement in the therapeutic context has been emergent. The following section summarizes two studies that alluded to attunement in their findings (Piliero, 2004; Schoettle, 2010) as well as two studies that had directly applied Stern's concept of affect attunement to psychotherapy (Davis & Hadiks, 1994; McCluskey, 2005).

Studies that allude to attunement. Piliero (2004) studied clients' subjective experiences in affect-focused therapies. She administered the Psychotherapy Questionnaire (PQ) (Strupp, 1964, 1969) to 110 former clients of Intensive Short-term Dynamic Psychotherapy, affirmation-

based dynamic affective therapy[4], and Emotion-Focused Therapy. She found the following factors related to satisfaction with therapy and the sense that change had occurred: experiencing deep affect in therapy, the therapist witnessing the affective experiencing, and a recognition of the techniques the therapist employed to elicit affect. Notably, although therapists were viewed by clients as warm and empathic, these factors were not related to satisfaction and change. The two factors most strongly correlated with effectiveness and change were the client's emotional connectedness to the therapist and the therapist's attunement with the client. In fact, Piliero underlined that "out of all the therapeutic variables investigated in this study, including therapist's warmth, empathy, and emotional connectedness to the client, the clients' perception of the therapists' attunement was most strongly related to satisfaction and change" (p. 90). The findings, Piliero declared, revealed that processing deep emotional experiences "in the presence of an empathically attuned other is what facilitates therapeutic change" (p. 95). The therapeutic consequence of processing affect in the presence of an attuned other was directly relevant to the current study.

A short-coming of Piliero's (2004) study was that she did not explicate how an empathically attuned other was to be defined or recognized as such. For example, how did the client view or describe an empathically attuned other? A richer description of this understanding and experiences of this phenomenon was limited because Piliero employed a questionnaire in her research. By utilizing a phenomenological qualitative approach in the current research and by conducting in-person interviews, I facilitated a deeper understanding of the experience of dyadic attunement in the therapeutic relationship.

Schoettle (2010) investigated the therapist's experience in an intersubjective psychotherapeutic process. The author conducted a phenomenological qualitative study employing Braun and Clarke's (2006) method of thematic analysis. She interviewed seven AEDP clinicians to investigate their experience as their clients moved through three state transformations: states of defense, core affect, and core state. The clinicians were asked about their cognitions, emotions, physical sensations and imaginal experiences as their clients transitioned through each of these states. Twenty-one themes emerged from the data. Particularly noteworthy with regard to attunement, Schoettle found that the clinicians' experience in each of

[4] Affirmation-based dynamic affective therapy is Accelerated Experiential Dynamic Psychotherapy (AEDP).

the three states paralleled the experience of the client in each of these states. The author suggested that this finding supported the intersubjective theory of unconscious dyadic processes, a theory that denoted that parallel processes and communication occur between therapist and client. However, Schoettle cautioned that more complex studies would need to be undertaken to determine whether the clinician's experience parallels their clients for other reasons. For example, the therapist's parallel experience could have been a reflection of the clinical task at hand (e.g., a clinician might have felt tense because the task of moving their client out of a state of defense was challenging).

The relevance of Schoettle's research to the current study was manifold. Akin to the methodology employed in this dissertation, Schoettle also employed a phenomenological qualitative approach to investigate the intersubjective process in AEDP. Additionally, the present study extended Schoettle's research by attending specifically to one aspect of the intersubjective process (i.e., ADR). Finally, therapists in Schoettle's research reported their experience with their clients retrospectively and there was no indication how much time had elapsed between interviewing therapists and their sessions with clients. The present study employed videotaped recordings when interviewing participants. As stated, videotaped recordings were advantageous because they assisted with a more detailed and accurate recall of events and facilitated the investigation of moment-to-moment micro-processes such as ADR.

Research that applied Stern's concept of affect attunement. Davis and Hadiks (1994) analyzed the therapist's non-verbal behaviour in a psychotherapeutic session. They analyzed the positions and gesticulations of the therapist with the aim of understanding how movement contributes to a working bond between therapist and client. Specifically, they applied Stern's (1985) conceptualization of attunement to the therapeutic context to investigate the "unconscious synchronization of actions between client and therapist, particularly the intricate blending of turn-taking alterations" (p. 394) that has been "recognized as a visible measure of rapport and relatedness" (p. 394). The researchers randomly selected ten videotaped sessions from 62 outpatient psychotherapy sessions. The positions and gesticulations of the therapist were coded by raters who were trained in the Laban/Bartenieff Institute of Movement Studies in New York City as well as the Nonverbal Interaction and State Analysis (NISA) instrument. The Therapist Experiencing Scale was employed to analyze and rate the verbal content for the therapist's own experiential involvement and to rate the experiential process of the client that was expressed by

the therapist's words. Their findings supported those of previous research that indicated that the positions of the body in therapy "reflect and possibly facilitate the development of rapport and self-disclosure in psychotherapy" (p. 401). Davis and Hadiks underlined the importance of research in non-verbal communication between therapist and client. They asserted that "although it is almost never explicitly discussed or attended to, the complex activity is 'read' by the participants to some degree and is vital to the therapy process and to clinical intuition and judgment" (p. 404).

A limitation of this study is that observations were made on one individual rather than multiple subjects. Another limitation is that Davis and Hadiks' study examined attunement as a process that occurred in the therapist rather than as an interactional process between therapist and client. Finally, Davis and Hadiks' research on body language within therapy approached the issue behaviourally with an attempt to understand body language by observing and identifying particular actions and charting their frequency. The reader was led to the impression that if one could quantify and encode the entire lexicon of body language, one would arrive at an optimal and effective mechanical means of predicting the client's mental states and steering therapy accordingly. The behavioural approach applied by Davis and Hadiks was reductive. Trying to understand clients by attending only to their overt behavior left out experiential and semantic aspects that were constitutive of the therapeutic process.

McCluskey (2005) conducted three experiments on attunement in psychotherapy. Her overall aim was to investigate whether Stern's concept of affect attunement can be applied to adult psychotherapy. In the proceeding pages, an overview of the three experiments within McCluskey's research are reviewed.

The first experiment. In her first experiment, McCluskey investigated whether attunement to affect could be identified in individual psychotherapy with adults. McCluskey prepared six 1.5 minute clips of clinical sessions and had these clips rated for affect attunement by nine senior clinicians. Based on the judgments made by the clinicians, three video clip excerpts were selected. Subsequently, 31 student social workers in training rated these three video clip excerpts for affect attunement. The majority of students (68%) were unable to decide whether the attuned excerpt was attuned and only 36% of students identified the non-attuned excerpt correctly. McCluskey attributed this discrepancy between students and senior clinicians to a difference in the description of attunement. What McCluskey surmised from her data was that rather than

focusing on the therapist/client interaction, the students generally observed only the therapist when attempting to identify attunement. As a result, McCluskey revised her definition of affect attunement as one based on a therapist/client interaction such that the process of affect attunement needs to be followed by affect regulation and empathy.

The second experiment. The objective of the second experiment was to investigate whether graduate students in social work can be trained to identify empathic attunement. McCluskey divided 16 students into two groups, a control group and experimental group. Each group was shown the following definition of attunement and asked to view a series of three 1.5 minute video clips:

> Attunement is a way of communicating to the other that one has recognized the affect they are experiencing. Attunement conveys to the other that one has a feeling sense inside of what it feels like to be them right now. (p. 92)

Before viewing the clips, the experimental group was given additional instructions to pay attention to the interaction between therapist and client in identifying attunement. The results of this study indicated that the experimental group did significantly better at identifying empathic attunement than the control group. However, the analysis revealed that students were evaluating the clips in different ways, even when they correctly identified empathic attunement in the clips. For example, some students identified respect for privacy in a clip while other students detected abandonment. Where some students interpreted intrusion, other students saw support for exploration. McCluskey inferred that perhaps the students' own attachment histories were influencing their judgments of the interactions they viewed. This prompted McCluskey's third experiment.

The third experiment. The goals of the third experiment were three-fold: (a) to investigate whether empathic attunement between a caregiver (e.g., student counsellor) and a careseeker (e.g., client) could be rated reliably; (b) to investigate whether caregivers who were effective had a secure attachment style; and (c) to investigate whether training could influence caregiving. The experiment occurred in three phases over a few weeks: on the first day, student counsellors interviewed clients, on a subsequent day, all students received a training program[5], and on the

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[5] The experimental group received training tailored to each individual's style of interaction based on their sessions, and the control group received training based on reading and a seminar related to the work on memory and dissociation.

final day student counsellors interviewed clients again. Fourteen students from a graduate program of social work participated in the study. To maintain a tightly controlled experiment where all the participants were exposed to similar experiences, McCluskey devised four scenarios around the theme of loss and hired four actors to play the clients. After each session, the clients rated their experience with their student counsellor and the student counsellors also rated themselves on a scale that McCluskey devised as a measure of empathic attunement.

Before McCluskey could analyze the data of the third experiment, she designed a measure of empathic attunement that would provide an independent and reliable score of empathic attunement for each of the students. In order to construct this measure, McCluskey had to revise her concept of what was being observed to reflect a complex understanding of attunement based on "the activation and deactivation of a process" (p. 161). This process involved (1) the activation of careseeking from a client through the expression of affect that is met by (2) cross-modal attunement and empathic input by the therapist such that it (3) assuages the client and enables him/her to self-regulate and (4) engage in exploration of his/her concern.

The results of the third experiment demonstrated that the scales of empathic attunement employed by the actors to assess the student counsellors, the scales of empathic attunement that the student counsellors used to assess themselves, and the independent measure of empathic attunement that McCluskey developed were significantly correlated with each other. The results also demonstrated a significant correlation between secure attachment style and the independent measure of empathic attunement (i.e., those student counsellors that had a secure attachment style scored higher on empathic attunement and effective caregiving than student with less secure attachment styles). Finally, the study demonstrated that training significantly improved the students' ability to display empathic attunement and to respond to emotional distress.

One limitation of McCluskey's research was that she employed actors to play the clients in her final study. It was possible that real life clients might have interacted differently and rated their therapists differently. A strength of McCluskey's research was that she applied a mixed method approach to the majority of her research and expanded information gained from quantitative measures by implementing interviews. The interviews enabled her to gain a deeper understanding of the process of attunement from the participants and provided pertinent direction for ensuing study.

In contrast to the research by Davis and Hadiks (1994) that focused on the attunement of the therapist, McCluskey's studies investigated attunement as an interactional process between therapist and client. McCluskey's body of research was highly applicable to this dissertation because she defined empathic attunement as an interrelated co-constitutive process that was activated and deactivated in the therapeutic dyad. This view of empathic attunement was reflective of the confluence of infant development research, psychotherapy and affective neuroscience that, as described in part one of this chapter, has elucidated the construct of attunement, disruption and repair.

Summary of Literature Review

This literature review comprised two sections: (a) the theoretical literature on dyadic attunement, disruption and repair and (b) the empirical research. The theoretical literature review identified relevant infant development research that has investigated the notion of intersubjectivity between infant and caregiver and that provided the backdrop for Stern's seminal theory of affect attunement, delineated the development of the construct of dyadic attunement in various approaches to psychotherapy, and concluded by discussing the influence of affective neuroscience in the development of attunement, disruption and repair. The review of the empirical literature appraised the current research in alliance rupture and repair, therapeutic presence and resonance, mirror neurons, and affect attunement. From the empirical literature, McCluskey's (2005) research was found to be highly relevant to the current dissertation. She identified empathic attunement as a complex interactional process in the therapeutic dyad. This definition of empathic attunement was employed in the present study to define dyadic attunement (see definition on p. 8).

Overall, it was evident that research in attunement, disruption and repair in the therapeutic process was still at a nascent stage. Nevertheless, I believe that it was precisely the scarcity of existing research that drew attention to the need for a phenomenological qualitative study of the kind presented herein focusing on ADR in the therapeutic process.

Chapter 3: Method

The goal of the proposed research study was to examine attunement, disruption and repair in the therapeutic relationship by specifically investigating the question: How is attunement, disruption and repair experienced by the therapist in an attachment-focused approach to psychotherapy? In studying this phenomenon in the context of the therapeutic process, I was interested in the meanings and interpretations that the therapist brings to, and makes of, her/his experience. Taking into consideration the insights of hermeneutic philosophy and the ways in which it is being adopted for psychological theorizing and inquiry, the meanings and interpretations that the therapist brings to her/his experience is interwoven with societal values and the historical, political and cultural context of the society in which the participant lives. Consequentially, I employed a thematic approach to data analysis (Braun & Clarke, 2006) while keeping a broader psychological hermeneutic perspective (Sugarman & Martin, 2005). The ensuing section states my personal assumptions, summarizes those aspects of hermeneutic philosophy that informed this study and outlines how this hermeneutic perspective was applied. Additionally, I detail the interpersonal process recall (IPR) interview protocol employed in this study, describe the selection of participants, delineate the procedures that were followed, and discuss data analysis, issues of delimitation, ethics, and criteria for rigour.

Research Subjectivity

I approached this study not as a "pure" objective observer, removed and detached from the phenomenon I sought to understand, but rather, as a living, breathing person possessed of subjectivity and whose interactions with participants in my attempts to understand the meaning they made of their experience cannot be separated from the phenomenon I sought to understand. In this respect, my subjectivity and interpretation of attunement, disruption and repair were personal assumptions and understandings that influenced my interpretations.

I was motivated to pursue this research because of previous research that I conducted on the somatic experience of the client in enactment group therapy[6] and from my experience co-facilitating enactment group therapy. I noticed that a nonverbal "mutual synchrony" appeared to exist between the client and other participants when they engaged in reparative scenes and that this mutual synchrony appeared healing and transformative. At the time, I did not identify this

[6] Enactment group therapy is a group therapy akin to psychodrama, but with more structure and containment to prioritize client safety.

phenomenon as dyadic attunement. The quest to comprehend what I had observed led me to undertake doctoral research on attunement in the therapeutic process.

Further, my quest to comprehend the experience of dyadic attunement and attachment processes in psychotherapy additionally led me to the study of Accelerated Experiential Dynamic Psychotherapy (AEDP). AEDP is a healing centred treatment approach which integrates experiential and relational elements within an affect-centred psychodynamic framework. It is one of the few contemporary psychotherapy that has operationalized attachment theory and processes within its approach (see Appendix 6 for a summary of the basic tenets of AEDP). My lens to this research topic has been influenced by my experience with AEDP. I have taken three levels of training in AEDP (level one immersion, Essential Skills, and Core Training), am a certified AEDP therapist, espouse AEDP as my theoretical orientation to psychotherapy, and have practiced as an AEDP clinician for the last six years. I chose to situate the present research within a purposive sample of AEDP clinicians because 1) AEDP was a contemporary psychotherapy that has operationalized attachment theory within its approach and, 2) AEDP clinicians are trained to track moment-to-moment shifts in client affect and dyadic attunement.

The Philosophical Foundations of the Study: Hermeneutics

A hermeneutic approach assumes that knowledge and interpretation are inseparable from history and culture, and that the prejudices we inherit from the cultural traditions in which we are born are a necessary pre-condition for understanding (Richardson, Fowers, & Guignon, 1999). Hermeneutic philosophy is a venerable and rich philosophical tradition. There have been many influential contributors to hermeneutics. The ensuing summary of relevant hermeneutic theories by Wilhelm Dilthey, Martin Heidegger, Hans-Georg Gadamer and Charles Taylor are drawn largely from texts written on an emergent field of psychological hermeneutics (e.g., Martin & Sugarman, 2001; Richardson et al., 1999; Sugarman & Martin, 2005).

Willem Dilthey (1926, 1985), one of the early hermeneutic theorists in modernity, argued that understanding human beings and their societies was more similar to interpreting texts than to the experimental study of nature (Sugarman & Martin, 2005). He asserted that we explain nature but we "interpret" human beings. Dilthey saw human life as a lived reality without distinctions between mind, body, self and world so that we can never step outside ourselves to offer an unbiased interpretation of our own existence. As a human science, psychological research for Dilthey would include our involved lived experience. The understanding of our lives is circular

encompassing a historical, cultural, social and political perspective. Dilthey believed that we can only understand our lives by seeing the connections as a whole and only understand other people's experiences by understanding our common humanity.

Heidegger's (1926,1962) ontological hermeneutics viewed human beings as embedded in a cultural context where the ways of being persons that are available to us already exist in the world into which we are born (Richardson et al., 1999). We create meaning through our interaction and participation in our culture, through the roles we choose or the personal stands we take and in doing so, we exercise personal agency. Heidegger (1926,1962) was concerned with the interpretation of how human action embodies expressions of who we are. Knowledge of human action was interpretative and dependent on the presuppositions of the observer. Heidegger sought to understand how it was that we are able to comprehend things. He described everyday practical activities that were pre-reflective and which he called preunderstanding. According to Heidegger, objects were situated in a context of relations with other things and with our purposes and intentions. We only comprehended things because they existed in relation to other entities and to human purposes. He suggested that we have already understood something before we begin to interpret it and that interpretation was the act of revealing something that was already part of our being. This theoretical perspective was important because it challenged Cartesian philosophy which viewed understanding as individual minds observing the world and separate from the world. Heidegger stated that we derived and created meaning from the social and cultural practices in which we were embedded during a period of historical time, an immersion from which we could not escape. However, Heidegger recognized personal agency in that we chose possibilities from our surrounding social and cultural practices and projected these possibilities into the future. By choosing possibilities from our cultural and social contexts and projecting this onto the future, we created our identities.

Hans-Georg Gadamer (1975, 2004) was a student of Heidegger. He shared Heidegger's view of understanding as an interaction between the shared cultural and social practices in which we were embedded and the possibilities we created from these practices (Sugarman & Martin, 2005). Gadamer (1975, 2004) clarified the concept of preunderstanding and suggested that all understanding, including scientific understanding, emerged from our cultural and historical traditions. He employed the term "fusion of horizons" to signify a context of meaning located in the background and of which we were not aware. Horizons served as the context in which we

made things meaningful. Horizons were horizons of intelligibility. Gadamer differed from Heidegger in that he believed that our preunderstanding was deeply rooted in unfolding traditions over the course of history rather than solely within a particular period of time (Richardson et al., 1999). According to Gadamer, the aim of interpretation was to accept traditions and cultural prejudices as requisite for understanding. This contrasted with the scientific method that insisted that we can and should remove ourselves from any bias. Gadamer argued that there is no final truth because understanding was inherently historical and always changing. In order to understand another person, our horizons must fuse with the historical meanings and assumptions of the other person or text "because it is these historical cultural horizons that steer and constitute our individual understandings and experiences" (Sugarman & Martin, 2005, p. 257). Gadamer avowed that for horizons to fuse, we needed to bring our own prejudices to the forefront, remain open to integrating another's horizon of meaning so that our own perspective may change. Gadamer placed emphasis on language and dialogue and suggested that understanding something means putting into words a previously unexamined part of tradition. What remains unsaid was just as important as what was put into words so that understanding was the relation between what was spoken and what was not spoken.

Charles Taylor (1985) expanded hermeneutics through his critique of the doctrine of naturalism. Taylor underlined that in the traditional scientific view of psychology and other human sciences our thoughts, motivations, feelings, needs, attitudes and values were not comprehended as part of nature, but rather, as subjective, arbitrary and therefore reducible to basic physical, chemical and biological processes. Against this naturalistic assumption, Taylor argued that our values and interests were real and exist in the world. The way we think, act, and experience life depended on cultural practices that were meaningful to us in our everyday life. Our identities were shaped by choosing and acting on what matters to us according to accepted interpretations of moral goods and standards.

Sugarman and Martin (2005) elucidated six implications for hermeneutics in the study of psychological phenomenon. First, they affirmed that psychology is an interpretive practice situated within historical and sociocultural contexts, contexts inundated with human interests and values such that "any psychological inquiry adequate to its subject matter must recognize and interpret human activity against and within the background of human meanings and significance that structures and orients us as psychological beings" (p. 259). Second, although hermeneutics

asserted that psychological phenomena were socioculturally constructed, this did not mean that such phenomena were not real. Psychological phenomena influenced human activity and experience, and made possible and limited our interpretations of them. Third, hermeneutic inquiry opposed biological reductionism. In this respect, hermeneutics rejected the view that "human psychology is reducible to neuropsychological blueprints that predetermine the nature of human psychology" (p. 260). While recognizing that there were biological requisites in human and psychological development, Sugarman and Martin underlined that "it is a mistake to equate human actions and experiences with those neurophysiological, chemical, and biological phenomena they require" (p. 260). Although hermeneutics situated human actions and experiences to a sociocultural and historical construction, human activity also was not reducible to social construction alone. To this effect, Sugarman and Martin recognized the existence of human agency:

> As agents, human beings are able to exercise some degree of individual self-determination. Once a psychologically capable person has emerged developmentally, his or her interpretation will be active in the further constitution of his or her personhood. Individual's interpretation can create possibilities for present and future understanding and action that are not entirely constrained by past and present sociocultural circumstances. (p. 260)

Fourth, hermeneutics underscored that the study of psychological phenomena was an interpretive practice. This challenges the notion that psychology can evaluate human behaviour objectively in a way that was sanitized of all human interest. Hermeneutics held that we are "self-interpreting beings" (p. 260) and that we make sense of life through our full participation in it. Fifth, hermeneutics claimed that although the study of psychological phenomena is an interpretive practice, our interpretations were never absolute and are "grounded in social, cultural, linguistic, and historical conventions and traditions and must make sense within these contexts" (p. 261). Sixth, Sugarman and Martin underscored that what was integral to psychological study was the "dialogue between specific readings of thoughts, actions and experiences and understanding of human life as a whole" (p. 261).

Application of a hermeneutic perspective to this study. In the current research, a hermeneutic perspective guided my interpretation of participants' experiences. I interpreted meaning through the interplay between the participants' behaviour as they viewed it from the

videorecording and through the interpretation of their experience of this behaviour in the interviews. Drawing from a hermeneutic perspective, their transcribed interviews additionally were viewed in relation to the historical, social, cultural, and political context in which we live, and the findings were interpreted through a broad lens of historical and sociocultural contextual considerations inclusive of the aforementioned six assumptions outlined by Sugarman and Martin (2005).

Participants

This study involved a purposive sample of six AEDP therapists who had a videotaped session of their work with a client where attunement, disruption and repair had occurred. I focused my research on AEDP because AEDP therapists are trained to attend to the moment by moment process of dyadic affect regulation. As a result of this training, I believe that for these individuals, sequences of ADR in the therapeutic session were more salient and more easily identified.

Unlike quantitative studies that are dependent on large sample sizes to demonstrate statistically detectable differences, qualitative studies typically interview a small number of participants intensively to gain a richly detailed and in depth understanding of individuals' experience and/or understanding. To this effect, six therapists were recruited to participate in this study. Among the six therapists, two were male and four were female, all were Caucasian. Five participants were between the ages of 45-65 and had about twenty years counselling experience. One participant was 30 years old and had ten years counselling experience. Additionally, participants had varying degrees of training within AEDP: three were AEDP faculty, two were certified AEDP therapists, and one had completed level two training.

Therapists were recruited through advertisements emailed to AEDP therapists in the Vancouver community (see Appendix 1). This advertisement additionally was placed on a central AEDP listserve that includes members throughout Canada and the U.S. The existence of only a few AEDP therapists with advanced training in the Vancouver community necessitated reaching out to AEDP therapists in other locations within Canada or the U.S. Therapists were asked to volunteer for this study. I maintained ethical research guidelines by not directly approaching individuals to solicit them as potential participants.

Participants met the following criteria of inclusion: (1) be an AEDP therapist that attended the immersion level one AEDP training or equivalent (e.g., equivalent can be

completion of the AEDP Essential Skills course or having received one year of AEDP supervision); (2) the therapist was actively employing AEDP in his or her therapeutic work with clients; (3) the therapist had a videotaped session of her/his work with a client where attunement, disruption and repair had occurred and the recording included both a visual of the therapist as well as the client; (4) the therapist signed an informed consent to agree to be interviewed; (5) the therapist had permission from the client to use the videotape for research purposes, and (6) therapists were required to be available for a three hour IPR interview and a one hour follow up interview.

Individuals who were interested in participating in this study were directed to call a confidential line and leave a message (see Appendix 1). I then called potential participants back and had a mini-interview with each one to make sure they met the criteria above and qualified for this study (see Appendix 2). I also explained to them that they would be asked to sign a release form and discussed any concerns they had about confidentiality or about the interview. Individuals who were selected to participate in this study were emailed consent forms (see Appendix 3) and asked to return them prior to the commencement of the study. A copy of the signed consent form was provided to each participant by email before the interview was scheduled.

Procedures

Interview procedure. Once a therapist contacted the researcher, and it was determined that the therapist met the criteria to participate in this study, and had signed and received a copy of the informed consent, an interview was scheduled. Participants were given a handout that defined the constructs of attunement, disruption and repair and provided examples of these constructs (see Appendix 5). At each interview, time was made to discuss any concerns participants had about confidentiality, about the interview, or about the informed consent. Participants had been provided with a copy of their signed informed consent by email. Ongoing consent was sought by asking the participant if he/she wished to proceed with the interview. At the start of each interview, the researcher reviewed the definitions of ADR in Appendix 5. Participants were interviewed using an interpersonal process recall (IPR) approach. This interview approach by Larsen, Flesaker and Stege (2008) will be subsequently explained.

Interpersonal process recall (IPR). In the current study, an interpersonal process recall (IPR) approach was employed to interview participants. Larsen, Flesaker and Stege (2008)

conveyed that qualitative research on client/caregiver interactions has depended predominately on client memories to seek an understanding of the client's experience. Such client recollections have raised concerns about client recall in qualitative research. To address this, Larsen et al. discussed the merits of IPR. IPR is a qualitative interview approach designed to "access individuals' conscious yet unspoken experiences as they occurred at the time of the interpersonal interaction under investigation." (p. 19) A therapist/client session interaction is video-recorded and viewed by the client or therapist with a research interviewer. The interview involves process oriented questions about the participant's experience as he/she views the tape. The advantages of IPR is that it permits researchers "to obtain firsthand insights into professional interactions through observation and by directly asking the client and the professional caregiver to comment independently on professional interactions as they unfold" (p. 19). Larsen et al. noted that IPR has been used frequently in counselling and psychotherapy research citing the following examples: "Clarke, 1997; Crews et al., 2005; Griffith & Frieden, 2000; Levitt, 2001; Lokken & Twohey, 2004; McLeod, 2001; Timulak & Lietaer, 2001; West & Clark, 2004" (p. 19).

The current study recruited and interviewed therapists who had a videotaped session of their work with a client where attunement, disruption and repair had occurred and employed an IPR approach to interview participants. IPR normally requires 48 hours between the client session and the interview. The research herein diverged from this requirement. There was no specified length of time between the client session and the interview in the recruitment of therapists (see Appendix 1 for recruitment criteria). The researcher and participants viewed the videotaped session together and participants was asked to identify the experience of attunement, disruption, and repair when viewing the videotape. The recording was stopped at intervals identified as significant by the participant or by the interviewer, and as per the IPR approach, therapists were asked process oriented questions by the researcher. For example, when an experience(s) had been identified by the participant, the researcher stopped the recording and asked the participant the following IPR oriented questions: In this episode of attunement (or disruption or repair), what were you thinking? What were you feeling? What were you doing?[7]

[7] In IPR, participants are asked to remember what they were thinking about during the session. They are not usually asked to reflect about what they feel right at the moment of the interview. This study used IPR but extended its scope to include therapists' reflections during the interview. Conducting IPR interviews in this manner is suitable for interpretative phenomenology and is a valid and productive way of doing IPR interviews in the context of interviewing therapists.

This interaction of stopping at intervals that had been identified as significant and answering process oriented questions continued until the end of the recording. Participants stopped the recording of their videotaped sessions at various intervals but on average every five minutes. The intervals that participants identified as significant involved episodes of attunement, disruption and repair separately and also involved cycles of ADR. Sometimes a disruption that occurred earlier in the session wasn't repaired until later in the session. At other times, the cycle of ADR was more closely connected in the session. All interviews were both video-recorded and audio-recorded and then transcribed for analysis.

Data collection. Each IPR interview took place in a private confidential room. The interview averaged about 4.5 hours. This was much longer than the initial 2-3 hours anticipated. After the first interview, I clarified this adjustment to the length of the interview time with participants before proceeding with further interviews. The written transcription of the interviews included both the transcription of the interview between myself and the participant as well as the transcription of the videotaped session. However, only the transcribed interview between myself and the participant was utilized in the data analysis. The transcription of the videotaped session of the participant with his/her client was included so that I could situate what episode was being explored in the interview. Additionally, I had videotaped copies of the therapist sessions with their clients that I could refer to when clarifying any queries I may have had about an ADR episode. Finally, because I had both audio and videotaped all interviews, nonverbal cues were captured in the videotape of the interviews.

Data Analysis

The data for this study was analyzed according to thematic analysis as outlined by Braun and Clarke (2006). Braun and Clarke defined thematic analysis as a "method for identifying, analysing and reporting patterns (themes) within data" (p. 79). The authors stated that thematic analysis was a tool that can be used across different theoretical and epistemological qualitative approaches such as essentialist, constructionist or contextualist frameworks. A contextualist method was situated between essentialism and constructionism and acknowledged both "the ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'" (p. 81). In line with a hermeneutic interpretation of the data, I situated thematic analysis within a contextualist method that acknowledged both how people interpreted their

experience to make meaning and the influence of historical and sociocultural practices on these interpretations.

Considerations for thematic analysis. Braun and Clarke (2006) further detailed considerations for the application of thematic analysis. These considerations were: (1) what counts as a theme; (2) the description of the data set; (3) inductive and deductive identification of themes; (4) semantic or latent themes, and (5) epistemology.

Themes. The authors conveyed that "a theme captures something important about the data in relation to the research question, and represented some level of patterned response or meaning within the data set" (p. 82). In the present study, prevalence of a theme was guided by the research question, "How is attunement, disruption and repair experienced by the therapist?" Prevalence was less about quantity but on whether a theme captured "something important in relation to the overall question" (p. 82).

Description of data set. This study provided a detailed and rich depiction of a group of themes within the data as they emerged from the reading and re-reading of the data. Although, I state that themes "emerged" from the data, I recognize that as the researcher, I played an active role in "identifying patterns/themes, selecting which are of interest, and reporting them to the readers" (Braun & Clarke, 2006, p. 80). In accordance with a hermeneutic tradition, I believe that in order to understand another person's experience, our horizons must fuse with the historical meanings and assumptions of the other person or text. This fusing of horizons required that I bring my own prejudices to the forefront, remained open to integrating another's horizon of meaning so that my perspective may change. This openness to fusing of horizons guided the depiction of themes as they emerged from the reading and re-reading of the data.

Inductive identification of themes. The themes from the data were identified inductively, that is, a bottom up approach. An inductive analysis is "a process of coding the data without trying to fit it into a pre-existing coding frame or the researcher's analytic preconceptions" (Braun & Clarke, 2006, p. 83). Braun and Clarke conveyed that in an inductive approach to data analysis, the themes identified may not relate to the research question because the themes are situated in the data. In practical terms, what this means is that I read and re-read the data without attention to previous research that might predetermine themes. As mentioned earlier, while I attempted to achieve this, I also espoused a hermeneutic view that the comprehension of a text was in the meeting of horizons between the reader's own interpretations and those that were

presented in the text. For example, Braun and Clarke underscored that the notion of themes emerging from a text:

> can be misinterpreted to mean that themes 'reside' in the data, and if we just look hard enough they will 'emerge' like Venus on the half shell. If themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them. (Ely et al., 1997 as cited by Braun & Clarke, 2006, p. 80)

Thus, there was an understanding that as much as I attempted to read the data without attention to previous research in order to permit themes to emerge from the text, I also recognized that interpretation was not only unavoidable but core to attaining meaning.

Level at which themes are identified. Braun and Clarke (2006) identified two levels at which themes are identified in the data: semantic or latent. Semantic analytical process progresses from description of the data to interpretation "where there is an attempt to theorize the significance of the patterns and their broader meanings and implications" (p. 84). By contrast, a latent thematic analysis examines the "*underlying* ideas, assumptions, and conceptualizations – and ideologies – that are theorized as shaping or informing the semantic content of the data" (p. 84). It was my view that the hermeneutic approach to psychological interpretation was more compatible with a latent thematic analysis because it situated understanding and meaning in a sociocultural and historical context. This study therefore employed a latent approach to thematic analysis.

Phases of thematic analysis. I applied Braun and Clarke's (2006) six phases of thematic analysis in the interpretation of themes. In phase one, I familiarized myself with the data. This involved reading and re-reading the data, recording initial ideas, jotting down codes to be refined in phase two. In phase two, I organized the data into codes with a latent approach to data analysis. A latent thematic analysis examined the "*underlying* ideas, assumptions, and conceptualizations – and ideologies – that are theorized as shaping or informing the semantic content of the data" (p. 84). Coding was the demarcation of "interesting features of the data in a systematic fashion across the entire data set" (p.87). Phase three involved sorting the different codes identified in phase two into themes. This entailed analyzing codes and combining different codes into overarching themes. Phase four required reviewing and refining identified themes. Themes were considered in relation to the coded extracts and in relation to the entire data. Phase five defined and named the themes. I fine-tuned the description of each theme and the aspects of

the data set each theme captured. In analyzing the themes, I employed Braun and Clarke's guiding questions:

> 'What does this theme mean?' 'What are the assumptions underpinning it?' 'What are the implications of this theme?' 'What conditions are likely to have given rise to it?' 'Why do people talk about this thing in this particular way (as oppose to other ways)?' and 'What is the overall story the different themes reveal about the topic?' (p. 94)

In both defining and naming the themes and in considering the themes in relation to the coded extracts and in relation to the entire data, a couple of issues arose. The theme of "attunement on the edge of fragmentation, building human relational capacity" was experienced by several participants but best articulated by one of the participants. In this case, I included quotes by the one participant that best captured the theme. The same situation occurred with the theme "therapist identifying with client defense." Additionally, one of the sub-themes, "laughter and playfulness" was salient and stood out as significant to the phenomenon of repair although it was only described by a few of the participants. This sub-theme also reflected the phenomenology of exploration and play when secure attachment develops, a phenomenon that is frequently depicted in the literature and as such, seemed important to include. These considerations and decisions on the inclusion of themes were discussed both with the peer reviewer and my supervisory committee.

Finally, in phase six, I generated a final analysis with the aim of telling "the complicated story" (Braun & Clarke, 2006, p. 93) of the data in a way which presented "the merit and validity" (p. 93) of the analysis.

In sum, this current study approached data analysis through thematic analysis as outlined by Braun and Clarke (2006). This entailed considerations of what counted as a theme, the description of the data set, inductive and deductive identification of themes, latent themes, and epistemology. The data was analyzed according to six phases: familiarizing oneself with the data, creating initial codes, searching for themes, reviewing themes, defining and naming themes, and writing the final report. Additionally, a hermeneutic perspective guided my interpretation of the data. The themes that emerged from the transcribed interviews were interpreted through a broad lens of historical and sociocultural contexts inclusive of the aforementioned six assumptions outlined by Sugarman and Martin (2005).

Ethical Issues

A first ethical issue arose with the potential discomfort for the participant upon viewing the recording of their clinical session. I informed each participant that we can end the research interview at any point if he/she wished to stop. I ensured that each participant had adequate support if this circumstance arose. I addressed this by asking each participant about his/her readiness to view the tape and by asking what support he/she may need if unpleasant feelings arose. If issues arose that participants believed needed attention, I encouraged them to discuss/consult about this with a colleague, in a consultation group, or with a supervisor/mentor.

A second ethical issue that I had to consider were situations in which a therapist might choose a videotape of a client they were still treating, and thus viewing the recording may have had an impact on the therapeutic relationship between the therapist and client. I addressed this by having conversations with participants about any potential risks and listing this in the informed consent.

A third ethical issue I considered was how I would address any disagreements when I presented the findings to participants through member-checking procedures. It was possible that a participant may not have agreed with my findings. The purpose of the follow up interview was to seek participant input about the findings and to give them an opportunity to express any concerns. Additionally, participants were given the contact information of Dr. Marv Westwood and Dr. Marla Buchanan, who have expertise in traumatic stress research at UBC and were willing to discuss with participants any concerns that arose. All participants interviewed supported the findings. One participant requested a few details to be changed for accuracy. I address more about participant feedback and member-checking procedures subsequently under Criteria for Rigour.

Criteria for Rigour

The research herein was guided by three criteria for rigour: trustworthiness, resonance and pragmatic usefulness. I will first describe each criteria and then outline responses that addressed this criteria from both the peer reviewer and participants.

Trustworthiness. Morrow (2005) explicates how both the quality of the investigative process and trustworthiness underlie rigour in qualitative research. Trustworthiness within this research project involved transparency about analytic procedure with colleagues, peer reviewer, and my research committee. With the aim of upholding the criteria of trustworthiness, I kept

journal notes with my reflections during the entire process from the onset of recruitment through the interviews and through the analysis. The peer reviewer read the data, the codes and the findings and ensured that the findings reflected participant experiences. In the hermeneutic tradition, the peer reviewer and I had a dialogue discussing her interpretations and I remained open to the possibility of altering my interpretations through our dialogue. In addition, I facilitated a member check by providing research participants with the findings in Chapter Four and discussing any concerns that arose. The member check will be described in more detail in the following pages.

Resonance. According to Siegel (2007) resonance "is the coupling of two autonomous entities into a functional whole" (p. 4). Siegel further explicated that "when such resonance is enacted with positive regard, a deep feeling of coherence emerges with the subjective sensation of harmony" (p. 4). In this dissertation, resonance was assessed by the question, "Is there a sense of harmony between the findings and the data?" The peer research and I both engaged with this question in reading and re-reading the data, the codes and the findings. Additionally, participants were asked a question about resonance in the member check.

Pragmatic usefulness. Building on trustworthiness as a criteria for rigour, Patton (2002) emphasized the importance of praxis, that is, the integration of theory and practice. I believe that the findings derived from this dissertation contributed to our knowledge of the construct and the role of attunement, disruption and repair in the therapeutic process, informed existing theory on affect regulation, attachment repair, and informed the process of change in therapy. As such, I espoused that the findings derived from this dissertation would be of clinical use to counsellors in comprehending more fully their interactions with clients. This third criteria, pragmatic usefulness, was chosen because counselling psychology is an applied field and this criteria addressed the practical implications of the findings to the field counselling psychology.

Peer Reviewer. A peer reviewer was asked to read the data, the codes and the findings. The peer reviewer had over 15 years clinical experience as counsellor. In regards to AEDP training, she had taken level one immersion, essentials skills, and core training, and had been a practicing AEDP clinician for seven years. The peer reviewer read over the data, the codes and the findings and was asked to judge the rigour of this study by its resonance and pragmatic usefulness. In reviewing the findings, she was asked the following questions, questions that underlined the criteria of rigour: Does it resonate with your experience of being a counselor in

AEDP? Are the findings relevant to the practice of AEDP? Based on your knowledge of AEDP, is it comprehensive?

The peer reviewer expressed that the findings resonated with her experience of being a counsellor in AEDP. She expressed excitement at the description of attunement as "degrees of attunement" and stated that "although I had never articulated the phenomenon as such, the findings spoke to my experience of deepening attunement at different intervals in AEDP sessions." The peer reviewer conveyed that the findings will be helpful and relevant to the practice of AEDP as it will offer clinicians a more nuanced comprehension of attunement, and enhance and strengthen the experience of dyadic regulation of affect through attunement. Further, the peer reviewer stated that the findings on disruption and repair will assist clinicians to be more aware of disruptions in the dyad and allow a more expansive process of resolution that involved multiple components. She stressed that "the multiple components of the repair process will give clinicians a road map on how to address disruptions with the aim of strengthening the therapeutic relationship and ultimately, supporting the development of secure attachment." The peer reviewer underscored that the findings were comprehensive by having "illuminated aspects of AEDP that had not hitherto been fully elaborated on."

Participants. The themes derived from the analysis of the transcripts (i.e., Chapter Four) were handed back to participants so that they had input as to the accuracy of the interpretations derived. Participants were emailed Chapter Four and asked to review the findings based on the criteria of rigour: trustworthiness, resonance, and pragmatic usefulness. Participants were asked, "Can you trust that the results accurately reflect what you shared? Do the findings resonate with what you shared? Do the findings resonate with your experience of AEDP? Are the findings of useful pragmatic value to counsellors in AEDP?" I invited participants to speak with me by phone or send their feedback by email. For those participants that were situated in my vicinity, I also extended the invitation to meet in person. Five of the six participants responded by email. I spoke with one participant by phone. All participants expressed support of the findings. They stated that the findings resonated and reflected what they shared, and that the findings would be useful to AEDP clinicians.

One participant expressed that I'd understood her work and her experience of her work "in a way that reflected deep seeing, feeling and understanding" with her. She conveyed that the way I presented her work "in the context of others' work" and through my "interpretive

framework," illuminated what she was "intending and doing" and made "it available for teaching purposes in a very clear and compelling way."

Another participant requested clearer definitions for AEDP phrases since he imagined that a reader with non-AEDP background may not be familiar with these terms. To this effect, Appendix 6 was added with AEDP terminology. This participant additionally expressed how useful it was to read the findings. He conveyed that the findings will assist him in his sessions and expressed a desire to have a "cheat sheet" for use in training and for practitioners that listed "the different forms of attunement with examples of how that's expressed both verbally and in body language and what evidence a therapist might see of rupture and repair."

A third participant found the "topics and commentary rich and interesting" and expressed feeling "impressed and great" about what she read. This participant along with four other participants conveyed appreciation of the diagram (i.e., Appendix 8), and relayed that it was very helpful in visually representing the findings.

As mentioned earlier under the section on ethical issues, a fourth participant requested a few details to be changed for accuracy. As well, this participant did not agree that the experience of "reaching and asking" fit under a theme of "disruption as therapist confrontation." As a result of our discussion, I clarified the excerpt in the findings and underlined that the experience was not directly confrontational but rather moreso about broaching a topic. Additionally, I changed the thematic heading from "disruption as therapist confrontation" to "disruption as broaching a topic," a theme that was more encompassing of participant experiences.

Finally, the fifth and sixth participants both stated they greatly enjoyed reading the findings. Both imparted that they found the descriptions on attunement and those on repair to be thorough and clear and pragmatically useful to clinicians.

Chapter 4: Findings

Introduction to Findings

In analyzing the transcribed interviews, I identified nine common themes and several sub-themes. The nine main themes were: attunement as connection; attunement as we're in this together; attunement to underlying affect attunement on the edge of fragmentation, building human relational capacity; disruption originating with therapist; disruption originating with the client; incomplete repairs; disruption in the repair; processing repair to completion. In this chapter, I initially present an outline of the themes and sub-themes and subsequently a description of each theme accompanied by excerpts from participants. A substantive summary of the main findings will be provided at the completion of the chapter.

When employing interpersonal process recall (IPR) to investigate the experience of ADR in the therapeutic session, meaning making occurred both in the conversation between therapist and client and in the mutual investigation of the subject matter between interviewer and therapist participant. In the interviews, participants and I were both watching the participant's videotaped session and I was investigating the subject matter alongside the participant. For example, occasionally I would notice something about a participant's nonverbals or statement that he/she had not detected. When it was brought to the participant's attention and he/she had a chance to reflect on the experience, its significance became clear. Thus, the participant was not the only one pausing the videotape when something significant occurred. In this vein, my observations, comments, and the dialogue that ensued during the interviews were part of a co-constructed meaning making process. Additionally, the therapist's experience of attunement, disruption and repair is multifaceted and cyclical. Some of the quotes from the transcribed interviews represented more than one common theme. Finally, because this was a purposive sample of therapists from Accelerated Experiential Dynamic Psychotherapy (AEDP), the therapists frequently employed AEDP terminology in their descriptions. To that end, I have provided a brief summary of AEDP and some of its terminology in Appendix 6.

Common Themes

Theme One: Attunement as Connection

1.1. Therapist's attempt to connect with client

1.2. Attunement to connect over common ground, create trust

1.3. Attunement through tracking and scanning

Theme Two: Attunement as We're in this Together

2.1. A sense of we-ness

2.2. Motherly, good enough other

Theme Three: Attunement to Underlying Affect

3.1. Attunement as dropping down

3.2. Attunement as holding the space, grounding

3.3. Attunement to vitality affects

Theme Four: Attunement on the Edge of Fragmentation, Building Human Relational Capacity

Theme Five: Disruption Originating with Therapist

5.1. Therapist misattuning to client experience

5.2. Therapist identifying with client defense

5.3. Therapist anxiety

5.4. Therapist wanting to keep client safe

5.5. Disruption as therapist broaching a topic

Theme Six: Disruption Originating with the Client

6.1. Client trying to please

6.2. Client disclosure of what didn't work in a session

6.3. Client defense as disruption

6.4. Client dropping down/coming up

Theme Seven: Incomplete Repairs

Theme Eight: Disruption in the repair

8.1. Therapist trying to connect

8.2. Staying the course

Theme Nine: Processing Repair to Completion

9.1. Exploring underlying affect

9.2. Exploring underlying attachment issue

9.3. Attunement in the repair

9.4. Laughter and playfulness

9.5. Repair strengthens relationship

9.6. Post-Repair

Description of Themes

Theme One: Attunement as Connection

Participants depicted attunement as a sense of connection with their clients. They portrayed three areas of attunement as connection: participant's attempt or invitation to connect with their clients; attunement to connect over common ground and to create trust; and attunement through tracking and scanning.

1.1. Therapist's attempt or invitation to connect with client. Participants attempted to connect with their clients as an invitation to attune or as an entry point to affect. For example, G described this experience as taking "a deep breath together" to get into "a place of connection." Generally, this occurred at the start of the session but could also occur at different points in the session when a therapist invited a client to somatically and affectively explore his/her experience. In G's session with her client, G inquired about an encounter her client had had with an ex. Dropping her voice, G attempted to meet her client at a deeper level of affect. G explained:

> I'm trying to lead her there. . . . I'm trying to gently shift her. So if I go up there (G motions to head), and use the same language it's going to just stay there, whereas I'm trying to let her know through my tone that I care, I'm interested, and it matters. And there's somewhere else we need to go.

Participants underscored this aspect of inviting closeness through dropping their voice and calming down. After L's client discloses he had been ruminating since their last session, L recounted hearing himself "drop down" in his voice and that this dropping down was "something about attunement." L explicated that "it happens when I feel like someone's getting closer to their experience and when I'm calming down and getting closer." L depicted this phenomena of getting closer but still seeking an "entry point" to his client's affective experience as follows:

> I feel I'm with him, like he's dancing around something here but he's inviting me into it and I'm inviting him into it also. So I am asking him to elaborate. . . . I'm choosing not to intervene, not to do too much just yet, because . . . there is this idea of choosing a target, choosing an entry point. And we don't have it yet.

The notion of connection as an invitation was captured in L's description of his client "dancing around something" while at the same time "inviting me into it and I'm inviting him into it also." L portrayed a mutuality in the invitation. At the same time, L raised the idea of an entry point to affect, that as an AEDP therapist, he was seeking and tracking for an opening to affective connection, a

concept further illuminated in sub-theme 1.3. (i.e., attunement through tracking and scanning). Notably, within this sub-theme of "invitation to connect with client," participants spoke of their attempt to connect in terms of "gradients of attunement." They conveyed that this initial attempt to connect was at a "preliminary level of attunement." The notion of "gradients" or "levels" of attunement was suggestive of stages or diverse degrees of attunements. Participants made further references to this experience of "gradients of attunement" in the proceeding sub-themes.

1.2. Attunement to connect over common ground and to create trust. At this preliminary level of attunement, i.e., attunement as connection, participants were more likely to seek common ground with their clients and/or to meet them where they were in their process. X described talking about coursework with her client who was a student as an attempt "to end on a good note." It was important for X to end the session with her client "feeling connected to me and trusting me" suggesting that the notion of finding common ground and creating trust does not only occur at the start of sessions but was an ongoing process. G spoke of this process as attempting to "crystalize:"

> Again, I'm working really hard to crystalize something about what it is that she wants. . . . I'm coming up and meeting her where she is, and trying to get some traction going. 'Cause she's confused and she's stuck, and there's so many moving parts. . . . and I am still trying to get us into a slower, more connected space, even if the content is about creating a boundary for outside, but I am still trying to attune with her so we can find that together.

G portrayed finding common ground and creating trust as "meeting her where she is," and specifically moving her client into "a slower, more connected space," and "finding that together." The notion of attunement depicted was one that was "slower," more "connected," and "crystalized" interpersonally within the dyad.

Z was in the difficult position of informing his client that his client's spouse did not want to reconcile. When Z was terminating the challenging session, his client praised Z's ability as a therapist. In reviewing the recorded session, Z viewed this as a "comraderie" and his client's expression of trust in Z:

> What I'm actually appreciating is that he wants to give me something back and that's a significant aspect if not a larger aspect than "save my marriage." I really feel it's kind of like, "Believe in yourself. I see you as good. Don't use wishy-washy language like 'may.'"

The quote above highlighted for Z the "lovely exchange of masculine energy" as common ground as well as a deepening of trust through a sharing that was "softer, strong, deep and good."

1.3. Attunement to tracking and scanning. Participants conveyed their experience of attunement when they tracked and scanned the client's nonverbals and verbals for "entry points" to underlying affect or for "entry points" to closeness and togetherness.

For example, in the session with G and her client, G tracked and scanned her client for an opportunity to attune. When her client recounted her experiences of the past week, G portrayed this experience as "just listening" and "waiting for a moment that I can get closer." In this attempt to "get closer," G aimed to "move that attunement into sync . . . to draw her back in to her and I." When G's client persisted in recounting the events of the past week, G continued to scan and "look for the essence of why she is telling me this story." G explicated that she tried to connect with her client in this place as if to say, "I hear you. I'm listening. I'm tracking you. I'm with you." When G asked her client to take a moment to connect together, G experienced an opening and was explicit about "dropping the anxiety:"

> I'm aware that the anxiety is there. And can you join? Can we connect? I invite her. I'm working hard to bring us together. Into connection. Into attunement. It's working with leading and pacing. Sometimes I'm just keeping pace with her. I'm sympathetic with what she's doing, and being as present as I can be and as present as she can be at that moment. And sometimes I lead us into attunement.

In the quote above, G painted her experience of tracking and scanning as an ebb and flow, "keeping pace, "being as present as I can be" and as "leading and pacing." With a client that distanced from intimacy by "telling stories," tracking and scanning was additionally portrayed as effortful, i.e., "working hard to bring us together."

Participants depicted tracking and scanning as looking for the "green light," an AEDP term signifying a client is ready to access a deeper level of affect. Y relayed tracking her client's nonverbals as an experience of "approaching the intensity" and "staying connected."

> What comes to mind right now is, you know, ET's finger. In a way, I'm touching fingers long distance. . . . and I'm wanting to somehow approach the intensity of this energy and stay connected and I'm feeling like we're doing it. At this point, I was noticing the breathing. . . . I was definitely saying, ok, green light here.

L similarly described tracking and scanning for the "green light" and depicted this experience as having found a "target. . .some self at best." In tracking his client's experience and "feeling into that," L portrayed this experience as "quiet…a kind of peace…a softness." There was a "stillness"

and a "leaning in" as L became "clear" within himself and "calm" and as he tracked the moment-to-moment process of his client's experience. L differentiated tracking and scanning from the notion of "holding the space:"

> I'm at ease. I'm being present. I'm very very focused on him. I know it's important. Look at my posture. I'm alert within me to the fact that something important is at stake right here. Like a pointer or setter. So I'm not really holding the space, but I'm curious what's emerging from the space. I am tracking him nonverbally and I'm noticing the sense he's making but also the physical gestures…. I'm tracking what's emergent for him.

The experience of tracking and scanning nonverbals for an "entry point" to affect or to track "what's emergent" ranged from effortful to ease at having found a "target" depending on the client's defense. Once an entry point was found, participants denoted this experience as "focused," "quiet," and "approaching intensity."

Theme Two: Attunement as We're In This Together

As conveyed in section 1.1., participants suggested through their descriptions of attunement that there are "gradients" of attunement. Participants chronicled a deeper "gradient" of attunement as: a sense of we-ness, and as motherly and/or attuning to the good enough other.

2.1. A sense of we-ness. Participants employed descriptions such as "being with me and with each other," "a secure base" and "we're in this together" to articulate their experience of we-ness. They described this attunement toward togetherness as being real, being in the moment, and employed the use of metaphors to capture this experience.

X's client spoke about her roommate and about subletting her place as she moved away for the summer. In sharing her experience, her client shifted into sadness. In that moment, X portrayed her experience of we-ness with her client as finding "that piece of her in me:"

> Initially I was still feeling that more "light hearted bantering" connection. We are making jokes together and then that sadness came up and all of a sudden there were tears. And it took me a second to see her tears and to connect with that sadness, to find that piece of me or a piece of her in me and give to that sadness rather than staying in the banter.

"We-ness" is eloquently depicted in the image of X finding that "piece of her in me," and the notion that with those "pieces" of therapist and client existing within X, that she can give to her client's sadness.

In G's session, when G and her client both took a deep breath together and touched upon underlying affect, G employed the metaphor of "flowing" and "moving with the river" to relay her experience of attunement as we-ness. Later on when G's client described feeling "contracted" and stated she was not used to asking for help, G described another "drop down" to underlying affect. G expressed this attunement as feeling "real" and conveyed feeling her client's "aloneness" as she sat "over there in another chair, which was only three feet away." G elaborated:

> I keep trying to connect with her, let's join forces. . . . and it's really hard to do that. . . . She doesn't feel me. We're sitting here. We are together. And she's alone. . . . We are as here as we could be. . . . We're not in the story about what happened during the week. We're here. And she's alone. And I'm really struck by that.

G's description accentuated a profound existential experience of being alone together and that attunement to "we-ness" can signify being accompanied in one's aloneness.

In Y's session, Y assisted her client in tracking the emotions in her body and she held the space for her client to be with her sadness. Y articulated the experience of we-ness as being together in the unknown and "holding hands."

> When she says that she's feeling spaciousness and presence, I want to really self-disclose and make myself feel as present as possible. But this moment it's really kind of a moment of "we're together" but I'm not sure we have our flashlights at this moment. There's a lot coming up right now. I don't see it. I don't think she sees it, but we're still together. So therefore here we can't see – hold my hand. Just feel my hand.

Further into Y's session, when Y's client disclosed deeper experiences of affect, Y likened the experience of attunement as we-ness to "reverence" and "breeziness . . . like wonderful relief into beautiful alive air."

X similarly recounted the experience of we-ness as being connected in the unknown together. For example, when X's client divulged her sadness about having difficulty with relationships, X relayed how the sadness she attuned to with her client felt like a "fast track" back to them feeling "attuned in a way" that X had been "missing her moments before." X acknowledged her client's experience that relationships are "hard for her and confusing" and empathized with how difficult it was for her client to articulate this. X expressed feeling "calmer, more ease and more comfort" in connecting in the sadness with her client while at the same time "holding the unknown:"

> I don't know what this is that we are simmering in either but I can feel how hard it is. . . . it still feels like there are so many tangled threads around attachment for her. . . . I feel like I am holding that and holding that sense of it's OK, being in the unknown is ok, none of us really understand why it's so hard right now and what the way out is but I have faith that we'll find it, we'll find the way.

Participants' depiction of we-ness as together in the unknown was reiterated by several. In L's session, for example, this togetherness was articulated as discovery: "I was feeling into this experience. We were breathing into it together. We might both be discovering it." L assisted his client to stay with both his feelings and with his awareness of L throughout his experience and when his client was able to stay in that "togetherness," L conveyed this as "the purest form of human experience." L further articulated the experience of attunement as we-ness as a sense of presence:

> I feel some sadness in the room. . . . I'm trusting him. I like that we're still. This feels really important and I feel like I'm not kind of worrying about why he drank. I'm not in anxiety. I think we're both very present. I mean this man has gone out and he's drank to the extent that he doesn't remember some of what he did. . . . We're both staying with it.

L additionally portrayed we-ness as being "touched and moved" by his client having had a "different experience." L recounted that his client used to "compartmentalize and move on with his life." When his client shared that he could "look in the mirror longer" and now say "this does hurt" and not run from his experience, L was moved and felt a stronger sense of we-ness with his client.

2.2. Motherly, good enough other. Participants depicted attunement as "togetherness" and as embodying the "good enough other" with their clients. This experience was illustrated through descriptions such as feeling "motherly" or through wanting to "soothe" clients.

When X's client became teary, X recounted feeling "tender" toward her client. X conveyed "there's a softness" about her client's tears and that she felt her client's "vulnerability." In this connection, X stated, "there is also a layer of feeling very motherly as well of wanting to sort of soothe her, be with her."

Y depicted the "motherly" experience of providing psychoeducation to her client. Y relayed, "She's really doing this and she needs help so I feel like I'm a mother teaching a kid here."

L made reference to the strength of his relationship with his client and that L as the therapist could be this "good enough other" for his client to feel safe enough to "self-correct," i.e., that his client risked being authentic rather hiding and appeasing and being defensive:

> That he self-corrected and we have a chance to re-attune and recalibrate and he's actually come forward and told me, “Well actually you know L that feels overinflated.” And he's got me as a good enough other who can say, “Ok great, we found something that feels better, let's notice how that is.”

L elaborated that he was tracking the relationship closely and that he was moved that “the relationship” with his client felt “important enough” for his client “to feel safe to self-correct and be truthful.” L described this attunement as being “congruent” with his client and as “resonating with the same feeling and experience in the same moment.” L captured the essence of this sub-theme when he referred to being the “good enough other” for his client and that this experience fostered the opportunity and ability to “re-attune and recalibrate” with his client.

Theme Three: ***Attunement to Underlying Affect***

Participants expressed attuning to a client’s underlying affect. They relayed this attunement as: a somatic dropping down into affect; as holding the space and grounding; and as attuning to vitality affects.

3.1. Attunement as dropping down. Participants conveyed an awareness of their clients "dropping down" when their clients had accessed and touched upon their underlying affect. This attunement to dropping down was depicted through various descriptors such as a "joining with," "letting barriers down," "working to deepen and expand," a "focusing" and “narrowing in to expand out," "resonating to the centre" and sense of "spaciousness."

Z’s client had had an affair on his spouse during a time when his spouse was pregnant. In the counselling session with Z, Z’s client minimized the affair. Confronting his client with his denial, Z states, “The truth is that you're hurt deeply and the reason you're hurt deeply is because you're important.” In confronting his client, Z explicated, he placed the “betrayal in the language” of his client “being needed.” Z assisted his client to drop down into his core affect by both confronting him and “joining with him….as a man,” and “trying to link him with me.” This intervention enabled Z’s client to access the underlying affect of “disgust,” which Z states was an “appropriate emotional response” and which Z experienced as a huge breakthrough for his client:

> For me to be in the presence of his disgust, to feel that I'm with him, that he's allowing me, that he's undefended, I'm proud of what I have accomplished with him and I feel connected with him. He’s letting his barriers down.

Z encouraged his client to stay with his feelings of shame and disgust and to deepen this experience. He understood his client's ability to feel shame and disgust as a "green light" to go deeper, an experience Z described as "engaging" because there was movement toward responsibility:

> In fact, he's saying "I deserve this because of my bad behavior." Total opposite from the blame on his spouse earlier in the session. It's really a powerful self-blame.

Z continued to work with his client to explore his client's underlying affect. He conveyed his experience of attunement as a feeling of "excitement" and "relief" and as a "gentle empowerment of mind and body:"

> It's very close because as I work to deepen and expand, he comes with me. We're in a trajectory here which is his dropping down and going further. I know I'm getting really close because there's a lot of activation. Emotionally he's sowing this. Also his chest is more open and his throat is revealed. It's vulnerability showing, "I'm safe here." He's opening up to me.

Later into the session, when Z's client "dropped down" further into the underlying affects of grief and shame, Z recounted how the attunement shifted. For Z, this shift in attunement was toward a mourning that goes beyond shame:

> There's a mourning the self here, "I had something good, I destroyed it." So it's profound sadness, grief. That, I would say, is bigger than shame. . . . He feels me with him and with his experience, it feels like energetically we're connected. I feel relieved because I know it's been there. He's been showing it to me in different ways and it's been implied in his defensiveness.

In the above quote, Z depicted the attunement of feeling "energetically connected" in the depth of grief that his client expressed. Additionally, Z presented the notion that the quality or degree of attunement shifted with the quality of the affect, that is, in this case, from his client's vulnerability where Z felt an "opening" and "relief" to his client's "mourning of the self" where Z expressed feeling "energetically connected" and portrayed his client feeling "me with him and with his experience." This sense of togetherness in Z's experience echoes earlier descriptions of attunement as "we-ness" (see sub-theme 2.1.).

Y portrayed assisting her client to drop down into a deeper experience as a "narrowing into affect" so her client can "expand out." She guided her client to "go into the energy, to let go of all of the causes, let go of all of the words, the stories, all the associations and just feel the raw, physicality of it." Y elaborated:

> So in places like this, she really loves to go into a lot of stories and analytic things and a lot of mentalization. . . . Cause I know she has a lot of capacity and I want to see if I can push it to be able to really work with the experience in the moment now. . . . This is really going to take resistance here and I'm really a bull dog here and it ends up working. . . . It's kind of a focusing . . . I'm narrowing in on how to expand out almost.

Y's notion of "narrowing in" to affect so that they can "expand out" painted a vivid picture of the experience of attunement as "dropping down." Additionally, Y's description captures the notion of dropping down to eventually create spaciousness and expansion.

In L's session with his client, L conveyed attunement to dropping down as a softness and a resonating to the centre and as "transformance." Transformance is an AEDP term that denotes an inner motivational force that is adaptive and self-righting and that strives for vitality, authenticity and genuine contact (Lipton & Fosha, 2011). When L's client stated that he didn't want to live the way he used to, L affirmed this "self-action:"

> It's got a spaciousness and a softness to it. . . . there's a gentleness to that but a strength to it also. I felt the sturdiness of it and I'm gesturing to my core right there, to my center. So it's a spaciousness and a channel from (motions to head) that inner channel feels open and drops right down to my pelvic floor.

In the aforementioned quotes, participants painted attunement to dropping down as a both a "deepening" and "a narrowing in," as well as an "expanding" and "spaciousness." Throughout, participants portrayed a sense of "joining" and "togetherness" in the dropping down.

3.2. Attunement as holding the space, grounding. Participants relayed attunement to underlying affect as "grounding" and "holding the space." They described this experience as "feeling connected," a "coming closer," "slowing down," and as "spacious."

X's client expressed sadness and overwhelm at having to pack and move from her apartment, and X articulated her experience of holding the space for her client:

> I remember feeling really connected to her and also curious about the hiding and the looking away and a wondering and wanting and a longing: "Come back, come back, come closer. . . . I'm right here."

The perception of holding the space as an invitation to intimacy in the therapeutic relationship was accentuated by X in her words "Come closer, I'm right here."

Y's client entered their session dysregulated and Y held the space for her client's underlying affect by grounding and slowing down. She portrayed a metaphor of a wild horse and the need to widen the coral so they're both inside:

> There's this sense of how can I open a safe space for this in the room because this is a woman with loads of spiritual practice and sets extremely high standards for herself. I kind of calmed down and opened up. And inside, what I'm self-consciously trying to do is become as spacious and as present as possible to allow this in without intensifying it. I want to open up and de-intensify it. We've got an angry wild horse here, how can I get this coral as large as possible and keep both of us in it.

In the quote above, X relayed the attunement to grounding and holding space for her client's dysregulation as "spacious" and "present" and opening up to "de-intensify."

L's description of attunement as holding space with his client depicted this space as "allowing for something new to emerge," providing the energetic space "to sort this out." When L's client spoke about his childhood, L comprehended this experience to be "integrative:"

> I'm holding the space that something's emergent that's been revealed to him. . . . he can stay with himself and he can also be in contact with someone else and still be with himself. . . . it's very hard to change yourself if you can't experience yourself. I'm not going to push it.

In the preceding excerpts, participants employed various descriptors (e.g., spaciousness, presence, emergent, I'm right here) and metaphors (e.g., corralling a wild horse) to convey attunement as grounding and holding the space.

3.3. Attunement to vitality affects. Vitality affects, as described in Chapter Two, are the dynamic, kinetic qualities of feelings that are composed of qualities such as intensity, shape and time and that we experience as "dynamic shifts or patterned changes within ourselves or others" (Stern, 1985, p. 156). Participants portrayed attunement to underlying affect through vitality affects such as biological rhythm, silence, gaze, and synchronized breathing.

> Z sat with his client in their session and in biological rhythmic breathing, shared tenderly: A tear rolls down your cheek . . . I want you to know I'm with you. You're not alone and you're not alone as you face what you've done and had the courage that I see. Mmm . . . right. . . . It takes a brave man to let another man see what you let me see right now. . . . Do you feel me with you right now?

When Z's client replied "yes" and expressed how painful it was for him, there was a long period of silence where Z was "holding the space" for his client by his gaze. This was followed by Z extending his hand to his client "holding his hand a little past what one does in a hand shake."

Similarly there were periods of synchronized breathing and silence between Y and her client during which Y described attuning through gaze:

> There are some deep gazes in her eyes. . . . the way she's looking at me, we're getting into some younger stuff here which I think is really important.

And later in the session, during more synchronized breathing and silence, Y elaborated how her client was "dropping down and things are really happening." At other points in their session, Y described her client's breathing as an avenue for tracking and dyadic regulation:

> These short coming up for breaths I feel are really important. It's her way of taking responsibility for dyadic regulation of our work. A little too fast you come up right now, take a breath. If I feel like okay there's a breath then we can go back down and then if she were to go back up, I would just follow that.

During a difficult moment later in Y's session, when Y's client was experiencing the underlying affect of fear and vulnerability, Y described her client's gaze as a resource, signaling a sense of togetherness and dyadic regulation:

> That gaze was so important right there. She is really fighting here. It's like she gets a dose of me and she goes right back. That was like, "I'm resourcing myself for this work right now, I'm not going anywhere." That's what I felt there. The intensity of that gaze. . . . let's do this together.

There was a palpable sense of vitality affects in the synchronized breathing, gazes, and silences that Y and her client shared.

L experienced a tender moment with his client through vitality affects when L's client began to make sense of his affect and connected his feelings to a dream. L attended to and tracked his client through paraverbals to relay, "I get it, we're on track, I'm with you." L underscored, "I'm resonating with his understanding through gaze, tone of voice, through rhythm, through head nods."

Theme Four: Attunement on the Edge of Fragmentation, Building Human Relational Capacity

Participants articulated attunement as being on the "edge of fragmentation," assisting their clients to stay with their affect, bordering on their window of tolerance (Siegel, 1999). This was best encapsulated by Y who described this experience of attunement in different capacities such as "being

in labour," "on the edge of dissociation," "developing self-regulatory capacity" and increasing human relational capacity.

In the proceeding segments, Y assisted her client to track her affective embodied experience. When Y's client expressed that a part of her wanted to blame her daughter, Y invited her client to stay with her experience. In the following excerpt, Y described her role as a therapist in assisting her client to stay with her experience:

> It feels continuous. I've got a job here or am in the middle of it. Just keep it up because all of these things I'm experiencing here, I've experienced many times before. So I'm like okay, time to talk about D (client's daughter). There are all sorts of ways to really avoid working with this experience. And I get it and I know she's on the edge of fragmentation. I bring her back. . . . what comes to mind is you're a midwife and labour's painful now. We need some time here, we just got to stick with this. I could stop it here but I'm not feeling there's a need. I'm getting enough green lights.

Having the "green light," Y persisted in assisting her client to stay with her somatic affective experiences and her client expressed a long period of silence. In this moment, Y wondered "how much silence to give and when to intervene" with her "voice" so that her client was still aware that Y was there. At the same time, Y recognized "a process is happening" and that she needed to "allow silence so it can keep happening." Y depicted her client as being "on the edge" between staying with her affect and dissociating:

> Is she in this process? Is she with me or is she dissociating? My sense is that she's on the edge, which is the absolute most I can hope for here, this is what she needs now because we haven't been able to really stay on this edge before. So she's staying in and of course she's wanting to go out but when I speak she gets my voice. . . . This is what's happening and so I think what I'm really feeling is what she's really feeling and we're together with this.

Y accompanied her client to go deeper into this process of tracking her somatic experience, to stay on the "edge of dissociation." Y explicated the longer she can "stand on this edge" with her client connected to her, the more her client can increase her capacity to self-regulate:

> Because this is the kind of thing that I can help her to go back to later in the processing and understand what was happening. If we can stay in the edges and talk about it and help her to notice how that impacts her way of experiencing the room when she's going into this. That's what people need in order to be able to have the capacity to regulate is to be able to recognize

> the symptoms, when it's happening. . . . to slow it down a bit and also time to make my presence more felt. . . . What we were really working on here is establishing of human relational capacity and I think people with complex trauma that's really an issue.

Y elucidated that the way her client was working reflected "extraordinary capacity she's developed in the spiritual practice" but that it was "all alone." Y attempted to "go into the psychopathology and be there with her." In this "being with her client," Y affirmed one of the fundamental tenets of AEDP, that "building self-regulatory capacity to experience affect is a relational experience." Y underscored, "There's no other way but in a relationship."

Theme Five: Disruption Originating with the Therapist

Participants described multiple aspects of disruptions that occurred with themselves as therapists. In analysing the data, I derived five sub-themes from these experiences, each of which will be subsequently explicated. They were: misattuning to the client experience; therapist identifying with client defense; therapist anxiety; therapist wanting to keep client safe, and therapist broaching a topic.

5.1. Therapist misattuning to client experience. Misattunements to client experiences occurred by prematurely inviting a client to experience underlying affect, misunderstanding the nature of a defensive response, and misattuning to a client's affect.

In Z's challenging session with a client who was going through a divorce, Z assisted his client to confront the pain his client had caused his spouse. He attempted to help his client access his underlying feelings of shame and disgust but was left with a sense that he may be moving too fast for his client. In the session, Z communicated to his client:

> You've been alone in particular with the unbearable feelings you've let me see today, right? Is that true? And here, you are not alone. You let yourself feel the disgust and the shame, you let yourself face without blame but face with courage the pain you've caused both your wife and yourself, right? And you are not alone right now, and now we can really together do something wonderful. Maybe I'm jumping ahead here, I'm not sure.

Z's validation of his client's affect and his invitation to "do something wonderful" was met with defensiveness by his client. Rather than staying longer with the underlying affect of disgust and shame, Z's client responded by talking about all that he has done and that he cannot do anymore to salvage the relationship. In reflecting on the defensive response by his client, Z shared that perhaps

his invitation was premature: “Too quick. . . . I don't know if I invited him back into defense by saying that.”

B recounted how she misattuned to her client’s affect. B’s client was having difficulty speaking about her past and stated that she didn’t want to talk about it. In processing this experience with her client, B reflected on how she misread what her client was actually feeling as a “defensive place that says I should be over this, it just should be in the past.” B missed that her client actually “didn’t feel safe.”

Along the same thread, L also misattuned to his client’s affect when his client disclosed his fear about something that he’s been experiencing for some time. L misread his client’s fear as being afraid to receive L’s care: “I told him we're in sync when in fact we're not. I'm just off in my head, thinking I know what's he's talking about but I don't.”

In the preceding excerpts, B, Z and L each describe misattunements to their client’s experience. Significantly, there are several “mini” misattunements throughout any therapeutic session. The examples listed above were salient in that they had more of an impact on the session.

5.2. Therapist identifying with client defense. Participants delineated disruptions that resulted from identifying with the client’s defense. This is best exemplified by B. B’s client was impacted when B attended to her computer at the start of their session. B’s client felt shut down by what she experienced as a lack of attentiveness from B, an experience B’s client described as being in a “hard place.” In a follow up session, B processed the experience of feeling like she couldn’t quite reach her client:

> She was kind of hardened and I was in a similar place. I think sometimes I get defended around her. As much as I want to not I think I do, I do get caught by her hard place. She was talking about these two people that she had huge disappointments and difficulty with. And then she was glossing over and keeping it light and so I was thinking, “This doesn't connect with what you've said before.” I was trying to figure out what she said before to undo the logic of that, rather than being the process about what’s going on for her.

B’s words, “I think sometimes I get defended around her. . . . I do get caught by her hard place,” captured the essence of the disruption. Significantly, in reflection, B noted that had she responded with process rather than logic, she would have invited exploration of experience and perhaps “softened” the “hard place” her client was displaying.

5.3. Therapist anxiety. Participants noted how their own anxiety as therapists would disrupt their experience with their clients.

X asked her client whether she wanted to have contact by phone over the summer, and her client expressed upset and implied that X was trying to control the situation. X steered the conversation away from the disruption to a conversation about the client's boyfriend. X conveyed how her anxiety got in the way of a potential repair with her client:

> I was pretty anxious and so I might have tried to lift us out of it no matter what. If maybe there was more time in hindsight, I think I might have wanted to stay and let her express some of the anxiety or anger or hurt or whatever was coming up about me asking her to imagine all these possibilities, to see what else was there for the summer.

As the session progressed, X's client disclosed her sadness about having to leave her friends for the summer to study elsewhere. X was unsure about the origins of the affect her client displayed. The aforementioned unresolved disruption earlier in the session impacted X's exploration of her relationship with her client:

> Feeling a little cautious and confused wanting to know what that emotion was really about. Was it about leaving therapy and us or about something else? Wanting to understand and feeling a little bit of longing to address whatever feeling is between us more directly. . . . I'm feeling a little shy about it given the rupture earlier in the session and not wanting to push her into something that is going to cause more distress. I'm worried about another misunderstanding where she thinks I'm trying to control her.

X conveyed anxiety about not wanting to cause further disruption and in the process missed an opportunity for further exploration of the client's experience and of their relationship.

L relayed how his anxiety precipitated him jumping in a little too soon with a question during a long pause from his client. L articulated not feeling connected to his client, feeling lost and then "overreaching:"

> So I'm fishing (referring to a question about client having lived in squalor). All of a sudden we're in some pocket of "I feel sad" and it doesn't connect to anything. He's saying it's not connected and I don't know how to track him and I'm feeling lost. He's feeling a bit lost as well. There's a parallel process and then I start overreaching just a tiny bit. . . . I just think that I'm almost intruding. This is the beginning of a capital "D" disruption, and then the capital "R" repair.

In the reflection above, L articulated how the anxiety of feeling lost prevented him from just being with the "not knowing" and "the heaviness" that his client was experiencing in the moment. Significantly, it also signaled the start of a larger disruption.

5.4. Therapist wanting to keep client safe. There were times when participants were unsure about how to address a disruption and were conscious of not dysregulating a client. This resulted in missed opportunities to deepen the relationship. This sub-theme is best exemplified by the disruption in X's session.

X's client arrived ten minutes late and asked X if she was annoyed by her lateness. Although X was experiencing mixed feelings toward her client, that is, her anxiety as well as feelings of protection toward her client, X withheld this expression. Instead, X and her client proceeded to talk about moving and packing:

> I remember feeling a little bit nervous about how to respond to the kind of anxiety that often comes up when something is directly relational. I'm worried about how much to self-disclose or how it's going to be received. So, I'm feeling a little bit nervous about how to show, not wanting to hurt her or damage her, and also wanting to be honest and sort of trying to examine my own experience and trying to search for any kind of "Did I feel annoyed?" and wanting to be real with her. So I remember feeling kind of anxious. There's a part that is empathizing with her self-criticism and self-judgment. That is a running theme with her feeling this young place in her that's kind of like, "Mom, did I do it wrong?" and "Am I in trouble?" kind of vibe. So, yes, the tenderness and there's often mutual feelings that come up with this client and that there is bit of wanting to soothe her, to say, "Nothing's wrong, it's okay."

As described earlier under sub-theme 5.1. "therapist anxiety," when X asked her client if she would like contact with X during the summertime, X's client questioned her motive. X hesitated to address the topic again during the session because she didn't want to "dysregulate" her client. X ended their session without addressing the earlier disruption:

> The process of us having this rupture and all these real feelings was triggering and distressing and needed to be titrated. I'm regretting that I didn't ask her any kind of metaprocessing questions about like, "How was this to have a rupture?" and work through it. To ask her, "Does it feel like we've worked through it? Does it feel like there's anything else that needs

> to be said?" And there's also the sense that I don't want to risk opening something up at the last minute even through metaprocessing.

In the excerpt above, X was conscience of her desire to not dysregulate her client and to keep her client safe so did not address their disruption. At the same time, X was aware of a missed opportunity for repair. X's experience encapsulated the fine line that therapists walk in balancing the need for client emotional regulation and client safety and the momentary dysregulation that sometimes accompanies addressing a disruption.

5.5. Disruption as therapist broaching a topic. Participants delineated situations where they either confronted their client, broached a topic or directed exploration of an unaddressed area. These interactions entailed the therapist being the bearer of bad news, confronting a client about an affair, and discussing an experience that was going unaddressed in the session.

At the start of Z's session with his client, Z brought some bad news to his client. Z had met separately with his client's spouse and she had no interest in reconciliation and wanted to proceed with a divorce. Z's client was clearly upset and responded defensively by saying there's no point in continuing with sessions. Z expressed how he was "doing a lot to regulate" himself because his client was "angry and has shut the door." He depicted his concern for his client in finding a way "to help him feel safer and softened since he's been clearly disappointed:"

> From his point of view, it's a rupture in our relationship. He was hoping I would convince his spouse to reconcile. I haven't delivered the goods that he wanted me to. So it's kind of like, "You're a very good counsellor," so flattering, "but you didn't do it." This is challenging. The way I think about it, my task is to help him deal with his feelings about this rather than argue with him or try to do any grief work around the end of a marriage. My task is really working to repair connection because he is, as I have said, disappointed hugely.

Z's client was having difficulty taking responsibility for how he had hurt his spouse. When Z confronted his client about having had an affair, he observed his client "drop his head, eyes and face" and noted that his client felt "ashamed." This authenticity engaged Z. Z shared that his response was "confrontation in service of self at best," something that he believed had not been explored much in the AEDP model. He conveyed:

> I consider him an abusive man. You can put them in that category. My task, very consciously in my mind, is to find the part of him that has remorse, shame, feels sadness in response to what he's done. My job is working for him is to find that "self at best" part of him which is to

> face that and to make it safe for him to eventually face that. I'm taking the older, wiser, other position. I'm inviting him to grow up. My connection with him here felt like wrestling. He wants to stay with defense. I'm saying, "I see your defense and I see that you're more than that." It's a threat to let go of defense, so at my core, I have compassion for how vulnerable that is. But I mean we're down there, we're working on it and we're together. The man that feels sadness, the man that is ashamed, those in my eyes at this point are all his self at best and they're exposed. So I'm not giving up on him.

In the excerpts above, confrontation was described as "wrestling" and Z emphasized "not giving up" on his client in the midst of the disruption, working to access through Z's gentle confrontation, his client's "self at best" which are the vulnerable parts of his client.

In his supervision group, L had shown a recording of a session of his work with his client. The next day, L's client arrived at their session stating he had blacked out over the week end after drinking to excess for the first time in a long time. L wondered if the showing of the tape (which occurred the same week end when the client over-drank) may have negatively impacted his client and L explored this with his client. When his client responded that it's a possibility, L experienced "a micro-moment of shame" and concern that he may have caused his client distress. L stated:

> He reassures me that this wasn't the case. On a very subtle level, he has just taken care of me and this foreshadows a bigger disruption later in the session.

As the interaction progressed, L's client expressed curiosity about the showing of the tape and L shared with his client how his supervision group responded positively to the taped session. L reflected on how he had taken a chance to ask his client about the showing of the tape:

> Sometimes we build relationship by leading, sometimes by following. I needed to reach and ask him if he wanted to hear about the feedback on showing the tape. I think it's fortuitous that I did because otherwise there would be this "hanging back curious" that I wouldn't have known about. And it's in the room. I mean, I've seen this man for three years and we have had a new relationship event. I took our very intimate work to a group. He allowed me to do that. He trusted me. He's offered a gift in some way for me.

L's experience with his client was not confrontational as was the case with Z but rather, moreso about broaching a topic that had not been addressed. L spoke of "reaching" or otherwise there would be this "hanging back curious" in the room that would impact his work with his client. The

discussion of the tape and his client's reassurance that L hadn't caused him distress also foreshadowed a bigger disruption later in the session.

Theme Six: Disruption Originating with the Client

Participants described the following aspects of disruptions that occurred on the part of their clients: client trying to please, client disclosure of what didn't work, and defense in client as disruption.

6.1. Client trying to please. Participants relayed experiences where clients responded to try to please the therapist, an experience that participants depicted as inhibiting attunement.

During X's session with her client, X noted an upward inflection in her client's response that didn't feel genuine and led X to feel that "she's giving me the answer I want to hear." X distinguished this response that felt less "genuine" and therefore less connected from those times when her client gave the same response but with a gaze that acknowledged she understood her.

Y's client came in to their session unsettled from having had an argument with her daughter. She began the session by showing Y a series of sketches she had done with her child. Having been aware of the argument that preceded the session, Y perceived in her client's actions her client telling her, "See I am a good mother, I spent an hour and half drawing with my daughter." Y was also aware that drawing together was an activity that Y had suggested her client do with her daughter as a way of engagement. Y conveyed:

> I'm feeling a lot of compassion and admiration and also that the connection is one of her trying to please me and so that there's a problem in our connection at this moment. And also I'm aware that there is a lot of shame coming up for her and I know that this can very quickly spiral into dysregulation with her. So I'm feeling cautious that we might be on the verge of some dysregulation.

Y shared feeling a lot of compassion for her client while at the same time realizing there was a problem in their connection when her client attempted to please her. She captured the complexity of the disruption when she perceived there to be underlying shame and dysregulation.

6.2. Client disclosure of what didn't work in a session. Participants divulged experiences where their clients confronted them about what hadn't worked in a session.

As described earlier (see themes 6, 6.3.), B had begun her session not feeling quite connected with her client, having felt like "there's something more here." B's client revealed that she had been

defensive in their last session together because B had been briefly distracted and attending to other business at the start of their session. Her client's confrontation helped B piece things together:

> There's a little bit of, "Oh no, what did I do wrong?" You know, but totally willing to hear what's going on and grateful that she's noticing that she wasn't willing to work last time. Hence those short notes and that sense that there's contradictions here and why I didn't get traction the time before.

B initially experienced this disclosure by her client as a disruption in their relationship, but one that inevitably led to a deeper processing of the client's defensiveness and a strengthening of the relationship, an experience that will be elucidated in the section on repair.

In Y's session, the video recording of their therapy sessions was the subject of disruption. During their session, at a moment when Y's client was attuning to her sadness, Y checked to see if her client can "stay with" the sadness longer, and in part, offered her a way out, "You tell me when you feel you just don't want to stay with this process anymore and that is absolutely fine." Y's client responded by disclosing her uneasiness with being videotaped. She confronted Y and suggested that Y does "deeper" work when they are being videotaped and questioned Y's motives. In reflecting on the transition they are making together as a dyad to the recording of sessions, Y conveyed:

> There is a growing intensity in the work that is coinciding with this and this is only the second session that we've been taping which I think in my experience was also serving to keep me more AEDP like. She's right. It's like we're taping, this could be AEDP material. And there are other factors operating as well.

In response to her client's concern, Y acknowledged the impact of recording sessions. Y's client took a moment to recap as if to ask, "Where are we? What are we doing?" In this moment of disruption, Y experienced her client as being at a cross roads, right on that edge of experiencing very deep sadness. She reflected on her client's expectations for therapy:

> She came to me because I was a Jungian analyst. . . . but this isn't just about exploring the meaning of archetypes. We really have early relational trauma that we're working with and it's been kind of hard for her to admit that. That's kind of typical I think people come to Jungian analysis. So "I won't do therapy, I'll do Jungian analysis." It's a spiritual bypass and we're going there here and now. There's the flirting with AEDP and the taping so I'm really getting more in your face psychotherapeutic.

The disruption was not just about how Y's approach altered to being more AEDP-like when sessions were being taped but also about the expectations Y's client had for therapy (i.e., Jungian analysis) and specifically spiritual bypass from early relational trauma. Y responded by acknowledging the impact of the taping while also exploring the other factors at play, (i.e., that they are working with early relational trauma).

L's client similarly disclosed what wasn't working in the session. When L shared with his client how people in the supervision group where he'd shown their taped session had celebrated how he and his client were both growing in their capacity to be together, and L explicitly expressed feelings of pride for his client's growth as well as for his own, L's client initially felt happy and close to his therapist, but something about that was "a little scary" for him. As the session unfolded, L's client further disclosed that he had been aware for some time that L was also growing through their work, and that something about that thought "hooked" him and he did not want to feel responsible for his therapist's "growth," but that he had previously been afraid to talk about this with L.

In exploration with his client, L became aware that when his client feels authentically connected to his own feelings and closely connected with L, another feeling that he knows "too well" comes up for his client: feeling responsible for others and fearful of losing himself in the connection. In their work together, L and his client explored how through much of his client's life, his client had to be responsible for others, including his parent. L assisted his client to make sense of his fear in the context of early attachment experiences of being in relationship. L described how his client was experiencing an intrapsychic rupture within himself, that when he gets close, he gets scared. "Unbeknownst to me," L recounted, "My focusing on my own growth here as well as that of the patient was a misattunement." L conveyed, "We are launching into a cycle of rupture and repair."

X's client was departing for the summer. When X invited her client to explore what it might feel like to not have contact with X (i.e., to not have therapy sessions) during the summertime, she questioned X's motives. X saw the distress in her client's eyes as they widened and noted how her client appeared scared:

> I was just sort of wondering what feelings would emerge as she imagined making contact? Does that make her feel anxious? Does that make her want to go into an avoidant attachment pattern and, you know, that kind of stuff. But, I felt anxious and worried that I was not

> explaining myself well, that she's going to be experiencing me as manipulative or confusing or indirect in my communication and I really wanted to be clear.

X conveyed how she felt "anxious" and that she could feel her "stomach tightening" as she attuned to the distress and discomfort she had caused her client. At the same time, X recognized the client's "confrontational relational style" as a "typical pattern for covering up her fear." X's client not only questioned X's motives but then questioned herself and her decision to not maintain contact with X as her therapist during the summer. X reflected on the worry and guilt she experienced in causing her client distress:

> That was a big spike in anxiety when she said I just want to know if you think I should do this? Or are you recommending this? And she was back at that place where she was hearing an indirect request from me or me trying to talk her into something or manipulate her into something and she was talking about being controlled by me.

X tried to explain and reassure her client that she did not have an agenda and that they do not have to talk about this further. X recounted "trying to pull those words back or take it all back." She conveyed wanting to pretend that it didn't happen and "really wanting to erase it or fix it rather than repair it." While the rupture seemed subtle upon watching the recorded session, X denoted how the rupture felt "really big" for both of them. In the session, X continued to reassure her client and validate her client's experience of what she needed for herself. However, X relayed that it didn't quite "feel right," that although her client expressed certainty about what was right for her, there was "still a sense that I'm trying to talk her out of it, and trying to talk her into meeting on the phone." The incomplete repair led to a missed opportunity for deepening of the client's experience, a situation that will be depicted further under the section of repair.

6.3. Client defense as disruption. Participants outlined several experiences of working with their clients' defenses and experiencing this defense as a disruption that inhibits access to a deeper attunement to affect. Client defenses as experienced by participants included feeling "held at distance," "held at arm's length," blame, focusing on a narrative to the exclusion of affect, dismissing one's own feelings, spiritual bypass, a sense of loss/leaving the relationship in the moment, and meeting the therapist's attempt to attune to affect with defense. Participants depicted these disruptions as a disruption from intra and interpersonal intimacy.

X recounted how her client shifted from experiencing a sense of sadness to talking about her goodbye party. In this moment of defense, X experienced a distance that she described as "losing

her," or that her client was "drifting away. . . . looking away." X struggled to find the "emotional truth" in what was happening for her client. When she could not access the emotional truth of her client's experience, X expressed, "It's hard for me to know what to reflect or where to be with her." Feeling "held at arm's length by her client," X divulged:

> She's rubbing her neck or her forehead a lot. She does that a lot when she cries, she almost never takes a kleenex. She uses her sleeve or her hands and I have the sense of her being very self-contained and self-soothing and I feel a little held at a distance. Like, it's hard to get in really to help soothe her. She doesn't really want to let me in. So, I get a sense of being held a little bit at arm's length.

In the aforementioned depictions, X encapsulated the sense of distance in their interaction through descriptors such as "self-contained" and "self-soothing" as well as when X conveyed that she was attempting to find the "emotional truth" but couldn't quite access it.

Z's client was having difficulty accepting responsibility for a divorce with his spouse and defended himself by blaming his spouse. On working with his client's anger, Z expressed agitation and reflected uncertainty in the moment on how he will address his client's "immediate quick defense" as well as his "blaming and expressive anger." Z's client conveyed settling things in court at a judicial hearing with his spouse and as he said this, Z observed his client "tilting his head," and noted in this somatic movement, a foreshadowing of "shame and emotional defeat." In this tense-filled moment-to-moment tracking, Z described the "pain in the room" that his client exhibited and that Z also experienced. Watching his client "pushing" his pain "down as hard as he can," Z articulated his sense of sadness. He described his desire to let his client know that "he's got a supportive friend in me rather than I'm just one of the string of people who doesn't deliver what he wants." Z accentuated that the situation was complicated in that his client had "historically been a controlling, dominating person" and that he was "a very powerful man in his business world." In this context, Z spoke of "trying to find a way in. . . . a bridge." When Z's client minimized his responsibility and admitted that he was "bad" to his spouse but not "as bad as other men are to their spouses," Z described his struggle in working with his client's defense:

> There's some acknowledgement in him but his anger and his defense is keeping him away from what's underneath. There's a lot of blame there but there's also the other part that's saying, "I'm bad." I think there's a part of him that is connected with core affect. That's a glimmer of something. . . . While I have some sense but I'm not exactly sure how well it's

> going to work. I mean he's saying, "She's giving up, she's a bad Buddhist, therapy is failing me," so there's plenty of pretty destructive comments to me.

Feeling "unfairly victimized," Z's client "intensified the blame" at his ex-spouse, denying things that his spouse had shared. Z was unsure how to respond and struggled to feel hopeful amidst his client's defense. Z conveyed feeling "perplexed" as to how to "get back into a good place."

> I'm amazed how powerfully he moves back into defense and reconstitutes denial of things he'd already acknowledged to me. . . . There's a certain way in which I'm pressured and the result of that pressure is that I have to trust, make it safe enough for him, bow to his view even if I don't agree with it and challenging him only in the context of his feeling that I'm working on his behalf. I'm not delivering the goods so it's going to increase the distance in him.

The above quotes by Z captured the experience of staying the course in the face of client defense and disruption. As Z poignantly conveyed, how can he let his client know he has a "supportive friend in Z" rather than being one of the "string of people who doesn't deliver what he wants?" This notion of "staying the course" will be elucidated under the theme of repair.

G described her client as defending against affect by anchoring herself in "thinking things through and creating a plan." In this process, G's client didn't allow herself space to attune to what's happening underneath. Her client's focus on a solution, G recounted, bounced her "out of feeling what we are doing in the moment." G observed that rather than "getting through this bottom-up," her client came "out of connection" to think her way through the experience. G portrayed how her client's defense prevented her client from attuning to her affect but also prevented G from connecting with her.

B similarly relayed how her client's defense impeded and disrupted connection and attunement. When her client disclosed to B how she felt neglected by her (i.e., by B's attending to other business at the start of their last session,) B's client dismissed her own feelings. B encouraged her client to stay with the emotional truth of the disruption, to "call her back," and to explore how "dismissing affect" was a protective defense:

> There's a complexity about her that is profoundly able to departmentalize and just knock this away and so I'm just very gently wanting to stay with, "This is real and this is important and what we're doing here is really important." What happened between us, the disruption, is real. And our trying to find our way back to each other is real. Wanting her to stay with that.

Instead, B's client moved away from her affect to talk about how she needed to commit to therapy even if something goes sideways. B reflected on the disconnection she experienced and attempted to make sense of her client's conversation. She relayed, "We just had a moment of connection and I think there's dysregulation around her but I'm not realizing that." B eventually realized that her client's "headiness" was her anxiety about "bringing herself into the moment," and doing "something new."

Y delineated how her client used spiritual bypass as a defense from inter and intrapersonal intimacy. Y's client, who was an experienced spiritual practitioner, would tend to move "negative energy into something positive" and "invoke images of the deities and make sacrifices and offerings and go into a high level to purify in these moments." Y was aware of her client's tendency to steer away from her negative affect through spiritual purification. Rather than "purify" the negative energy, Y encouraged her client to "to let it in" and "not judge it."

> I think the primary awareness is excessive guilt about negative emotions, that's how part of spiritual bypass works. I'm aware that we're very likely to have some intense shame and guilt and punishment coming quickly if I don't do something to acknowledge that that may happen and try to get in before it happens. . . . I'm tracking her breath, her voice, her pace. . . . My sense is she's got a vigilant gaze here and it's a desperate vigilant gaze that she's trying to hold on . . . and I am mainly tracking the gaze.

Y identified the self-judgement in her client as a "disruption brought on by her internal judge." When her client experienced shame, Y extended an invitation, "Can we let this judgment go?" As the moment to moment tracking of her client's somatic experience unfolded, Y's client disclosed feeling "a force field of energy." This force field of energy, Y denoted, shielded her from the intensity of her employment and also prevented her from accessing her affect. Y reassured her client that she's confident the "shield" will be there when she needs it:

> Her force field is a defense and defense is a disruption from core affect. It's a defense against intimacy. And her defenses keep bringing her out of core affect and that's the disruption, and I'm there. I'm her anchor. That's why this work is so amazing because how else would one get through this.

The above excerpts by Y articulated how being her client's "anchor" helped guide her client through intra and interpersonal defenses.

G imparted her experience of working with her client's anxiety, a defense G experienced as inhibiting connection and intimacy. G experienced this defense as a sense of loss and leaving the relationship in the moment. When G made an analogy, she could see that her client "wasn't on board with it." In an attempt to connect with her client, G inquired about what her client was experiencing in the moment and noted her client's "agitation" and "anxiety" as G tried to "feel her way in with her." G had the awareness that her client was "not really there." A vacant look on her client's face told G that she was "listening, but she's not really present with me." G elaborated, "it's that recognition . . . we're not in the sweet space of being in-sync . . . she left me, and I want to get her back." G's description portrayed a sense of deep loss of connection that accompanied her client's defense.

Along with the preceding experiences of client defenses as disruptions, participants additionally reported times when they attempted to attune to their client's affect and felt that something wasn't quite right or that their attempts to attune to affect were not being received. They recounted feeling disconnected to their client during these times.

For example, on a verbal level, G was seemingly connecting with her client. G asked her client questions about affect and her client was responding, appeared introspective and was attempting to convey her experience. But G recounted not feeling "attuned" to her client and that she was "still trying to find her." G elucidated that "although she looks like there's a lot of fear, I don't know if she's feeling a lot of fear." G further described the sensation of not feeling connected as her client "goes into her narrative" about her week. The phenomenon of G's client being disconnected from one's own internal experiencing of affect and how G experienced that disconnection as a disruption in the dyad was encapsulated by G's words, "still trying to find her." When G asked her client what is happening for her in the here-and-now, G noted her client's "resistance to being attuned in the moment:"

> She obviously hears me. I can hear her, but she's still far away in a certain sense to me. She says, "I'm anxious," and there's a way in which she talks about it as opposed to experiencing it. Even though she says, "My stomach's in knots," it's almost like she is disconnected from her embodied experience. And I am feeling that disconnection. . . . When I'm working with her - that's what I feel. There's all these places that are just - she's starting in and out all the time.

G conveyed the moment when she acquiesces and attends to her client's narrative. This type of "attending," G conferred, was different from the experience of attunement which she portrayed as "centering in the heart." G's session with her client "starting in and out all the time," highlighted the sensation of disconnection that participants experienced when clients had difficulty receiving their therapist's attunement to affect.

B reported a similar situation of sensing that something "was off" with her client but "not being quite sure." When B's client began the session with jokes about her retreat, they both laughed together, an experience B described as "moving away rather than towards." B articulated a sensation that something didn't "feel right," that this laughter felt different than having "a casual conversation" as they have done at the beginning of sessions. B was left pondering "when are we going to get to what's really going on here." This notion of "moving away rather than towards" illustrated the feeling of disconnection that both G and B experienced as they attempted to attune to their client's affect.

6.4. Client dropping down and coming up. Participants conveyed how their clients undulated between defense and core affect. They described how their clients "dropped down" and touched upon their affect and then "came up" into defense.

G portrayed the experience of her client dropping down and coming up as a "sense of loss." G's client was challenged to attune to and stay with her core affect. This experience, G imparted, felt like they couldn't stay with her client's feelings "for longer than a nanosecond" before doubt emerged. The interaction, G affirmed, felt like a "loss of that connection, loss of the sweet spot," as well as a sensation of being out of synch:

> Come back. We were there. Let's just really take that and embody it, and be there….
>
> I don't play tennis, but I have played tennis. And you know, when you hit the ball in the right place at the sweet spot of the racket? It bounces right, it goes right, it's like that, you know. I'm always trying to be in the sweet spot. And so when we move up - shoot - let's go back. It doesn't feel in sync.

As the session progressed, G's client described her discomfort and self-judgements around experiencing her affect. When G attempted to explore this discomfort further, her client changed topic, a phenomenon G denoted as building "a scab to look after herself." G recognized her own body language shifted because "we're back up away from her affect," an interaction she portrayed as "anxious attachment:"

> We have that connection. She looks, she drops down. When I ask her how she's feeling, she goes inwards to see how she's feeling. There is that sense of hope that sense of connecting, and then her response moves away from affect describing her story. She's really wanting something from me, but won't connect with me. And when she does connect with me, it runs away very quickly.

In her persistence with her client to explore affect, G described a sense of "fragmentation" and being in an "unproductive place" with her client. Aware that they have 10-15 minutes left in the session, G denoted wanting to "come back . . . drop back down and make some connections" because they seemed to be "going into this swirl again, that is, not as present, not as grounded, it's fragmented, it's lots of three-quarter sentences." The sense of loss and disconnection was underscored when G conveyed there is a "sense of hope of connecting and then her response moves away."

Y also experienced a 'dropping down/ coming up' from affect with her client, an experience that Y described as a disruption from intrapersonal process. By inviting her client to 'unravel the narrative…to take the armature away' and to be in the raw core affect of her experience, Y accompanied her client to the "the edge" of her window of tolerance of affect. She supported her client to "notice the sadness and stay at that edge." At the same time, Y conveyed to her client that they "can stop this anytime." When Y's client noticed "a quality that's different in our work together," she inquired if they are exploring a deeper affective experience because Y wanted "to use this material." Y imparted:

> I'm aware that yes, you know, there's a different feeling here. This is being taped– this is such great work. I want to use this material and I want to say, you know, you're right . . . this taping is affecting things. Also that's not the whole story. We're in that place of disruption and yet we're still connected. It's a disruption from that intrapersonal process, that journey we're on together to go deeper.

Y contextualized the dropping down and coming up from core affect as both an intrapsychic experience, i.e., a "disruption from intrapersonal process," and an interpersonal process, "that journey we're on together."

Theme Seven: Incomplete Repairs

Participants delineated situations where a disruption had occurred but the therapist did not explore the core affect that underlied the disruption nor the underlying attachment issue. This

resulted in the awareness that the situation had not been "repaired" and that things were left "incomplete."

This theme is best recapitulated by X. As presented in previous sections (see 5.3., 5.4., 6.3.), when X invited her client to explore her feelings about not having contact with X for the summer, X's client misunderstood this and wondered if X was trying to control the situation. X attempted to repair the disruption by clarifying what she meant. In the clarification, X noticed her client's "eyes got less big" and that her client looked "less hurt in that moment." X conveyed feeling "a little bit of relief that we are back on the same page, that she understood me" and at the same time wondering "what damage I'd caused or what rupture I'd caused." Rather than stay with the myriad of feelings they were both experiencing in the dyad, once X had clarified what she had meant, she changed the subject with her client:

> I remember asking about her boyfriend and feeling a sense of relief to get off the topic of us. It felt less charged. I felt less cautious or worried. And I can see myself talking louder and feeling more engaged - a little bit less anxious or scared myself. Just taking the focus off of the two of us and the mistake that I made and the rupture I had caused. It's the same topic, relationships, but it's just that we are talking about her boyfriend instead of me – it's a little easier for her, and me.

X worried that had they continued talking about their therapeutic relationship, that they would "continue spiraling down this misunderstanding," and that the more convinced her client would be that X "had a secret agenda." This interaction left X feeling "anxious and worried" about the disruption and about the "path we were going down." Sensing that this was "potentially a bad direction," X shifted the focus "as a way to correct that path." Since this was the last session for the next three months, X did not want her client to leave the session on a "note of her feeling distrusting of me or being dysregulated." By shifting topics away from the disruption, X hoped to "start us back on the path of something where we would connect again." However, by the end of the session, X was left feeling concerned about the disruption she had had with her client at the start. She approached the topic again with her client in a way that X recognized felt like a "leading way of revisiting the topic" as if to ask, "Everything is okay, right?" Despite having acknowledged the disruption, X conveyed, there wasn't a lot of space for her client to "say anything but yes." This left X feeling "not a hundred percent solid that we really repaired it." Some of the factors that X

recognized contributed to the lack of full repair was feeling tired at the end of the session, her own anxiety and taking care of herself, along with the lack of time:

> There's a layer of just looking at myself at the end of it and remembering that I felt tired. And felt like there was a lot going on inside me and there was a lot going on between us in the session. I felt I could ask this or that and I just don't want to. I was just tired. I just didn't want to explore that with her right now.

X depicted the many choices that therapists need to balance in addressing disruptions, including concern for further dysregulation in the client, timing, and therapist self-care. At the same time, the incomplete repair left X feeling uncertain and with the awareness that there had been a missed opportunity to deepen the process.

Theme Eight: Disruption in the Repair

Participants' experience of repairing a disruption was not a linear process but more akin to circular or a series of spirals. Participants experienced this nonlinearity as further disruptions in the process of repair. These were: therapist trying to connect and staying the course.

8.1 Therapist trying to connect. As participants tried to repair a disruption with their clients, they experienced a period of trying to find their way back into attunement with their clients.

When X attempted to repair the disruption with her client, X relayed not feeling "very connected" to her client in that moment of repair and not "feeling her with me." X attempted to connect through "a little joke" and self-disclosure of "fucking-up." Upon reflection, X realized that it didn't land with her client, an experience that left X feeling "sad and lonely" that "I'm not getting her" and that she can't "find her way back in." X imparted feeling "left out or held away in that moment . . . distant. . . . and hoping and wanting to reconnect." In an attempt to "find her way back in," X changed the topic again. She revisited her client's tears about her boyfriend because "that was the most recent moment where I felt connected to her." X denoted, "trying to go back, hit rewind or something and get us back there." These descriptions, "trying to go back," "finding her way back in" and hitting "rewind," underscored the experience of trying to re-connect and the non-linearity of the repair process.

When G attempted to metaprocess the disruption with her client, her client responded by "going off again into her narrative" and defending against what she was feeling in the moment. G elaborated that "we have a moment of connection, so we come back, and then she goes off again… and I'm trying to attune." Mid-session, G reflected on her internal struggle as a therapist, "we're still

disconnected. . . . we are not any closer to any kind clarity" and "we have to find something that she can hang onto." G's experience portrayed attempts to attune to her client, her awareness of being disconnected and the pressure of time left in the session to process the repair, i.e., "something she (her client) can hang onto."

B described similar experiences of disruptions in the process of repair. In reflecting upon the disruption, B divulged feeling complicit in the original disruption and apologizing for it. However, her client did not initially receive B's apology. B denoted of her client, "She's a hard one right here. I'm willing to say, 'What can I do better?' And she's not willing to take it yet." The unwillingness to accept her apology, B recognized, was "important" and exemplified her client conveying that the apology was "not enough." B added that although her client may not know "what the right thing is," she was in the experience of "I'm not sure." The complexity of the repair, B conveyed, lay in how she felt complicit in the disruption. B expressed feeling like she did something "to set this off" and as a result leaned more toward what she could have done as a therapist to make it up. In reflection, B expressed it would have been more helpful to "really explore what's so hard about the experience" for her client. B "misjudged her client's ability to roll" with B's apology because it had more to do with B "being off." In the repair process, B recognized the need for B to "stay the course" and persist in her apology:

> That moment when I said, "This is really important," and she responded, "Yes, I'm glad we're talking about it." That was huge. That marked the repair. It's not a linear process. It's not like repair starts and okay you're there. And it wasn't like she didn't receive my apology. I think that (the apology) landed and I think that went in. But it was a cursory lip service to it. She wasn't really expressing and meeting, attuning to my level of disclosure. I do think that it matters to her that I tell her I feel regret and that I don't want to do that, and that I persisted in my apology.

With B's persistence to "stay the course," B's client accepted her apology and this was the first step in exploring what underlied her client's defensiveness. As will be explicated in sub-theme 3.3.2., there were underlying attachment issues at play. Even so, B conveyed upon reflection, that she would have wanted to metaprocess and deepen the repair by exploring with her client "What is it like for you to accept my apology?" B felt "anxious about really wanting to own" her part and was overly focused "on making the repair." Consequentially B realized she did "not check carefully to see how she (her client) was receiving my repair." The experience of not feeling in attunement

during the repair felt saddening to B because she was "really trying to reach her." B articulated "not having enough dual awareness" to see how her client was "struggling with my apology." B imparted:

> Her voice sounds flat when she says, "I accept your apology." She dismissed it. So to really say, okay yeah. "And how are you doing with my apologizing? How are you doing with me sharing this vulnerability with you?" That feels like it would be very useful right here. To build that capacity about "I don't really know what to do with you being vulnerable." Because I want her to be able to stay open to our work and if she closes down the apology then a part of her is closing down something between us. And it concerns me.

B considered what stops her from exploring how her client received her apology. She reflected on helping her client remain within the "window of tolerance" by not "pushing too far" and "walking a fine line:"

> You know the right brain goes both ways and so I think sometimes I attune to her defense rather than staying with my depth, as a way to try to regulate her. Ok I'll go to the playground if I can't go the vulnerability route. Vulnerability is the edge of this round. But I remember trying to get her to express anger with her dad at one point where I just went too far and then she got dysregulated and wanted to leave. And so I've had this dance with her if I push too far, we are out of the window of tolerance. It's walking a fine line.

B is conscious of keeping her client within her "window of tolerance" and at the same time is aware of how attuning to her client's defense both disconnects B from staying with her own depth and from accompanying her client to the edge of vulnerability.

8.2. Staying the course. In repairing a disruption with their clients, participants described their attempts to "stay the course" with the repair and assist their clients to access the core affect underlying the disruption. This theme was best exemplified by Z's session with his client.

Z's client had hoped that Z would have been able to help him reconcile with his spouse. He acknowledged his client's disappointment and worked with his client's defense, (i.e., blame) to help his client feel safe enough to explore what's underneath the blame. In the actual session, Z apologized to his client and empathized with the irreconcilability of the marriage, a phenomenon Z described as "pressuring with empathy." Z conveyed to his client:

> I'm sorry that you feel so let down; I know it's hard too for a relationship and a marriage to end, I know that very well. I've been through it myself. Sometimes things are irreconcilable

> and it's very heartbreaking and it feels empty and frustrating and maybe even confusing for you.

During the apology, Z noticed tears in his client's eyes and reflected back his client's sadness, inviting his client "to put words to his tears:"

> "Everybody knows the world is unfair, I didn't know it was so unfair," that's what he expresses his tears would say. I would say this falls under pressuring with empathy. Something shifted right here. His countenance. He's dropped it down into touching primary affect, but the primary affect is not anger at all. It's sadness. I feel like we can go somewhere. I'm touched by his response. I know that there's an opening. I'm feeling creative in my ability to reach underneath defenses with someone who's so, well you know, there's a lot of misogyny here, there's tremendous irresponsibility. There are a lot of things with good reasons to dismiss him but I haven't been sucked into any of those because I don't believe them. I know that he's responding to my empathy because of the sadness. The reason he looks away is that's how he's regulating. There's a softening, there's some resonance happening and I feel like, 'Okay, we're back.' There's a rhythm between us.

As the session continued, Z's client responded defensively blaming his spouse for being a "bad Buddhist." His client's retreating "into his philosophical system in that branch of Buddhism" and "blaming his spouse" was his client's "protection." Z stayed the course with his client's underlying affect:

> He says, "The problem with women today . . . she's just out for money . . . I am disappointed in her spirituality, she's just a waste." I want to deepen that, make sure that I understand from his point of view so I'm working the relationship and dismissing all the content because he keeps going back into defendedness and blame. I think it could be, for most female therapists and I would say a great majority of men too, a really difficult invitation not to engage with, you know?

Z's client asked that Z share what his spouse had told Z in their individual session together. Before sharing this information, Z slowed things down and ensured that his client felt Z's support and that his client felt Z was "with him." Z disclosed, "You came to me and you asked for my help, and it's important that you not feel let down by me." In reflecting on the session, Z explained the importance of reinforcing the relationship with his client before giving his client more information:

> What I'm doing is slowing things down. It's somewhat like a transinduction in our pacing to try to slow his neurological system down. I'm doing that at this time because, again, in reflection, I think there was in me on some conscious level the need to metaprocess his feelings after I have just said, "You came to me for help. It was my job so I want to be able to help you." Nothing's going to happen that's real until he feels our connection again and until he's feeling his affect and I was able to stay with that. Also, I already sniffed that the primary emotion here was sadness. Sadness is a big part of it but there's more besides that and I don't think that more is anger.

In the session, Z discussed with his client the impact of his client's anger on his spouse. Z's client dismissed and denied that he had been angry with his spouse. This response was "disconcerting," Z conferred, because his client had previously acknowledged his problems with anger. Z imparted, "You can see he's in the ocean, when you're with him it's like riding the big swells, sometimes up, sometimes down on the trough. That's what it's like, it's kind of riding it out." Z's descriptions of "riding it out" like the big swells of the ocean underlined the theme of staying the course. As elucidated in the quote above, "Nothing's going to happen that's real until he feels our connection again and until he's feeling his affect and I was able to stay with that."

Theme Nine. Processing Repair to Completion

Participants delineated how they processed repair toward resolution, toward understanding, and/or toward further insight. This process of repair entailed: exploring underlying affect; exploring the underlying attachment issue; attunement in the repair; laughter and playfulness; strengthening the relationship, and post-repair

9.1. Exploring underlying affect. Participants conveyed how they worked to repair disruptions by acknowledging and exploring underlying feelings.

Z attempted to move the conversation with his client away from blame and back to their therapeutic relationship by exploring how his client felt let down by Z. Z conveyed this exploration as "pivotal," because his client replied that he felt "let down" by both his spouse and Z. In this exploration, Z grasped that his client felt "betrayed" and "disappointed" by Z:

> I was supposed to do the job. He hired me to do a job which was to get her to agree to a reconciliation. When he says, "Yeah, I'm disappointed with both of you," actually, I'm relieved to have him speaking the truth because then we can get back into something real. It's less blame and more of a truth sense.

In this truth sense, Z recognized that his client's underlying affect was more than "anger," it was disappointment. This disappointment, Z elaborated, was from an "attachment frame" and "a word that was more about loss and failure of connection in one person's experience." In the session, Z attempted to "reach for the softer feeling" because underneath the anger, there was both the "let down," and the "experience of our relationship." This experience of their therapeutic relationship was what Z underscored as "key" because it affirmed "the language of attachment." When Z's client responded by "making a number of invitations" for Z "to argue with him or adopt his point of view," Z persisted in attuning to his client's underlying affect and "acknowledging the feelings that are underneath the attack" with the aim of moving through the repair. Z resisted the invitations by his client to argue with him and instead invited his client to "drop down." Z conveyed:

> I'm thinking in attachment terms, to let him know that he's not alone at being distressed. I'm the bearer of bad news and "counselling's a waste of time, so I might as well leave now." How do I get underneath? I'm also going for the meaning here. Validation as a way of repairing his experience of the rupture.

When Z validated his client's underlying hurt and expressed that his client "probably judged himself more harshly than even his spouse could," his client softened and disclosed his pain, a pain that his client stated he had never shared with his spouse. Z affirmed feeling connected to his client in this softening, "He's staying with his affect, he hasn't jumped into defense. It always feels good to have a truth sense in the room." This softening and connection, Z denoted, was "a coordinated relational experience" that felt like a "bridge." At the same time Z conferred that "it's not permanently repaired…which no repair ever is." Z described this awareness of repair as a "bridge" and attuning to underlying affects as "attuning to the truth sense." Significantly, he also depicted the notion of repair as impermanent, that there's always more connections to make, more awareness to be had, and in this case, a "reconstituting" to be out in the world.

B's client shared how she shut down internally during a counselling session when she felt B was not attending to her. Her client was able to articulate that she "wasn't willing to do any work if B was not going to attend fully to the session." Now that her client had "labeled that there's a defense," B needed to know more about "what to repair." B sought out what might be underlying the disruption by validating her client's defense and exploring further. She asked, "I'm really grateful and glad that you're telling me and I wonder if we peel back and undo the defense, what you feel about me being busy?" In this dialogue, B felt more connected to her client because they are "talking

about something that's really happened" between them. At the same time, B still wanted to "understand the impact of what happened." In the aim of repair, B conveyed "inviting more" and wanting to explore and understand the feeling that was "under the defense of shutting down."

9.2. Exploring underlying attachment issue. Participants delineated how they attempted to repair disruptions by exploring underlying attachment issues. They did this by allying with the client against his/her defense, providing corrective emotional experiences for early attachment trauma, repairing old models of other and models of self, and by forming new trust.

G's client had difficulty being vulnerable with G. When G offered her help, she touched upon the underlying issue of aloneness. G explored what it was like for her client that G wanted to be there for her and "be with her." Her client responded that she felt "more alone." G elucidated:

> She says that I'm in front of her and she can't let me in and I let her know that I want to connect and 'undo that aloneness.' And I think that's part of why she keeps me out in the way she does. She really believes no one can help her. She touches down and comes up. Because it's hard for her to go in there and believe that someone's going to help. So things have really shifted now.

G felt attuned with her client in that moment, that although there was resistance, her client was talking about the aloneness and "everything is on the table." G imparted feeling a "togetherness," "on the same page," and "hopeful." She underscored that it was this process of togetherness that was going to take them "to something that can be healed." The underlying attachment issue of aloneness was poignantly depicted when G stated, "I'm in front of her and she can't let me in."

In B's session, when her client expressed that she wanted to terminate therapy because she was angry and felt shut down, B conveyed wanting to find the "kernel of truth" in her client's experience, the part "inside me and her where I let her down."

> I am trying to get more of the feel for what makes her shutdown when she feels I'm not here. So I think I'm just feeling into that, just wanting to gather myself. She talks about going on this retreat, and that she's going to be convinced that Dharma's her answer and she doesn't need therapy. I want to go to the place where she's saying that there's something that I did that really disturbed her. So I want to really find where the kernel of truth is in that? And really try to meet that before trying to say whether or not she's going to quit therapy or not. I feel that there's something that's really important to find inside me and her like where I let her down?

B accentuated that her client "has such a history of disappointment" and that if B has disappointed her, she would like to get to the "core of that and let her know her worth to me and my commitment to her." When her client spoke about the retreat, B surmised that her client was saying that she could go on that retreat and stay away because she's not "feeling connected" with B. B articulated that repair was not only about apologizing but about the process of exploration and giving voice to her client's feelings:

> There's a part of me that would want to go with, "Oh I'm so sorry. I didn't mean to type of thing." Or "I didn't da-da-da . . ." but part of me is riding the edge of wanting to keep enough tension around it so that she can express more feelings to me about what she felt. I'm in that process of wanting to give that voice.

Further exploration revealed the underlying attachment issue at play, i.e., her client's need to protect herself from disappointment. B described being in a "discovery process together" and how their exploration shifted from "talking about the apology" to actually talking about her client's "need to protect herself, to guard." B's apology was not received because her client's "guard" was there. This enabled B to facilitate "defense work" at not just setting the "guard aside," but more importantly asking "the guard to reconceive that it can be a temporary presence…that being there when needed but not being needed all the time could be a new possibility." In exploring her client's "guardedness" and sense of mistrust and by meeting her client and "receiving her," B provided a corrective emotional experience:

> In her saying, "Yes, I think it is." That feels like a moment of connection. That feels really like an attunement. It's part of the thread that's going to work its way through. What I've said has landed with her. And that sort of strengthens the connection.

B conveyed that "the next piece is to go further with this exploration" and "doing deeper work." She imparted having "these micro moments in session" where her client was really "sensitive" now to B's attention. Significantly, B underscored that unlike what her client "could not do when she was a kid she's doing with me." It was unsafe for her client as a child to express her affect or be in her vulnerability because "she had not been met." In their work together, B was "meeting" her client and "receiving her" and that, B avowed was "the emotional corrective experience:"

> I am inviting her to tell me more and move closer to the moment of disruption. Then she connects the disruption that we have had together to previous childhood experiences, her own patterns of how she reacts to those. There's a deepening that feels real to me and I'm glad that

> she's making connections. We're settling into the present and I have this sensation of my legs feeling really heavy and grounded when we're in a deepening process, a deepening with her and also it feels spacious, true, just wanting to see what will come in.

As B continued to explore what underlied her client's defense, her client's core attachment issue emerged, i.e., trusting that she can express her vulnerability and have it received in the context of safe and caring other. B provided a corrective emotional experience by being that safe and caring other who can receive and "hold" her client's vulnerability.

Y provided a corrective emotional experience for her client by allying herself with her client against a defense. When her client stated, "If I was really a good client, I wouldn't be feeling stuck after two years of this work," Y responded, "Bullshit." Y conveyed:

> There's a repair in me saying that. I'm saying, "Don't you dare treat yourself like that." I'm allying with her against this part of herself, against the defense. It's her and I against this aspect that is wrong and doesn't belong in here. The warrior woman. She has rarely had that alliance. She can give it but I don't think she's quite let it in experientially this way yet.

Y's client was aware of her defense which she described as a "force field" and Y supported her client to "just notice it, invite it." In reflecting on the session, Y spoke about her client's complex trauma, about a history of intrusiveness from her client's mom and about the repair process of "relational intimacy:"

> Her mother was invasive. She also realized very young when she was 8 or 9 that she was a lesbian and she came out. She was out in junior high school and she did take it for that in terrible ways. And there's something when I say bullshit, when I ally with her against the defense, there's something about the good enough mother. Here she says that if I just observe that force field that is separating me from you, if I allow it to drop, if I allow myself to take you in, then the defense, the intrusiveness comes up. It's complex trauma. Her mom never defended her right to her feelings. It's really complicated place to be but we're both here together and we're choosing to stay now. This repair is about relational intimacy, i.e., Can I let you in? She sounds like she is five right there. With an intrusive mom, she needed that force field, she really did.

Y's client did "put aside the force field" and let Y in emotionally, an experience Y depicted as "both being here together." By sharing her vulnerability and being held in the safety of a caring other (i.e., Y), relational intimacy was being "repaired."

L delineated the emergence of a new model of other through a corrective emotional experience with his client. L's client harboured conflicting feelings about being responsible for another person. He shared that he did not want to take responsibility for L's growth as a therapist but also felt selfish for saying so. L worked to repair the disruption by providing a corrective emotional experience and a "new model of other." L expressed:

> All of a sudden I became an 'other' where he felt close and connected but where there's a hook in it that was scary for him. That scariness was being responsible for my growth. There's a very early young part of him that is very afraid of connection because it's going to become about the other person and it's going to be at the expense of his experience and he's going to have to take care of the other person. His mom used to tell him he was selfish when he would say, "I don't want to take care of you," and he judges himself as selfish for this. I show up really forcefully and say that I don't think it's selfish to take care of himself and when I ask, "Can you feel the forcefulness of my conviction here?," he says, "Yes, I can." So we both are feeling the importance that he gets it, that I don't want him to be responsible for me. And we're both feeling that energetically.

In the position of a strong, caring other, L conveyed to his client, "I don't want you to feel this way." The look on his client's face was child-like, almost as if he had the expectation that he would be shamed. L recounted that his client did feel a sense of shame, because he was continuously told as a child that he was selfish for not taking care of his mom. L responded in a manner that differed from this client's mom and it was "reorganizing." The child-like look on his client, L imparted, was his client "trying to make sense of that, trying to take that in…almost as if he's heard that for the first time from a caring other." L described himself as being "stalwart and steadfast in the repair," that he "stayed with where his client needed to be" and that this was "critical." In doing so, L affirmed that he was assisting his client to rework his model of self and model of other. During this process, L's client disclosed his fear about losing his connection with his therapist. L stated:

> There is an internal rupture that happens right then between wanting connection and feeling connected. And then feeling responsible for me, so he gets this kind of short circuit/ disorganization in a way. What I want is going to cost me or something. And the reparative part was that he could feel how strongly what I want for him is that he doesn't have to take care of me, that I want him to have his experience in relationship. That's moving him right now. My strength is what moves him so much right now. My strength that he can be himself

> and not damage me. Because the fear here for him is that his model of other is fragile. So here he's showing up as himself and I am strongly wanting that and we are not threatened and that is what's moving him to tears now.

Toward the end of the session, as part of the reparative process, L assisted his client to metaprocess and reflect on his experience. L considered how the disruption and the repair were both a reworking of model of self and of model of other. In reflecting on the interaction, L realized that his client's model of self was not only fragile, but "dangerous," that is, "If I have my experience I am a danger, I will destroy my beloved." L recounted:

> If I had the presence of mind I would have been able to say, wow I get it. What we revealed to you today is that you having your experience isn't dangerous *and* that the relationship and I aren't' fragile.

In depicting the experience with his client of connection and coming together in the repair, L spoke of "spirals of repair." He imparted that his client needed to have "safety for him to have more of his feelings" and that this was one cycle of repair. Another cycle was when his client realized his fear and how "big his feelings were," and "he trusted me with it." L underscored that "repair builds on itself." L affirmed:

> There is another level, it's like Diana Fosha's nonfinite spiral of transformation, we're building on it, we're building on it, it's changing even more and now it's changing even more in that he is kind of literally finding a place to park what's newly revealed to him right in this moment.

The notion that "repair builds on itself" and that there is a nonfinite spiral of transformation through repair is appealing. It is reminiscent of Z's comment (see section 9.1.) that repair is not fixed or permanent but instead as L stated, repair is an ongoing "spiral of transformation."

9.3. Attunement in the repair. Participants recounted several experiences of attunement in the repair process. Such attunements included helping the client dyadically regulate, processing affect to completion, cross-modal matching, being with self and being with other, and consolidating.

B's client shared how vulnerable she felt disclosing her inner experiences and being an "open book" in sessions. She expressed her need that B was truly there to listen and honour this. B reflected on the intimate level of attunement she shared with her client in this moment of dyadic regulation:

> All that nodding on her part is very attuned. I'm reflecting back and really owning and taking in what she's saying. The nodding feels really important. It feels like one of those coordinated

> moments. I'm getting her. She says, "This is scary. I have to be vulnerable." I know from being with her through these different times, the importance of her sharing her secrets and so when she says, "I need to be honored," that drops me into what I know to be true. And I know that I have a privileged place with her and I want to honor that and make right by that.

B's words, "that drops me into what I know to be true" reflected the deep level of attunement that was occurring through dyadic regulation.

L's client was fearful of telling L that he did not want to be responsible for him. He expressed fear that he would "lose" L. L described helping his client dyadically regulate and undo aloneness:

> As I watch it now, he is dropping, interrupting himself, dropping, interrupting himself, so I am dyadically regulating his affective experiences by saying just let the feelings come. Stay with it. I am right here. I am helping him drop down.

As L's client continued to "drop down further into core affect," L described assisting his client to "regulate the affect" and experience his "affect to completion:"

> When he takes a big breath, it kind of marks the end of his wave. Then I just kind of hold him in it by saying "a lot of feeling." That's regulating because there is a lot going on, he takes a nice big breath, and I track his sigh but in a kind of a non-intrusive way. We're re-coordinated after the disruption, we're in a re-coordinated state. I am very much in my heart, holding him in my heart and in the space. I am feeling calm with him myself. I don't have to push…. I am letting him metabolize.

L's client continued to express his fear that he would lose the relationship he had with L. L conveyed this experience of attunement as "soft, spacious, confident and in synch," and depicted this process as "mentalization."[8] Mentalization, L conveyed, transpired in how he acknowledged his client's fear from a place of, "It is all going to be okay. I can handle it and I know you can handle it too." L stated that attunement in this respect felt like a "confidence" that L is in his capacity, was there for his client. In his description of the attunement that was occurring during the repair, L elaborated on and described diverse versions of attunement:

> A moment ago I was attuned to him when he tells me about the hook and I get strong when I say, "Can you feel the force of my conviction?" That's attunement but it is a very different

[8] Mentalization was a term coined by Fonagy (2002). In this perspective, security of attachment transpired through the ability by a caregiver to accurately reflect upon a child's mental state.

> version of attunement. On some level, it is attuned with a part of him who says, "No, don't let me put my feelings aside to be in the relationship." It is a kind of a part of him that is not even showing up. If someone is telling me I got robbed last night and they are not telling me it was scary, they're saying it is such a violation, I am so mad about it, I am going to be attuned to that, my attunement is going to be different energy. So the form is similar, in that I'm going to be matching. I am attuning to the affect and responding. But here, I am not reciprocating the same affect. He's deeply dropped down and I am matching that affect by a soft, calm confidence, spacious place. It's always going to be dyadic, and it will depend on the dyad.

In the excerpt above, when L outlined the different versions of attunement, L made reference to the notion of cross-modal matching in his description that he was "not reciprocating the same affect" with his client. Cross-model matching was a term developed by Stern (1985) to reflect the ways in which caregivers help develop secure attachment with their infants by attuning to and helping to regulate their infant's affect.

In sifting through the experience of attunement, L delineated the difference between empathy and attunement and depicted attunement as "being with self" and "being with other" simultaneously. L underscored the need to check in on his client's "receptive affective capacity" by exploring whether and how his client was receiving the experience of attunement:

> I want to make sure while he was hooked up to himself, can he look at me? Can he be with me? What happens when you look at me? I don't know if there is something that we need to regulate or not but I want to just find out.

L stated of his client that "his growing edge is to be himself and also to be with another" and that like for many adults, this was "a very nuanced, life-long journey." As the session and the repair progressed, L asked his client what's his sense of L was right then and his client expressed a childlike gaze into L's eyes that was "very vulnerable and trusting" and that was like "a six year old looking at his dad." L was moved by his client's ability to be "open" because his client was usually someone who displayed a "shiny kind of smile and polished exterior." L affirmed:

> This is something I want him to take in. Let's really, really situate this and hang out here in the preferred state of trust, of openness, of connection, let's really dwell on it. So, you've been afraid of me, really look at me and see what you see. And I am very aware that he just took a long, slow look at me.

L underscored that he was “on the other side of the repair” where L was “amplifying and deepening” and “consolidating” his client’s experience of L as “a true other who takes care of him.” In describing this process of being “on the other side of the repair,” L presented the idea of stages to the repair process.

9.4. Laughter and Playfulness in the repair. Participants relayed that laughter and playfulness were avenues of connection and avenues for attunement during the repair. This sub-theme was best elucidated by B’s session with her client.

B depicted the mutual laughter with her client as building a container and as building the possibility of repair:

> You know I just like her. I like us. I feel like we're going to get through this. I know there's more but I love the generosity of enjoying the not getting it and sharing her not getting me with me. And so that feels like we are building some container for whatever is next. There is playfulness here. This feels connecting. Here's the attunement in the midst of healing the disruption. On the way to repair, there are these moments of attunement that build the possibility of repair.

B indicated how this deeper level of attunement with her client allowed for laughter and playfulness. She described this type of connected laughter as a “coming closer” in contrast to the laughter they shared when they started the session which felt like “a moving away.” B affirmed how they were connecting through laughter “around the disruption.” She denoted that part of the pain that her client experienced was that she had not been met by a caring other. It was significant that her client was now able to say to B, ‘‘You really weren't here. And I wasn't able to do the work. And that's just not going to work for me.” B underlined the need to really own a disruption when it occurred because only then does “it get to be real,” and only then does what unfold become real and the “repair more real.”

There are a few salient points that B raised. First, she distinguished between a laughter that felt like “a coming closer” versus the laughter they shared at the inception of the session which felt like “a moving away.” Second, she delineated that this connection and playfulness can only happen because they had experienced a “deeper level of attunement” together. As with L in the sub-theme of attunement in the repair (see section 9.3.), B’s description of playfulness was suggestive of stages in the repair process.

9.5. Repair strengthens relationship. Participants indicated how repairing a disruption strengthened the therapist/client relationship by laying a foundation for further repairs, by building the capacity for reparative conversations and by supporting vulnerability.

B's client had a personal history of not trusting and had had years of therapy where she had not wanted to come back to therapy. Not wanting to come back to therapy, B asserted, was due to a part of her client that would say, "don't trust, don't feel, don't let everyone know what's going on with you." B's client felt in "turmoil" when she did allow herself to trust because she "would have broken her allegiance" to that part of her that said "don't trust." Much of their work together in the dyad focused on "getting more coherence" in her client so that she was able to come to sessions and access both her feelings and vulnerability. B relayed the impact of previous disruptions and repairs:

> We've had a lot of practice of one kind of disruption or another over the year . . . for two, three years. And one of the things that happened in the repair of the disruption in December is that we talked about our relationship so much. That was something that she realized was what she hadn't been able to do with other people in her life who just left. So the repair of that laid the foundation for this repair. Because for her to come in and disclose what she discloses, that's very courageous. And she may not have disclosed had she not had those previous sessions around the repair.

In the quote above, B outlined how the previous disruptions that occurred in their therapist/ client dyad when repaired, helped her client trust that her vulnerability would be honoured. Additionally, B maintained that previous repairs assisted her client to find the courage to voice her concerns. B elaborated further on how repairs lay a foundation for further repairs. She depicted the concept of "reparative conversations" and the idea of "conscious disruption." B conveyed that at times, there's a need for disrupting the situation consciously "in service of integration." For example, when B's client stated, "Yeah my brothers, they're shut down and you're not going to get them to say anything about themselves and that's how I am," B challenged her client's "way of seeing herself" and consciously didn't "attune" to this. B conveyed the importance of affirming to her client that this was not B's experience of her client, that B had "a different experience" and that what B's client was doing with B was different. B stated:

> I am in service of her expanding capacity for reparative conversations. So I want to keep my foot in the door that we're doing something different today that's along the lines of a corrective

> experience. I feel like I'm holding her with me and I think she's acknowledging, yeah it's true. So we're still building. We're moving towards each other.

B's words, "I'm holding her with me" as they moved through a repair are especially poignant and spoke to the sub-theme of strengthening the therapeutic relationship.

In the following excerpt, with the aim of expanding her client's capacity for reparative conversations, B outlined how disclosing her own vulnerability as a therapist supported her client's vulnerability:

> We've dropped down to a deeper level of feeling. We are more connected, more attuned. And then I go even further by self-disclosing that I feel sad, regretful and remorseful that my behavior would in any way slow down her process or impede her abilities. And she starts to shift. It's hard for her to be vulnerable and it's hard for her to receive my vulnerability. She's just coming to know through our relationship that "I can disclose my feelings and someone will share their vulnerability in return."

What B pointed out is that it was not enough to help a client access their vulnerability. There was a need to go even further in the repair process so that clients know they can disclose their feelings, what it feels like to have those feelings acknowledged, and that vulnerability is shared in return. In this, B alluded to what L underscored about building relational intimacy (see section 9.2.). The repair, L elucidated, is about "relational intimacy, i.e., can I let you in?"

9.6. Post-repair. Participants conveyed a post-repair experience that reflected a deeper vitality, freedom, and openness.

B's client experienced a new sense of self when she realized that her defense of shutting down had actually been protective. B depicted this experience as being in mutual "truth" and "vitality:"

> There is a freedom, an openness and a deep level of connection right now between us. We have just come into a truth, vitality, that she can have this self-protection. Because she has felt such guilt about feeling shut down. And so now it's like, 'Oh she gets to redefine that that was her defense in service of self-protection and that we get to talk about it.' So in a way it's like rewriting a narrative of what gets to happen.

Similarly, Y experienced a new vitality with her client in the post-repair period. Y's client disclosed a dream that reflected the experience she had had in the session, i.e., of dropping her defense, the "forcefield." Y depicted the attunement she experienced with her client as "walking side by side:" Y

stated, “We are metaprocessing and consolidating and it feels like walking side by side with just a sense of wonder and appreciation at the richness of our work together.”

In L’s session, during the post-repair period, L reflected on the cycle of attunement, disruption and repair with his client and how it created “security, more latitude, and flexibility.” L described how “getting it wrong together” and “getting it right together” built the trust that they can “get out of coordination and the bond is still there and it is more flexible and it doesn't feel like it's snapped.” L underscored that “attunement does not need to be whole,” but that there is a “partialness of it being good enough:”

> I don't need to totally get his world all the time for us to be in a coordinated place. It's like a difference between perfection and life. I still see this client. He comes once every two weeks now, we referred back to this session a few times because it was so momentous for both of us. In his life I think it was a water shed. He started living more authentically, taking more risks. And his parenting, he is a much more engaged parent now as well. He's modeling being the kind of dad that he wants to be and that is incredibly satisfying to him.

L underscored that a successful repair or successful multiple repairs created security and flexibility, and reassurance that a bond when disrupted, can still be there. Additionally, L emphasized the necessity as a therapist to be “good enough,” the notion that as a therapist, he can’t be in a coordinated place with his client at all times, a concept that made reference to Winnicots’ (1965, 1970) notion of good enough parenting.

The preceding section presented the theme of repair and outlined three sub-themes on how participants repaired disruptions: incomplete repairs, disruptions that occurred during the repair process, and processing repair to completion which included multiple sub-themes. The following pages will provide a substantive summary of the main findings in this chapter.

Summary of Common Themes

Chapter Four listed nine overarching themes. The nine main themes were: attunement as connection; attunement as we’re in this together; attunement to underlying affect attunement on the edge of fragmentation, building human relational capacity; disruption originating with therapist; disruption originating with the client; incomplete repairs; disruption in the repair; processing repair to completion. I presented an outline of the themes and sub-themes and subsequently, a description of each theme with excerpts from participants.

1. Attunement as Connection. Attunement was experienced by participants as a sense of connection. The theme of attunement as connection explicated three sub-themes: participant's attempt or invitation to connect with their clients; attunement to connect over common ground and to create trust; and attunement through tracking and scanning. Therapists attempted to connect with their clients by inviting them to attune to their somatic experience. Frequently this occurred through the therapist dropping his/her voice, calming the space and inviting closeness. Additionally, therapists attuned to clients by seeking common ground and creating trust. For example, G conveyed, "I'm coming up and meeting her where she is, and trying to get some traction going, 'cause she's confused and she's stuck, and there's so many moving parts." X stated that as a therapist, "I have been through this too and we can talk about this." Therapists also connected with their clients by tracking and scanning for entry points to affect and for entry points to closeness and togetherness. This was elucidated by G, "I'm just listening, and I'm looking for an opportunity to bring her back with me, in this moment, in this sharing of the story, still waiting for a moment that I can get closer, to move that attunement into sync."

2. Attunement as we're in this together. Participants articulated an awareness of "attunement as we're in this together" and chronicled a deeper "gradient" of attunement as: a sense of we-ness, and as motherly and/or attuning to the good enough other. The theme of "attunement as we're in this together" was described as a sense of being "with me, with each other," as when X attuned to her client's sadness to find that "piece of her in me" or to "connect in the unknown together." Therapists elucidated this attunement through depictions of "we-ness" as "flowing," "moving with the river," feeling "real," "we are as here as we could be," "we can't see – hold my hand. . . . just feel my hand," "reverence," "breeziness," and "presence." Attunement as "we're in this together" was additionally conveyed as providing a "secure base" for the client and being with a "good enough other." X conferred "feeling very motherly" towards her client's sadness and "wanting to soothe her" and "be with her." L relayed that the "good enough other" fostered the opportunity to "re-attune and recalibrate." Y referred to this attunement as "reverence" and L as "the purest form of human experience…he's with him and with me."

3. Attunement to underlying affect. Participants expressed attuning to a client's underlying affect. They relayed this attunement as a somatic dropping down into affect, as holding the space and grounding, and as attuning to vitality affects. When their clients had accessed and touched upon their underlying affect, participants conveyed an awareness of their

clients "dropping down." This attunement to dropping down was depicted through various descriptors such as a "joining with," "letting barriers down," "working to deepen and expand," a "focusing" and “narrowing in to expand out," "resonating to the centre" and a sense of "spaciousness." Additionally, participants relayed attunement to underlying affect as “grounding” and “holding the space.” Y conveyed, "I calm down and open up…. become as spacious and as present as possible to allow this in without intensifying it." Similarly, L spoke of "holding the space" for something "emergent” in his client and in their relationship. Finally, participants also portrayed attunement to underlying affect through vitality affects such as biological rhythm, silence, gaze, and synchronized breathing. Z sat with his client in the session and in rhythmic breathing, shared tenderly, "A tear rolls down your cheek… I want you to know I’m with you." Y explicated how her client "resourced" herself for their work together through gaze, "That gaze was so important…she is really fighting here."

4. Attunement on the edge of fragmentation, building human relational capacity. Participants delineated attunement as building human relational capacity. This was best encapsulated by Y who assisted her client to develop the capacity to regulate her affect by facilitating the experience of affect at the edge of her client’s “window of tolerance.” Y spoke of this experience as her client being on the “edge of fragmentation.” In this, Y underscored the need to make her presence felt by her client. She accentuated that "self-regulatory capacity to experience affect is a relational experience" and that "there’s no other way” to develop this capacity “but in a relationship."

5. Disruptions that occurred with therapist. Participants described multiples aspects of disruptions that occurred with themselves as therapists: misattuning to the client experience; identifying with client defense; therapist anxiety; therapist wanting to keep client safe; and confrontation by the therapist.

Misattunement to a client’s experience transpired when a therapist prematurely invited a client to experience underlying affect or when they misunderstood the nature of a defensive response. For example, when Z assisted his client to access his underlying feelings of shame and disgust, Z’s client responded with defensiveness. Z reflected on having moved too fast and possibly having “invited him back into defense.” Likewise, B shared in reflecting on her session with her client that she misunderstood her client: “I misread that as a defensive place. . . . I didn't

get that there was actually part of her that was wanting to do the work and part of her. . . . didn't feel safe."

Participants explicated identifying with the client's defense such as when B relayed, "I think sometimes I get defended around her. As much as I want to not I think I do, I do get caught by her hard place."

Anxiety on the part of participants additionally disrupted their experience with their clients. X stated, "I was pretty anxious . . . in hindsight . . . I might have wanted to stay and let her express some of the anxiety or anger or hurt." L articulated, "I'm lost. . . . I start overreaching just a tiny bit. . . . if I had just been able to say, 'It's ok, let's just be with the not knowing.'"

There were times when participants were unsure about how to address a disruption and were conscious of keeping a client safe and not dysregulating a client. The desire for therapists to keep their clients safe often sidestepped a deepening of process. X divulged that the process of having the rupture "was triggering and distressing and needed to be titrated." She expressed regret that she didn't ask her client "any kind of metaprocessing questions."

Participants delineated situations where they broached a topic with their clients as disruptions. Z recounted of his session with his client, "From his point of view, it's a rupture in our relationship. . . . He was hoping I would convince his spouse to reconcile. I haven't delivered the goods." Z portrayed the confrontation as "wrestling" and emphasized "not giving up" on his client. L broached a topic with his client by "reaching." L shared of his session: "Sometimes we build relationship by leading, sometimes by following. I needed to reach and ask him." Otherwise, L stated, there would be this "hanging back curious" that would have impacted his work with his client. The therapeutic relationship was strengthened when the therapist allowed for processing and deepening of this experience,.

6. Disruptions that occurred with the client. Disruptions that occurred with the client included portrayals of how clients tried to please their therapists, how clients disclosed what wasn't working for them in therapy, and several disruptions in the form of client defenses.

Participants relayed experiences where clients responded by trying to please the therapist, an experience that participants depicted as inhibiting attunement. X noted an upward inflection in her client's response, "where it feels as if she's giving me the answer I want to hear." Y's client tried to demonstrate that she really was "a good mother." In observing this, Y conveyed feeling

"compassion and admiration" for her client while also very aware that there was "a lot of shame coming up" and that they were not "connected."

Participants divulged situations where their clients confronted them about what hadn't worked in a session. For example, B's client revealed that she had difficulty when B began their session attending to other business. Y's client confronted Y about the recording of sessions. L's client expressed not wanting to be made responsible for his therapist's growth. Similarly, X's client confronted X's motives about maintaining contact (i.e., therapy sessions) during the summertime.

Participants outlined several experiences of working with their clients' defenses and experiencing this defense as a disruption that inhibits access to a deeper attunement and affective experience. Client defenses as experienced by participants included feeling "held at distance," "held at arm's length," blame, focusing on a narrative to the exclusion of affect, dismissing one's own feelings, spiritual bypass, and a sense of loss/ leaving the relationship in the moment. Additionally, therapists' attempts to attune to affect was sometimes met with defense on the part of the client. They recounted feeling disconnected to their client during these times. G conveyed, "I'm still trying to find her . . . she's talking about fear. . . . She obviously hears me. I can hear her, but she's still far away." B remarked on her client's laughter, "I love laughing with her. But I didn't go there, in the same place. This to me feels like it's moving away rather than towards." Participants depicted these disruptions as a disruption from intra and interpersonal intimacy.

7. Incomplete repairs. Participants expressed situations where a disruption had occurred but the therapist did not explore the core affect that underscored the disruption nor the underlying attachment issue. This resulted in the awareness that the situation had not been "repaired" and that things were left incomplete. For example, X divulged her sentiments about leaving a disruption unaddressed, "I didn't know what damage I'd caused or what rupture I'd caused." X discussed the "relief" she experienced when she changed the topic, that it "felt less charged." Towards the end of the session, X acknowledged the disruption with her client but stated "there wasn't a lot of space for her to say anything" and "I'm not a hundred percent solid that we really repaired it."

8. Disruptions in the repair. Participants' experience of repairing a disruption was not a linear process but more of a series of spirals of further disruptions in the repair. Participants described a sense of circularity in the repair process. As participants tried to repair a disruption with

their clients, they experienced a period of trying to find their way back into attunement with their clients, of trying to reconnect. X conveyed trying to connect with her client through “a little joke” and a “self-disclosure of ‘fucking-up,’” but not getting “the sense that it landed." B discussed feeling complicit in the original disruption, apologizing for it, and her client not initially receiving her apology. B expressed, "She’s a hard one right here. I'm willing to say, “What can I do better?’ And she's not willing to take it yet."

In repairing a disruption with their clients, participants described their attempts to “stay the course” with the repair and assist their clients to access the core affect underlying the disruption. This theme was best exemplified by Z’s session with his client where Z speaks of "pressuring with empathy." Z said of his client, "There are a lot of things with good reasons to dismiss him but I haven't been sucked into any of those because I don't believe them." Z portrayed the need to stay the course in the repair with a metaphor of the ocean, “When you're with him it’s like riding the big swells, sometimes up, sometimes down on the trough. . . . it's kind of riding it out.”

9. Processing repair to completion. Participants delineated how they processed repair toward resolution, toward understanding, and/or toward further insight. This process of repair entailed exploring underlying affect; exploring the underlying attachment issue; attunement in the repair; laughter and playfulness; strengthening the relationship, and a post-repair experience.

Participants conveyed how they worked to repair disruptions by acknowledging and exploring underlying feelings. Z attempted to move the conversation with his client away from blame and back to their relationship by exploring how his client felt let down by Z. Z conveyed how that was "pivotal" because his client disclosed that he had felt "let down" and "betrayed" by Z. Z added, "I'm working to repair the rupture he's held by acknowledging the feelings that are underneath. . . . and inviting him to drop down." B also sought out what might be underlying the disruption in her session with her client by exploring her client’s defense of "shutting down." B stated, "I know she said she shutdown, but that to me is the defense…. I want to actually know the feeling of what's under there."

Alongside acknowledging and exploring underlying affect, participants delineated how they attempted to repair disruptions by exploring underlying attachment issues. Uncovering the underlying attachment issue was a step beyond exploring the underlying affect of a disruption, it was about relational experiences. Participants worked to comprehend the underlying attachment issue by allying with the client against his/her defense, providing corrective emotional experiences for early

attachment trauma, repairing old models of other and old models of self, and by forming new sense of trust with their client. For example, B remarked about her client, "unlike what she could not do when she was a kid she's doing with me. It was unsafe. . . . I am meeting her and receiving her and that's the emotional corrective experience." When Y's client stated that if she was really "a good client," she wouldn't feel "stuck" in therapy, Y responded, "bullshit." Y elaborated on her response, "I'm saying, 'Don't you dare treat yourself like that.' Y portrayed "allying" with her client against the defense. She relayed "it's her and I against this aspect that is wrong and doesn't belong in here. . . . she has rarely had that alliance." L assisted his client to explore the underlying attachment issues by helping his client rework a model of self and model of other. The "reparative part," L denoted, was that his client could feel "that he doesn't have to take care of me." L added that what moved his client and what was reparative was L's "conviction" and "strength" that his client can "be himself and not damage me."

Participants recounted several experiences of attunement in the repair process. Such attunements included helping the client dyadically regulate, processing affect to completion, cross-modal matching, being with self and being with other, and consolidating. B reflected on the deep level of attunement that occurred with her client through dyadic regulation. When B's client stated, "'I need to be honored," B expressed how that dropped her into what she "knows to be true," acknowledging that she held "a privileged place" with her client. As L discussed the disruption with his client, L grounded in an attunement that dyadically regulated his client's affective experiences. He stated, "Just let the feelings come. Stay with it. I am right here." L portrayed this experience of attunement as, "I am holding him in my heart and in the space. . . . I don't have to push. . . . I am letting him metabolize." Moreover, L made reference to the notion of cross-modal matching in that he was not "reciprocating the same affect" but was "deeply dropped down" and matching his client's affect by a "soft, calm confidence, spacious place." Participants reported one final experience of attunement in the repair, the notion of "consolidating" a repair by "amplifying and deepening" their client's experience in the presence of a caring other.

Participants relayed that laughter and playfulness were avenues of connection and avenues for attunement during the repair. This was best elucidated by B's session with her client. B depicted the mutual laughter with her client as building a container and as building the possibility of repair. She relayed, "I love the generosity of enjoying the not getting it and sharing her not getting me with me… we are building some container for whatever is next, there is playfulness here." B

distinguished between a laughter that felt like “a coming closer” versus the laughter she shared with her client when the session started which “felt like a moving away.” B delineated that this connection and playfulness can only happen because they had experienced a “deeper level of attunement” together, suggestive of stages in the repair process.

Participants indicated how repairing a disruption strengthened the therapist/client relationship by laying a foundation for further repairs, by building the capacity for reparative conversations, by supporting vulnerability and developing relational intimacy. In repairing the disruption with her client, B conveyed how she wanted to keep "her foot in the door" that they were "doing something different today that’s along the lines of a corrective experience." She accentuated, "I feel like I'm holding her with me…so we're still building, we’re moving towards each other." B’s words, “I'm holding her with me” as they moved through a repair underscored the strengthening of the therapeutic relationship.

Finally, participants conveyed a post-repair experience that reflected a deeper vitality, freedom, and openness. B’s client experienced a new sense of self when she realized that her defense of shutting down had actually been protective. B denoted this experience as being in mutual “truth” and “vitality:” Similarly, Y experienced a new vitality with her client in the post-repair period. Y depicted the attunement she experiences with her client as “walking side by side with just a sense of wonder and appreciation at the richness of our work together.” In L’s session, during the post-repair period, L reflected on the cycle of attunement, disruption and repair with his client and how it created “security, more latitude, and flexibility.”

Chapter 5: Discussion

The current research investigated how attunement, disruption and repair (ADR) was experienced by the therapist in an attachment-focused approach to psychotherapy. In this final chapter, I will briefly re-visit the problem of the study, its rationale, and provide a summary of the research. Second, I will discuss each of the findings in light of existing theoretical and empirical literature. Third, the findings will be additionally interpreted through a broad lens of historical and sociocultural contextual considerations (Sugarman & Martin, 2005). Fourth, I will discuss the clinical implications of the current study for the field of counselling psychology as well discuss the study's strengths and limitations. Finally, I will conclude by providing suggestions for further research.

Summary of the Research Problem and Rationale

The purpose of this study was to investigate the question: How is attunement, disruption and repair (ADR) experienced by the therapist in an attachment-focused approach to psychotherapy? As presented in Chapter Two, various realms of inquiry such as infant development theory, relational psychology, and affective neuroscience had conceptualized ADR as a key process of mutual affect regulation that occurred in the therapist/ client dyad. A review of these realms of inquiry and their conceptualizations of ADR raised queries about how ADR was experienced within the therapeutic process, queries that had not been robustly investigated in the empirical literature. Additionally, as encapsulated in Chapter Three, while there have been several theoretical suppositions on ADR within the therapist/ client dyad (e.g., Safran & Muran, 2000; Fosha, 2000; Schore, 1994; Siegal, 1999; Stern, 1985), there have been scant empirical investigations of ADR within the therapeutic process. The extant research on ADR investigated attunement (e.g., Davis & Hadiks, 1994; McCluskey, 2005), disruption and repair (e.g., Coutinho, Ribeiro, and Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Norcross & Wampold, 2011) as discrete processes with the large majority of these studies employing a methodology of task analytic paradigm or randomized control. The lack of empirical qualitative research about a phenomenon that has been theorized to be fundamental to affect regulation within the therapist/client dyad has left a remarkable gap in our comprehension of ADR in the therapeutic process. This gap in the literature has been particularly prominent in the last few decades as psychotherapy has moved away from cognitive models of psychotherapy toward emotion focused and attachment oriented psychotherapies (e.g., Elliot et al., 2009; Fosha, 2000;

Johnson, 2009). The present research project was the first qualitative study that investigated ADR as a co-constitutive interrelated process in the therapeutic relationship and addressed this significant gap in the literature. Further, the research herein contributed to our knowledge of the construct and the role of ADR in the therapeutic process, and informed existing theory on affect regulation and attachment repair, as well as the process of change in therapy.

Summary of Research

The current research comprised a qualitative micro-analysis of the moment to moment shifts in the interactive process of ADR as experienced by the therapist in an attachment-focused approach to psychotherapy. This study recruited and interviewed six participants (i.e., therapists) who had a videotaped session of their work with a client where attunement, disruption and repair had occurred. An Interpersonal Process Recall (IPR) approach was employed to interview participants. As per the IPR approach, participants were asked process oriented questions by the researcher while the researcher and participant viewed the videotape together.

In studying this phenomenon in the context of the therapeutic process, I was interested in the meanings and interpretations that the participant brought to, and made of, her/his experience. Consequently, I employed a thematic approach to data analysis (Braun & Clarke, 2006) and situated the thematic analysis within a contextualist method. A contextualist method acknowledged both how people interpreted their experience to make meaning and the influence of historical and sociocultural practices on these interpretations. In analysing the transcribed interviews, I identified nine overarching common themes and several sub-themes.

Discussion of Findings

In the following pages, I will outline the nine main themes of attunement as connection; attunement as we're in this together; attunement to underlying affect attunement on the edge of fragmentation, building human relational capacity; disruption originating with therapist; disruption originating with the client; incomplete repairs; disruption in the repair; processing repair to completion. Subsequently, I will depict a description of each theme as it relates to the theoretical and empirical literature.

Attunement. Within the data, the first two themes, attunement as connection and attunement as we're in this together, exemplified the AEDP notions of creating a therapeutic environment of trust, therapeutic resonance and facilitating access to core affect. If we were to view attunement as

gradations as participants depicted in the data, these first two common themes would exemplify initial gradations of attunement.

Fosha (2000) illuminated the first two themes on attunement by explicating the importance of creating a therapeutic environment of trust and facilitating access to core affect. In elucidating the AEDP model of affective transformation, Fosha (2000) provided a description of both the therapist stance and affective coordination. The therapeutic presence, Fosha conveyed, was one that "is informed by an understanding of the affective phenomena of empathy, affect contagion, affective attunement and resonance, and the reaching of a coordinated state" (p. 29). A coordinated state is the "moment-to-moment mutual emotional attunement" (p. 61) between therapist and client within the "complex, survival-dictated functioning of the attachment system" (p. 57). AEDP maintains that transformation occurs through and is accelerated by experiencing core affective states in the presence of an attuned caring other. In this respect, the aim of the AEDP therapist is to help their clients facilitate access to core affect and reach a state of dyadic affective coordination within the context of relational safety. Relational safety, Fosha underscored, nurtures and makes possible "the willingness to experientially immerse oneself in the core affective phenomenon so crucial to deep therapeutic change" (p. 34). The therapeutic relationship in AEDP prioritizes the therapist / client attachment relationship and is characterized by "affective resonance, sharing, and empathy" (p. 29). The therapeutic environment is one akin to Winnicot's (1965) holding environment, a growth promoting environment intended to provide safety by attending to a client's psycho-emotional needs. Establishing trust and facilitating a safe environment is at the forefront of the AEDP therapist's first interaction with a client. Within this interaction, the attuned therapist guides the client "toward exploring emotional regions that might otherwise remain unchartered, allowing the unfolding of self experience" (Fosha, 2000, p. 38).

What emerged in the data on attunement was participants' attempts from the start of a session to 'coordinate,' that is, as underscored by Fosha (2000), to assist the client to explore "unchartered" (p. 38) emotional experience within the affective regulatory capacity of the dyad. As elucidated in Chapter Two, the notion of dyadic affective coordination is rooted in infant development research and affective neuroscience. Affective neuroscience defined a coordinated state as the synchronization of the neural circuits of two individuals such that the individuals are in biological rhythm with each other (Schore, 2001). Schore (2001) portrayed this coordination of biological rhythms in the infant/caregiver dyad as "an inner psychophysiological state similar to the partner's"

(p. 19) whereby they are sharing or experiencing the same feeling state. In this mutually attuned communication both partners "move together from low arousal to a heightened energetic state of high arousal, a shift from quiet alertness into an intensely positive affective state" (p. 19). Schore purported that these energy shifts are fundamental features of emotion, occur through right brain to right brain resonance, and permit a "coherence of organization in the infant" (p. 19). Further, as explicated in Chapter Two, the concept of coordination in the infant/ caregiver dyad had been applied to elucidate the affective coordination that occurred in the therapist/client dyad (e.g., Schore, 1994; Siegal, 1999; Safran & Muran, 2000; Fosha, 2000). Siegel (2003) referred to this coordination as the "joining of two minds" (p. 32). The first two sub-themes, attunement as connection and attunement as we're in this together demonstrated participants' attempts from the inception of a session toward a "joining of two minds" (p. 32) in the dyad, that is, affective coordination. The third and fourth sub-themes, attunement to underlying affect and attunement as building human relational capacity, further exemplified the psychobiological coordination of affective states but at deeper "gradations" of attunement. It appeared from the findings, that AEDP therapists are primed to seek a coordinated psychobiological state from the start with their clients and that this coordination occurred through increasing degrees or gradations of attunement.

The findings herein on attunement to underlying affect captured the experience of attuning to categorical affects and vitality affects and support the notion of dyadic affective coordination elucidated by Fosha (2008) and Stern (1985). Fosha (2008) affirmed that dyadic attunement was the process through which the client is assisted to re-experience and regulate his/her affect in the context of a safe and trusting relationship with a therapist. This dyadic attunement, Fosha avowed, occurs through "the moment-to-moment affective communication between dyadic partners that occurs through non-verbal, right-brain-mediated processes involving gaze, tone of voice, rhythm, touch, and other vitality affects" (p. 8). Stern (1985) asserted that vitality affects are dynamic, kinetic qualities of feelings and are composed of qualities such as intensity, shape and time. He conveyed that both categorical affects and vitality affects can be objects of attunement. Categorical affects according to Fosha (2005) are "universal phenomena that initiate in the subcortical regions of the human brain (Damasio, 1999) and that are characterized by specific neurophysiological, face and body signatures . . . and by adaptive action tendencies" (p. 516), examples of which are joy or sadness. This affective communication of categorical affects and vitality affects, Fosha (2008) attested, facilitates the establishment of

coordinated states. The third finding in this study, i.e., attunement to underlying affect, support the notions of attuning to categorical affects and vitality affects and of dyadic affective coordination.

Likewise, the fourth theme, attunement on the edge of fragmentation and building human relational capacity additionally exemplified the psychobiological coordination of affective states and the attachment relationship in the therapist/ client dyad. This finding was best encapsulated by Y who facilitated moment to moment tracking and regulation of affect by staying with her client on the edge of her "window of tolerance," an experience Y relayed as being on the "edge of fragmentation." In this, Y accentuated the relational experience and affirmed that the "self-regulatory capacity to experience affect" can only be developed in a relationship. Y's depiction alluded to both the psychobiological coordination of affective states and relational safety, the growth promoting holding environment that as explicated earlier in this section, both nurtured and made possible the willingness "to immerse oneself in the core affective phenomenon so crucial to deep therapeutic change" (Fosha, 2000, p. 34).

The findings in the current research on degrees or gradations of attunement demonstrated that as these gradations deepened, participants experienced increasing resonance. In Chapter Two, I quoted Siegel (2010) to explicate and differentiate the concepts of presence, attunement and resonance:

> Presence permits us to be open to others, and to ourselves. Attunement is the act of focusing on another person (or ourselves) to bring into awareness the internal state of the other in interpersonal attunement (or the self, in intrapersonal attunement). Resonance is the coupling of two autonomous entities into a functional whole. A and B are in resonance as each attunes to the other, and both are changed as they take the internal state of one another into themselves. When such resonance is enacted with positive regard, a deep feeling of coherence emerges with the subjective sensation of harmony. (p. 4)

A central notion in the aforementioned quote is the idea that resonance moves beyond presence and attunement. Resonance has been conceptualized as the aspect of synchronizing with attunement so that "both are changed as they take the internal state of one another into themselves" (Siegel, 2010, p. 4). What emerged in the data on attunement was a sense of spiraling down through successive changes or degrees of attunement with increasing resonance.

Further, the finding that there were gradations or degrees of attunement advanced research on affective attunement conducted by McCluskey (2005). At the start of this study, I employed McCluskey's conceptualization of dyadic attunement. Her definition of empathic attunement reflected a fourfold process that involved (1) the activation of careseeking from a client through the expression of affect that is met by (2) cross-modal attunement and empathic input by the therapist such that it (3) assuages the client and enables him/her to self-regulate and (4) engage in exploration of his/her concern. From McCluskey's perspective, empathic attunement was an interrelated co-constitutive process that was activated and deactivated in the therapeutic dyad. While the findings in this study on attunement reflected Mcluskey's definition of attunement as explicated by one part of the dyad (i.e., therapists), the current study also elaborated on this phenomenon. In contrast to McCluskey's definition which depicted affect attunement as a singular phenomenon, albeit co-constitutive, the current research recognized gradations of attunement. Further, while Mcluskey's definition situated the activation of attunement through *client* careseeking, the current research demonstrated that the activation of attunement can be initiated through a therapist's caregiving. This was exemplified in the first sub-theme, attunement as connection, where participants "tracked and scanned" their client's nonverbals and verbals for "entry points" to underlying affect or for "entry points" to closeness and togetherness.

Finally, the findings in the current study on attunement advanced Schoettle's findings on the clinician experience of core affect and second state transformational affects (see Appendix 7 for a chart of AEDP transformational processes). In describing the experience of core affect, Schoettle (2010) stated, "the primary intervention with a client in this state is the dyadic regulation of affect, which involves affective attunement and matching (Fosha & Yeung, 2006) and likely leads to mutual experiencing" (p. 108). The current study illuminated the process of accessing core affect through attunement and mutual experiencing by elucidating the various nuances and/or gradations of attunement in assisting a client to access core affect.

Disruption. The data portraying disruptions involved two principal themes: disruption with the therapist and disruption with the client. Each of these two themes contained several sub-themes that illustrated the types of disruption that occurred with the therapist and those that occurred with the client respectfully.

The notion of disruptions as described within the theoretical and empirical literature comprised three components: the alliance literature which viewed ruptures as "episodes of tension or breakdown in the collaborative relationship between patient and therapist" (Safran et al., 2011, p. 80); the attachment and infant development literature which spoke to lapses of caregiving, good enough caregiving, and miscoordinated states;[9] and affective neuroscience that encapsulated disruptions as misattunements in right brain to right brain dyadic affect coordination. The findings in the present research on disruptions will be discussed in relation to the aforementioned conceptualizations of disruptions.

As elucidated in Chapter Two, Safran and Muran (1996), in their research on the therapeutic alliance, recognize two types of alliance ruptures in the therapeutic dyad, confrontational and withdrawal:

> In ruptures marked by withdrawal, the client withdraws or partially disengages from the therapist, his or her own emotions, or some aspect of the therapeutic process. In confrontation-type ruptures, the client directly expresses anger, resentment, or dissatisfaction with the therapist or some aspect of the therapy, with variations in terms of how directly or indirectly the confrontation is initially expressed. Withdrawal and confrontation reflect different ways of coping with the dialectical tension between the needs for agency and relatedness (Christian, Safran, & Muran, 2012, p. 62).

Although the findings in this study on disruption reflected both confrontational or withdrawal ruptures as delineated by Safran and Muran, within the context of AEDP, what was most salient in the data on disruption is the attachment relationship and the experience of dyadic affective coordination. In this respect, the phenomenon of disruptions within AEDP becomes less about the "dialectical tension between the needs for agency and relatedness" (p. 62) and more so about the need for mutual regulation within the dyad and the establishment of secure attachment. This finding lends support to one of the current directions of investigation proposed by Safran and Muran (2006), that is, the role of relational factors in the change process and specifically, an exploration of mutual regulation in the therapeutic dyad, where and how that mutual regulation was disrupted and its impact on client affect regulation.

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[9] A miscoordinated state (sic) is a term employed by researchers in infant development and affective neuroscience (e.g., Gianino & Tronick, 1988; Schore, 2001;) to denote a departure from mutual coordination in the infant/ caregiver dyad.

In order to comprehend the phenomena of disruptions through the relational lens of how mutual regulation is disrupted, it is helpful to comprehend the centrality of mutual affect regulation in the development of secure attachment. Mutual regulation between therapist and client has been a foundational concept in the model of AEDP. One of the fundamental avenues to secure attachment, Fosha (2000) has explicated, was how a child feels they securely exist "in the heart and mind" (p.57) of the other. Fonagy (2002) named this process reflective functioning or mentalizaton. In this perspective, security of attachment transpired through the ability by a caregiver to accurately reflect upon a child's mental state. Through reflective functioning, a child assumed that a caregiver will reflect upon and respond accurately to his or her mental state (Fonagy, 2002). Reflective functioning or mentalization permitted a child to experience the feeling of being understood. Fonagy elucidated that the capacity to mentalize emerged from a caregiver's capacity to attune to, read, and modulate a child's internal state. Mentalization facilitated a child's ability to comprehend her/himself as separate from a caregiver and as having distinct thoughts, feelings, wishes and desires from an other. Such an attuned interaction, assisted a child to regulate affect so that affective experiences were not overwhelming but manageable. In this capacity, mentalization exceeded imitation of affect (i.e., mirroring). Through mentalization, Fonagy avowed, a child learned to experience and communicate affect and to employ their understanding of the mental state behind an action to guide their behaviour.

Most importantly, in order for secure attachment to develop, one's reflective functioning needed to also allow for lapses in caregiving and their reparation (Tronick, 1989). As underscored by Stern (1985) "mental states between people" (p. 27) cannot only be "'read,' matched, aligned with, or attuned to" (p. 27) but also "misread, mismatched, misaligned, or misattuned." (p. 27). In describing caregiving lapses, Fosha (2000) accentuated:

> The caregiver's acknowledgement, honesty, and acceptance of lapses and failures, as well as her readiness for reparation, brings painful matters back into the realm of what can be talked about, felt, experienced, and processed together with a trusted other – particularly when the negative feelings are about that very other. In a truly affect-facilitating environment, loss, disappointments, offenses, lapses, and emotional pain that accompanies them do not require defensive exclusion (Bowlby, 1980); they need not be put away and disconnected or borne alone. (p. 59)

The AEDP therapist, Fosha underscored, prioritizes an "affect-facilitating environment" (p.58) within the therapist/client dyad, an environment that departs from traditional psychodynamic therapy where therapists have been trained to respond with "cool" and "detached reflection" (Fosha, p. 58.) and restricted to providing interpretations of the patient's intrapsychic experience. Rather, Fosha underlined that this "affective holding" (p. 58) in the therapist/ client dyad is one constituted by "empathy and caring" (p. 58) and "sensitive responsiveness (attunement)" (p.69) where the therapist is "emotionally engaged and willing to share in affective experiences" (p. 69).

The experience of affective holding has been further illuminated in the notion of mutual coordination. As stated earlier in the section on attunement, Fosha (2000) defined affect coordination as the "moment-to-moment mutual emotional attunement" between therapist and client (p.61) within the "complex, survival-dictated functioning of the attachment system" (p. 57). This coordination of affect is:

> the realm in which the tone of emotional life is set and in which affective expectations are structured: the level of arousal that promotes optimal interactions (what's too little to elicit a response or too much, which ends up being disruptive); the range of affects and affective intensities that can be regulated reliably with the flow of interaction (what is responded to and what isn't, what is approved of and what isn't, what is expressed and what isn't, etc.,). These dyadically constructed patterns are based in a give and take that reflects the temperamental requirements of both members of the dyad. (p. 62)

Coordination of affect has been extensively researched by infant development theorists (e.g., Bateson, 1971, 1975, 1979; Murray, 1980; Trevarthen, 1979; Tronick, Als, & Adamson, 1979; Tronick & Cohn, 1989; Stern, 1985) who proposed the existence of an innate striving for mutual coordination in the infant/caregiver dyad. Any departures from mutual coordination, that is from positive affect to negative affect, were viewed as interactive errors and miscoordinated states (Gianino & Tronick, 1988), concepts that denote a sense of "failure to get in sync" (Fosha, 2000, p. 63).

Within AEDP, Fosha has pointed out three areas where the positive affects associated with mutual coordination in the infant-caregiver dyad correlate to the therapist /client dyad: receptive affective experiences, that is, how the self experiences their dyadic partner's responsiveness; healing affects (i.e., affects experienced when change is realized); resonance and

mutuality from being in a coordinated state. Where there was resistance, Fosha affirmed, this was often a result of "lack of in-syncness that is, a miscoordinated state between patient and therapist," (p. 64), that coincided with a patient not feeling understood. Significantly only 30 percent of dyadic interactions are in "affectively positive, mutually coordinated interactive states" (p. 64) and that "the rest of the time is spent in miscoordinated interactive states, accompanied by negative affect, attempts to get back to coordinate states, and positive affect" (p. 64).

The ability to allow for caregiving lapses and their repair aligns with Winnicot's (1965) notion of good enough caregiving. Fosha (2000) adduced how caregiving lapses and their repair both strengthen the dyad and also support individuation:

> Good enough caregiving promotes growth and doesn't require perfection; in fact, some discrepancy between the child's needs and his emotional environment often catalyze psychic growth. Self-other boundaries, the separation –individuation process, healthy aggression, symbolic and creative capacities and intersubjectivity can blossom in a context of frustration and lack of harmony (Mahler, Pine, & Bergman, 1975; Stern, 1985; Winnicott, 1964). . . . What matters as much as (if not more than) the natural capacity to be in sync is the capacity to repair out of syncness so as to re-establish optimal connection. (p. 65)

In the therapist/client relationship, Fosha underscored that "good-enough affect facilitation is not the perfection of seamless empathy or flawless selflessness, but rather something more akin to the willingness to engage authentically, compassionately, and responsibly" (p. 60).

Within affective neuroscience (see Chapter Two), the concept of mutual coordination has been depicted as the synchronization of the neural circuits of two individuals such that the individuals are in biological rhythm with each other (Schore, 2001). To briefly recap, Schore purported that the attuned dyadic communication occurs through right brain to right brain resonance where an individual attunes to the rhythms of another's internal state. Within the infant/caregiver dyad, researchers in affective neuroscience conjectured that it is through this coordinated affective state that a caregiver assists an infant to soothe his/her negative affect and by which the infant learns to self-regulate negative affect. Lapses of caregiving, interactive errors, or miscoordinated states were portrayed within affective neuroscience as misattunements in right brain to right brain communication. Moreover, it was understood that these

misattunements are an essential and regulatory pattern of disruption and repair, that is, the experience of negative affect followed by positive affect was paramount for the development of resiliency by teaching a child that negative affect can be "endured and conquered" (Schore, 2001, p. 21). This regulatory pattern of attunement, disruption, and repair has been conceptualized to occur in the therapist/client dyad and has been believed to be the process by which a client learns to regulate affect.

Drawing from the aforementioned literature on attachment, infant development research, and affective neuroscience on the attachment processes in the infant/caregiver dyad and therapeutic process, disruptions are portrayed as "lapses in caregiving," "interactive errors," "out of sync-ness," "miscoordination" and "misattunements" in the mutually affective right brain to right brain regulatory processes of the dyad. The findings on disruptions in the present study support this notion of miscoordinated states. Within the data, participants described multiples aspects of disruptions that originated with themselves as therapists: misattuning to the client experience; identifying with client defense; therapist anxiety; therapist wanting to keep client safe; and confrontation by the therapist. Disruptions that originated with the client included portrayals of how clients tried to please their therapists, how clients disclosed what wasn't working for them in therapy, and several disruptions in the form of client defenses. What the data on disruption demonstrated is twofold: a) within the context of AEDP, where therapists are trained to be tracking and scanning for mutual coordination of core affect from the get go, disruptions were experienced as *miscoordinated states* and b) that AEDP therapists were keenly aware of miscoordinated states in the dyad and attempted to re-coordinate with their clients.

Participants' experiences of disruption in the current study paralleled Schoettle's (2010) findings on the clinician experience of defense. Schoettle defined defenses as "dysregulated or inhibitory affects" (p. 109) that cause "unease" (p. 116). When this definition was applied to each of the sub-themes outlined in this study on disruptions, it painted a picture of disruptions as defenses. The research findings herein on disruptions elucidated that dysregulated or inhibitory affects (i.e., defenses) have the effect of *miscoordinated states* in the dyad. That is, regardless of whether the disruption originated on the part of the therapist or the client, what participants experienced was an attachment/ interactional/relational process where disruption was experienced as a miscoordinated state.

The current findings on disruptions as miscoordinated states within the dyad was contextualized within AEDP, an attachment-infused relational therapeutic approach. Existing research has suggested that the therapeutic approach influences how disruptions are experienced and addressed. Haskayne et al. (2014) underlined that one of the problems with rupture and repair research was that "different psychotherapies report varying levels of rupture and repair" (p. 70). They suggested that "it would be beneficial to focus on one specific theoretical model when understanding the impact of rupture and repair" (p. 70). It may be that the therapeutic focus of AEDP influenced how disruptions were experienced and addressed relationally, regardless of the origin of the disruption. Indeed, Soygüt and Gülüm (2016) in their qualitative study on therapist's perspectives on ruptures found that therapists were most likely to cite the patient's contribution as the cause of the rupture than to attribute the cause to the therapists or the therapist-patient relationship. In regards to recommended resolutions to the ruptures, therapists were more likely to suggest technical resolutions (e.g., using Socratic techniques) as opposed to relational resolutions. Soygüt and Gülüm attributed this to the psychotherapeutic orientation of the participants, that is, participants' therapeutic approach was not relationally oriented. The authors noted an increased "adherence to the therapy and use of available resources" (p. 120) when there was a rupture and that there was a "lack of process oriented perspective" (p. 120) inclusive of patient and therapist contributions in resolving the rupture. The thematic analysis in the research herein demonstrated, by contrast, contributions by both clients and therapists alike in the cause of disruptions. More specifically, participants within this study described these disruptions relationally as a loss of connection and out of sync-ness in the therapist/client dyad, where resolutions involved a relational attachment focused response, regardless of with whom the disruption originated.

Within the thematic analyses of the current study, it proved somewhat challenging to sift out the experience of disruptions apart from the resolution process. In the framework of AEDP where therapists were trained to seek out mutual coordination from the start of sessions, when miscoordinated states transpired, participants attempted to attune or re-attune to re-establish dyadic affective coordination, that is, to 'repair.' In the next section I will discuss the findings with regard to the repair process.

Repair. There were three central themes on how participants repaired disruptions: incomplete repairs where therapist did not explore underlying affect; disruptions that occurred

during the repair process; and processing repair to completion. Each of these themes will be discussed in the context of the theoretical and empirical literature.

The theme of incomplete repairs was characterized by situations where a disruption had occurred but the therapist did not explore the core affect underlying the disruption nor the underlying attachment issue, resulting in an experience that things were left incomplete or that the situation had not been "repaired." The finding in the current research on "incomplete repairs" supports findings in previous studies on unresolved ruptures (e.g., Hill et al., 1996; Hill et al., 2003; Rhodes et al., 1994). There is a general consensus within the literature on resolution of ruptures that failed repairs are missed opportunities to strengthen the therapeutic alliance. The current qualitative study on the therapist's experience of disruptions accentuated the need to explore the core affect and attachment issues associated with disruptions so as not to miss opportunities to deepen the therapeutic relationship.

The theme of disruptions in the repair involved participants' experiences of "trying to connect" and "staying the course." This finding revealed that resolution of disruptions was not a linear process but rather, a series of spirals, a finding that lends support to the existing literature on rupture resolutions. As explicated in Chapter Two, the literature on rupture resolution involved both studies on the development of resolution models (i.e., Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008; Bennett, Parry & Ryle, 2006; Cash, Hardy, Kellett, & Parry, 2014; Safran & Muran, 1996) as well as several qualitative studies on the resolution of ruptures (i.e., Haskayne, Larken, and Hirschfeld, 2014; Hill, Kellems, Kolchakian, Wonnell, Davis, & Nakayama, 2003; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Rhodes, Hill, Thompson, & Elliot, 1994; Soygüt and Gülüm, 2016). The non-linearity of repair was a finding that is echoed in various rupture resolution models. For example, Safran and Muran (1996) stressed that the resolution process is "circular, repetitive, and nonlinear" (p. 455). Bennett et al. (2006) underscored that resolution of ruptures is non-linear and that "cycling within and between stages will occur" (p. 408). Cash et al. (2014) found that rupture resolution was a cumulative process with resolution attempts reflecting only part of the solution. While the current research supports the non-linearity of repair in the literature, the finding in this study on "disruptions during repair" advances the existing research on rupture resolution models by providing qualitative experiences of the "cycling within and between stages" (p. 408). Within the current research, as participants tried to repair a disruption with their clients, this "cycling within and

between stages" (Bennett et al., 2006, p. 408) was experienced as a period of trying to find their way back into attunement with their clients. Participants described this phenomenon of trying to re-connect as "trying to go back," finding their "way back in," hitting "rewind." They underscored the need to remain within the "window of tolerance" and expressed this as "walking a fine line." Additionally, in repairing a disruption with their clients, participants described their attempts to "stay the course" with the repair and assist their clients to access the core affect underlying the disruption.

The final theme in the area of repair was "processing repair to completion." As evinced in Chapter Two and summarized earlier in this chapter (see section on attunement), affective neuroscience viewed the repair process as a re-establishment or re-engagement of coordinated states. With children, the regulatory pattern of disruption and repair, that is, negative affect followed by positive affect has been underscored as paramount for the development of resiliency by teaching a child that negative affect can be "endured and conquered" (Schore, 2001, p. 21). Within the therapist/client dyad, this regulatory pattern of attunement, disruption, and repair is believed to be the process by which a client learns to regulate affect and by which secure attachment develops (Stern, 1985; Schore, 1994; Siegal, 1999; Safran & Muran, 2000; Fosha, 2000). Fosha (2000) underscored that negative affect brings up the desire to attenuate and to strive to repair the unpleasant state such that there is a "motivational spur to reparation" (p. 63).

In AEDP, Fosha (2008) has drawn from research in affective neuroscience to centralize the processing of emotions and the therapist/client attachment relationship. According to Fosha, attunement, disruption and repair in the client/therapist dyad is the process in which the client is accompanied and assisted to re-experience and regulate his/her affect in the context of a safe and trusting relationship:

> Through the moment-to-moment affective communication between dyadic partners that occurs through non-verbal, right-brain-mediated processes involving gaze, tone of voice, rhythm, touch, and other vitality affects, members of the dyad establish coordinated states. The process of dyadic affect regulation proceeds through countless iterations of cycles of attunement, disruption, and then, through repair, the re-establishment of coordination at a higher level. Though invariably accompanied by negative affects, the disruption of coordination, if repaired, is a major source of transformation. (Fosha, 2008, p. 8)

The findings in this study on "processing repair to completion" illuminate the phenomena involved in the "re-establishment of coordination at a higher level" (p. 8) as well as the heightened and expansive transformation that ensues when a repair occurs.

As mentioned under the section on disruption, Haskayne et al. (2014) affirmed that focusing on "one specific theoretical model when understanding the impact of rupture and repair" (p. 70) would be beneficial because of the "varying levels of rupture and repair" (p. 70) found within diverse psychotherapies. The current research on disruption and repair undertook Haskayne et al.'s recommendation by focusing within one model of therapy: AEDP, an attachment based psychotherapy where a re-coordination of affective states in the dyad and the development of secure attachment underlied the reparative process. While it was not the intent of the current study to develop a model of rupture resolution, the finding of "processing repair to completion," along with its six sub-themes touch upon what a rupture-resolution model might look like in an attachment-based therapeutic approach like AEDP. The theme of "processing repair to completion" derived six sub-themes: exploring underlying affect; exploring the underlying attachment issue; attunement in the repair; laughter and playfulness; strengthening the relationship, and post-repair. Each of these sub-themes in this finding will be discussed sequentially in the context of the theoretical and empirical literature.

The sub-theme of exploring underlying affect referred to participants working to repair disruptions with their clients by acknowledging and exploring underlying feelings. This sub-theme supports previous research in rupture resolution models (e.g., Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Bennett, Parry, & Ryle, 2006; Cash, Hardy, Kellett, & Parry, 2014; Safran & Muran, 1996), specifically those stages within these models that address attending to and exploring the client's experience. For example, the exploration stage within Bennet et al.'s (2006) model involved the therapist fostering a "collaborative, participative style" (p. 409) so that patient and therapist can explore and clarify what is perceived and felt and "ideally reach a shared understanding" (p. 409). The authors espoused an affective model of rupture resolution within a context of "authentic human contact" (p. 412) where the therapist is "in tune with the patient's experience and affect" (p. 412) and attends to this underlying affect through "reflective and linking statements" (p. 412). This exploratory stage of underlying affect was also recognized within less affect-focused models of rupture resolution. Aspland et al.'s (2008) model encouraged a change of approach stage where therapists summarized, explored and

validated the client's experience rather than proceeding with technical interventions. Similarly, Cash et al.'s (2014) model recognized a change in approach stage that involved, "exploration of patterns of interpersonal interaction" (p. 142). Finally, Safran and Muran's (1996) model detailed an exploratory stage where the therapist "probes for underlying fears and expectations" (p. 451).

Within the qualitative research on rupture resolution, Haskayne et al. (2014) described an exploratory process of therapeutic discovery underneath their finding on "struggling" (p. 79). They conveyed that "as therapeutic discovery progresses, it was likely to discover painful, difficult areas, which may feel unsafe and dangerous to explore for the client" (p. 79) and that through the gradual process of therapy, patient and therapist were able "to make sense of painful, difficult emotions within the therapeutic discovery" (p. 79).

In sum, each of the aforementioned studies referred to an exploration stage where underlying affect of the rupture/disruption is explored. The finding in this study on "exploring underlying affect" supports the existing literature. However, the current study enhanced the existing research by qualitatively exploring the phenomenon in the context of attachment based psychotherapy.

The sub-theme of exploring the underlying attachment issue delineated how participants attempted to repair disruptions by exploring underlying attachment issues within their clients and within the therapeutic relationship. Fosha (2000) has elucidated two ways that affective responses prevail in therapy, the triangle of experience response and the triangle of expressive response. She explicated that if the patient is not feeling safe, "interventions to address lack of safety, to lower resistance, and decrease anxiety are called for" (p. 109) and that the "possibility of 'interactive error' and 'interactive repair' must be considered (Gianino & Tronick, 1988; Tronick, 1989)" (p. 109). If the patient feels "safe, understood, and supported within the therapeutic relationship and good, strong, capable, and clear within himself" (p. 109), that this signals a "green light" (p. 109) to engage with deep affect. When participants in the current study attempted to explore underlying attachment issues pertaining to a disruption, they addressed defensive responses by allying with the client against his/her defense and providing a corrective emotional experience (CEE). The corrective emotional experience in turn helped clients proceed with deep affect work (i.e., the triangle of expressive response), repair old models of other and models of self, and form new trust.

Bennett et al.'s (2006) model of rupture resolution referred indirectly to CEE when they spoke of "enactments" to convey how threats to the alliance are understood in cognitive analytic

therapy. Threats to the alliance were "seen as re-enactments of dysfunctional interpersonal patterns in which the therapist is as active as the client (i.e. the difficulty is not located within the client but is seen as fully relational, or dialogical)" (p. 397). These re-enactments were met with a "collaborative, participative" (p. 409) therapist that invited the client to link "the episode to earlier examples in the therapy, to other shared tools or metaphors, to relationships with others or with childhood memories" (p. 409). While in Bennet et al.'s model, there was some association of linking the rupture with childhood memories, there was no indication of the therapist/client attachment relationship as a corrective and reparative experience as has been presented in this study's findings.

Safran and Muran's (1996) model directly identified the corrective emotional experience as a significant process in rupture resolution. The findings from the present research on exploring an underlying attachment issue through CEE in the repair of disruptions support Safran and Muran's model. Safran and Muran (2012) explicated that working through ruptures entailed a "process of clarifying both underlying needs that are dissociated and tacit fears and expectations that lead clients to dissociate these needs" (p. 62). In line with a contemporary relational perspective of psychotherapy and building on infant development research on the notion of miscoordination and repair, Safran and Muran (2012) conceptualized "the therapeutic process as an ongoing cycle of mutual enactment and disembedding" (p. 62). The authors linked this process of repair to the notion of the corrective emotional experience. They asserted that:

> therapists unwittingly become partners in enactments, or interpersonal dances, that reflect the unique intersection of unconscious aspects of both clients' and therapists' subjectivities. It is only through the process of collaboratively exploring what is taking place at such times that both therapists and clients can begin to understand the nature of the enactments that are taking place. This process of developing an experientially based awareness of what is taking place helps the client and therapist to disembed, or unhook, from the dance in which they are trapped. This process of disembedding functions as a CEE insofar as it challenges the client's stereotyped expectations of the way relationships will play out. (p. 62)

Safran and Muran accentuated that the therapist needed to maintain a "curious and nondefensive stance" (p. 62) so that clients felt "safe to express dissociated needs and wishes in the therapeutic relationship" (p. 62). Thus, clients experiencing withdrawal ruptures learned that "they can express dissociated needs for self-assertion and agency without destroying relationships" and

clients experiencing confrontation ruptures learned that "the therapist can tolerate and survive their aggression" and that their "needs for dependency and nurturance are safe to express" (p 62).

While the findings herein on CEE in repairing disruptions support Safran and Muran's rupture resolution model, the depiction of CEE by Safran and Muran was about challenging stereotypes and expectations of relationships where a client was to be met with a "curious and nondefensive stance" (p. 62) by the therapist. This description differs substantially from the attachment infused approach to CEE in AEDP. Within AEDP, the therapist's stance is one that extends beyond curious and nondefensive. The findings presented in this research were situated within an attachment based therapeutic approach where the therapist/ client relationship was constituted by relational safety, affective resonance, empathy and trust, and moment-to-moment dyadic affective regulation. Within this therapeutic context, the central agent of change was the "somatically-rooted experience of previously unbearable core affects in the here-and-now of the patient-therapist relationship" (Fosha, 2008, p. 9). The aim of CEE within AEDP is to assist a client to develop secure attachment through dyadically regulating previously unbearable core affects in the presence of relational safety. The finding in the present study on exploring underlying attachment issues through CEE in rupture resolution advances the literature on rupture resolution by its emphasis on the attachment relationship and dyadic affective regulation as reparative.

The sub-theme of attunement in the repair process captured a mutuality of attunement that was heightened and qualitatively different than the attunement experienced at other moments during the sessions. Fosha (2007) in her description of dyadic affect regulation referred to the attunement that occurs when a disruption is repaired as heightened coordination and depicted its transformative power as follows:

> Repair involves establishing a new, expanded coordinated state where differences can be encompassed and integrated at a higher, more expansive level. "The flow of energy expands as states of brain organization in the two partners expand their complexity into new and more inclusive states of coherent organization, enabling the infant to do what it would not be able to do alone" (Sander, 2002, p. 38). The achievement of the new coordinated state is a vitalizing, energizing human experience. It gives rise to new emergent phenomena which transform and expand both dyadic experience, and the experience of each

> dyadic partner, reflecting how being together changes each of them (Fosha, 2003; Hughes, 2006; Sander, 1995, 2002; Schore, 2001; Tronick, 2003). (p. 7)

Within this research, participant descriptions of attunement in the repair reflected Fosha's notion of a "higher, more expanse level" (p. 7) at "a new, expanded coordinated state" (p.7) and support Fosha's assertions.

Notably, none of the rupture resolution models hitherto touched upon attunement in the resolution process, a micro-process that is more richly explored within qualitative studies. Within the qualitative literature, Haskyayne et al.'s (2014) investigation on ruptures and resolutions in long-term therapy discussed attunement as one of their thematic findings. They underscored how "attunement fluctuated throughout therapy (to and fro) similar to a dance" (p. 82). They elaborated:

> Attunement is an essential part of therapy in which the therapist empathically responds to the client's emotional state and uses their feelings to guide the therapeutic process (Holmes, 2001). This continuous oscillation seemed to help to develop the expectation that ruptures can be reconciled, and negative emotions transformed into positive ones (Safran et al.,1990). (p. 82)

While the findings in the current study supported Haskayne et al.'s finding of attunement as a continuous oscillation and an essential part of therapy, the present finding on attunement in the repair was more refined and aptly captured by Fosha's portrayal of a heightened state. As previously discussed, AEDP therapists are trained to attune, that is, trained to seek out mutual coordination from the start of sessions. The AEDP approach by the participants within this research could account for the more enriched and detailed finding of attunement in the repair. Indeed, in their qualitative research on rupture resolutions with therapists whose approach was cognitive behaviour therapy and schema therapy, Soygüt and Gülüm (2016) found that therapists lacked this 'attuned monitoring' ability:

> the resolution of the ruptures requires moment-by-moment awareness, attunement and monitoring of the process by therapists. The tendency observed in our participants might be a reflection of a lack of awareness of rupture moments, and this is a major obstacle in facilitating resolution of ruptures in the alliance. Accordingly, we can speculate that participants might tend to overlook their own role in the therapy process, particularly the

> key role of the therapeutic relationship itself, when considering rupture moments in their sessions. (p. 120)

The sub-theme within this study on attunement in the repair illustrated a unique dyadic engagement that was differentiated by a heightened sense of mutual coordination, that was transformative and that generated an expanded dyadic experience of togetherness. Further, it appeared that this phenomenon was the tapestry from which the next two sub-themes in the repair process transpired, i.e., laughter and playfulness and repair strengthens relationship.

Laughter and playfulness was an avenue of connection and avenue for attunement during the repair. Mutual laugher was portrayed as a "coming closer." This phenomenon transpired in the dyad as a result of experiencing a "deeper level of attunement. . . . on the way to the repair." Within AEDP, Fosha (2008) depicted this sensation of lightness, relief and laughter as post-breakthrough affects. Post-breakthrough affects occur at the completion of a wave of core affective experience. When a therapist assists a client to drop down and stay with core affect until this emotional experience has been processed to completion, there is a sense "feeling relief, as well as feeling lighter, clearer, stronger" (p. 14). Within the findings, "staying with" a disruption and moving through the emotional waves to fully experience the underlying core affect around the disruption, allowed laughter and playfulness to emerge.

The experience of laughter and playfulness has been additionally reflected in the literature on attachment. Attachment provides a secure base from which a child can explore the environment, engage in play and take risks toward growth, a haven of safety to which a child can return when he or she is afraid or fearful (Bowlby, 1980, 1988). During times of distress, if a parent attends to a child and soothes him/her through the emotional wave, positive affect including laughter and playfulness emerge. This connection through mutual laughter and playfulness is paramount to co-engendering secure attachment. The finding within this study of laughter and playfulness in the repair supports the phenomena of both post-breakthrough affects within AEDP as well as the literature on developing secure attachment.

Participants indicated how repairing a disruption strengthens the therapist/client relationship by laying a foundation for further repairs, by building the capacity for reparative conversations and by supporting vulnerability. The finding that repair strengthens relationship supports the existing literature on rupture resolution. Numerous studies have demonstrated that resolution of ruptures are associated with positive therapeutic outcome and strengthen the

therapeutic bond (e.g., Coutinho, Ribeiro, & Safran, 2009; Eubanks-Carter, Muran, & Safran, 2010; Hill, 2010; Haskayne, Larken, & Hirschfeld, 2014; Safran & Muran, 2011; Norcross & Wampold, 2011). What is unique about the finding in the present research is a rich and detailed depiction by participants of how the therapeutic relationship is strengthened in the framework of an attachment based approach to therapy. The concepts of fostering relational intimacy and building the capacity for reparative conversations support the notion within AEDP of building resilience through repair. Fosha affirmed that AEDP therapists "seek to deepen patients' experience, and work it through to completion until their adaptive action tendencies are released and the patient's access to resources and resilience opens up (Fosha, 2000b; 2004b, 2005)" (Fosha, 2008, p. 10). Drawing on affective neuroscience, Fosha (2008) further elucidated the neurobiological processes involved in the fostering of resilience:

> The dyadic affect regulation characteristic of metatherapeutic processing entrains the integrative structures of the brain, i.e., the corpus callosum, the prefrontal cortex (especially the right prefrontal cortex shown to mediate emotionally loaded autobiographical narrative, Siegel, 2003), the insula and the anterior cingulate (van der Kolk, 2006). These structures have been shown to be adversely affected by trauma (Teicher, 2002), and to play a significant role in the healing from trauma through the coordination of left-brain and right brain aspects of emotional experience (Lanius et al., 2004; van der Kolk, in press). Entraining them through metatherapeutic processing is both a one-brain process and a two-brain process: while the dyad supports the integrative work that takes place within the individual's neural processing, it also supports a dyadic brain-to-brain communication process involving the integrative brain structures of the dyadic partners. The result is the patient's nascent capacity to generate a coherent and cohesive autobiographical narrative, the single best predictor of security of attachment and resilience in the face of trauma (Main, 1999; Siegel, 2003). (p. 14)

If, as affective neuroscience espouses, dyadic interaction consists of countless iterations of attunement, disruption and "hard-won repair" (p. 34), the capacity for relational intimacy and for reparative conversations are then essential to both generating a coherent narrative of one's experience and to developing resilience and secure attachment.

The notion of reparative conversations in strengthening a therapeutic relationship is further elucidated in AEDP through the concept of metatherapeutic processing which denotes actively reflecting with the client on what an experience felt like. Fosha (2008) explicated:

> Having processed emotional experience to completion, and thus effected a transformation, we do not stop. A major aspect of AEDP is the focus on, and the affirmation of, the experience of transformation itself, particularly the experience of the transformation of the self in the context of a healing dyadic relationship. (p. 10)

Fosha underscored that metatherapeutic processing becomes the "departure point for the next round of exploration. . . . a cascade of transformations" (p. 10), a phenomena that will be elucidated further in the next sub-category, post-repair.

Participants conveyed a post-repair experience that denoted what occurred once a rupture had been resolved and that reflected a deeper vitality, freedom, and openness. Within the literature on models of rupture resolution (e.g., Aspland et al., 2008; Bennett et al., 2006; Cash et al., 2014), this post-repair period was captured by the final stages of the models that entailed processes such as the restoration of the therapeutic alliance, reformulation, the focus of therapy on the therapeutic relationship, and a collaboration and engagement on a new therapeutic task. Because of the task analysis method utilized, the literature on rupture resolution models lacked an intricate portrayal of how this 'restoration' of the alliance was experienced by the dyad. In their qualitative research on rupture resolutions, Haskayne et al. (2014) provided a more woven depiction of the final stages of rupture resolution. They found that "positive connection" (p. 79) proceeded resolution of ruptures. Positive connection involved the sub-themes of "emotional sensitivity" (p. 79) and "shining a light" (p. 79). Under the heading of emotional sensitivity, participants described a post-rupture experience of feeling "emotionally in tune, setting an optimal pace in therapy and the therapist providing care and containment" (p. 79). Shining a light portrayed how patterns of behaviour were discussed in the dyads following a rupture. The post-repair findings in this study support Haskayne et al.'s finding of positive connection both in the attunement, care and containment of client affect and in generating a narrative of patterns of behaviour. However, while the research findings in the present research on post-repair support the finding by Haskayne et al. of positive connection, the current study advances this notion by portraying a more intricate tapestry of positive connection, one that reflects and supports the AEDP model of state transformations (see Appendix 7).

Within the AEDP model of state transformations, the aspects of 'metatherapeutic processing' and 'the truth sense' within core state are specifically relevant to the post-repair findings in this study. The transformational affects that accompany metatherapeutic processing involve a new energy, vitality, openness and aliveness. Fosha (2008) elucidated:

> A felt sense of vitality and energy characterizes transformance-based emergent phenomena. AEDP, along with others interested in exploring the progressive motivational forces of transformance operating in development and in therapy (e.g., Buber, 1965; Eigen, 1996; Gendlin, 1981; Ghent, 1990, 2002; Sander, 1995, 2002; Schore, 2001; Trevarthen, 2001), recognizes these very positive phenomena as energizing developmental growth, glorious development and expansive, enriching exploration. Rooted in the body, they mark transformational processes on an optimizing path: going beyond symptom relief and stress reduction, we are in the realm of thriving, flourishing and resilient functioning (Frederickson & Losada, 1995; Tugade & Frederickson, 2004; Russell & Fosha, in press). (p. 301)

Within AEDP, the felt sense of vitality and energy described above heralds in a truth sense where this "new sense of self" is consolidated. Fosha depicted the truth sense as an experience of core state:[10]

> In core state, the patient experiences a sense of expansion and liberation of the self, as well as openness to and capacity for deep contact and interrelatedness. Fully able to move back and forth between compassion and self-compassion, between wisdom and generosity, True-Self-True-Other relating --AEDP's equivalent of I-Thou relating-- is quintessential core state phenomenon. Thus, the transcendent qualities Maslow associates with "godlikeness," are front and center in core state. (p. 304)

The post-repair finding in the current research provides support for the phenomenon of core state in the AEDP model of state transformation.

Notably, several of the findings in the current study on the repair process parallel the phenomenon of core state that Schoettle (2010) found in her investigation of the therapist's experience of an intersubjective psychotherapeutic process. Schoettle highlighted that core state not only involves the "authentic, alive, real" (p. 48) and "spiritual" (p. 48) feelings portrayed in Fosha's description above but also underscored that "in core state, affect and cognitions come

[10] See Appendices 6 and 7 for an explanation of core state and other AEDP concepts.

together for clients; cohesive and coherent autobiographical narratives emerge, therapeutic work is consolidated, and meaning is made (Russell & Fosha, in press)" (p. 48). The findings in the present research on repair, namely, "repair strengthens relationship" and "post-repair," support the findings of core state in Schoettle's study. Moreover, the current findings advance Schoettle's research by further refining the experience of core state in the repair process of AEDP.

Summary of Findings on Attunement, Disruption and Repair

To summarize, the findings in this research provided qualitative explications and richly nuanced depictions of ADR as experienced by the therapist in an attachment-focused approach to psychotherapy. ADR involved: 1) attunement as a coordinated state (i.e., the "moment-to-moment mutual emotional attunement" (Fosha, 2000, p. 61) between therapist and client within the "complex, survival-dictated functioning of the attachment system" (p. 57); 2) disruption as a miscoordinated states, (i.e., an experience accompanied by negative affect when the dyad is no longer in a coordinated or attuned state), and 3) a repair process that occurred when a client was met by an attuned other, re-established a coordinated state with the other, and was subsequently able to self-regulate and engage in exploration.

What emerged in the data on attunement is a sense of spiraling down through successive changes or degrees of attunement with increasing resonance. The first two common themes, "attunement as connection" and "attunement as we're in this together," transpired at initial stages of attunement, followed by the third and fourth common themes, "attunement to underlying affect" and "attunement as building human relational capacity," which represented a deeper gradation of attunement.

The findings on disruption demonstrated that within the context of AEDP, where therapists were trained to be tracking and scanning for mutual coordination of core affect from the get go, disruptions were experienced as *miscoordinated states*. The findings on disruption further demonstrated that AEDP therapists were keenly aware of miscoordinated states in the dyad and attempted to re-coordinate with their clients. The thematic analysis in this study demonstrated contributions by both clients and therapists alike in the cause of disruptions. More specifically, participants within this study described these disruptions relationally as a loss of connection and lack of in-syncness within the therapist/ client dyad. Likewise, resolutions involved a response that was relationally and attachment focused.

Repair was experienced as a re-coordination of affective states in the dyad and understood to be a "circular, repetitive, and nonlinear" process (Safran & Muran, 1996, p. 455) that involved various components such as: disruption in the repair, exploring underlying affect, exploring the underlying attachment issue, attunement in the repair, laughter and playfulness, strengthening of the therapeutic relationship and post-repair experiences. While it was not the intent of the current study to develop a model of rupture resolution, the finding of "processing repair to completion," portrayed an idea of what a rupture-resolution model might look like in an attachment-based therapeutic approach like AEDP.

A Hermeneutic Perspective on Attunement, Disruption and Repair

Implications of hermeneutics on psychology affirms that psychology is an interpretative practice situated within historical, sociocultural and political contexts, contexts that "orient us as psychological beings" (Sugarman & Martin, 2005, p. 259). Applying a sociocultural and political lens to the current research revealed several assumptions. While ADR transpires within a relational two-person psychology, it can be viewed from a sociocultural perspective as an intrapsychic phenomenon situated within postmodern and neo-liberal values of individualism and contextualized within a culture of white western monotropy. Further, in as much as it is defined by affective neuroscience, ADR risks being reduced to biological reductionism or what Pitts-Taylor (2010) has termed "biomedical neoliberalism" or "being 'embrained'…in the current social context" (p. 640). In the following section, these cultural and sociopolitical assumptions will be elucidated.

Carr and Battle (2014) in investigating Bowlby's attachment theory and its socio-political positioning within psychological research, situated attachment theory within a context of neoliberalism that emerged in the 1970s. Neoliberalism, they explicated, underscores values such as "the single-minded pursuit of policy and ideology prioritizing the commercialization of everyday life, the corporatization of human services, the dismantling of the welfare state, the militarization of public space, ruthless individualism, and the increasing privatization of the public sphere" (p. 1). In the discourse of neoliberalism, health was identified as those "actions, objects, attitudes, and processes through which people define and achieve their state of 'being,' be it well or ill, with regard to certain norms, values, and goals." (Galvin, 2002, p. 127). Carr and Battle (2014) explicated how attachment research "might unwittingly serve neoliberal values and shape human behavior" (p. 2). While the authors acknowledged that attachment theory fosters

psychological and emotional connections that can reconceive social structures toward well-being and social justice, they additionally demonstrated how attachment research can be employed to idolize neoliberal values of "individualism, performativity, and production" (p. 16). For example, the authors summarized and critiqued current research that examined the attachment styles of individuals within tennis and computer science. Such research, Carr and Batlle contended, highlight the benefits of individuals with avoidant insecure working models of attachment because they can succeed in ventures that require "cool, competitive, mechanical, and individualistic" (p. 16) attributes. The authors pointed out and cautioned the cost to society and to an individual's mental health in such idolization. The gist of their argument was that researchers within attachment literature needed to develop a psychology that was critical of the contextual values within which such research was conducted.

Carr and Batlle raised important questions about the sociopolitical values in which research is embedded. In regards to the current research, one may ask, how does ADR shape human behavior so that it supports values of "individualism, performativity and production?" (p.16) Despite the emphasis on the relational in the theoretical underpinnings of AEDP, the current data delineated a phenomenology that was not only relational and interpersonal but also intrapersonal or intrapsychic. For example, under the theme of attunement as connection, participants portrayed this connection as an invitation to attune or as an entry point to affect, that is, when a therapist invited a client to somatically and affectively explore his/her experience. Descriptions such as tracking a client's nonverbal as an "entry point" to affect, scanning for the "green light," or tracking "what's emergent" were not only a common experience of attunement for participants, but also portrayed affect as being somewhere inside the individual. The assumption being that affect is experienced inside the individual, underneath layers of "defenses." Similarly, the common theme of attunement to underlying affect depicted this phenomenon as a somatic "dropping down" within oneself into affect. This attunement to dropping down was characterized through various relational descriptors such as a "joining with" and sense of "spaciousness," but also through intrapsychic depictions such as "letting barriers down," "working to deepen and expand," a "focusing" and "narrowing in to expand out," and "resonating to the centre." This somatic exploration of affect, as delineated in the data, was portrayed both interpersonally and intrapsychically. The emphasis on the intrapsychic within mental health has been historically criticized for locating psychopathology within the individual while ignoring the context within

which psychopathology emerged. An individualistic psychological perspective exhorted:

> that our everyday being originates from a subjective, internal private world. This position, descended from Cartesian dualism, bifurcates human experience, rendering an isolated subject and a decontextualized external world….parting off experience in such a way, as Rollo May (1983/1994) suggested, loses the richness of the living, existing human being's relationship to and engagement in the world. (Reuther, 2014, p. 101)

In so far as the affective aspects of ADR reside within the individual, ADR risks locating psychopathology within the individual. Within a sociopolitical context, Carr and Battle have cautioned against an emphasis on individualism within psychology, an individualism that increasingly privatizes health care and makes health maintenance "a responsibility or a duty rather than a right," and where "bodies and selves are targeted for intense personal care and enhancement" (Crawford, 1977, 2006 as cited by Pitts-Taylor, 2010, p. 640).

Keller (2013) further critiqued and illuminated the assumption of individualism within attachment theory. Keller argued that attachment theorists have historically fallen short of addressing both developments in evolutionary science and cultural/ anthropological perspectives of parenting and child development. She contended that child attachment styles are culturally specific, that the fundamental ideology of attachment theory stressed independence from others as a healthy human ideal and that this moral ideal has become a judgement on "maternal adequacy (p. 181)." Additionally, Keller (2013) argued that attachment discourse universalized monotropy as a norm when in fact, it was the exception across human populations.

While attachment theorists affirmed the universality of child attachment styles (i.e., secure, insecurely avoidant, insecurely ambivalent, and disorganized), Keller maintained that there are few cross-cultural studies that demonstrated its universality. For those studies that do exist, they display cross-cultural biases. For example, Keller asserted that although Ainsworth's initial study on attachment styles was conducted in Uganda, Ainsworth could not replicate her study in North American homes. Unlike the infants Ainsworth had studied in Uganda, North American infants were accustomed to the comings and goings of their mothers. To accommodate the cultural context with the U.S., Ainsworth devised the Standardized Strange Situation Procedure in a laboratory setting where a child is observed while a mother and stranger take turns leaving the room. From this work, a standard distribution was set asserting that children in the general population are "66% secure, 12% avoidant, and 22% resistant" (p. 177). Note that this standard

distribution was contextually specific on a Western middle class population, a sample population that constituted less then 5% of the world's population. Keller underscored that while the Strange Situation derived from Ainsworth's work in Uganda and was further developed to apply to the cultural context of middle class Euro-American families, it had never been additionally adjusted to apply to the context of other cultures. Ainsworth's Strange Situation has been implemented in cross-cultural environments such as the Gusii in Kenya, Huasa in Nigeria, and other "Western and non-Western middle-class families" (p. 180), yielding research that Keller noted, solely recognized deviations in the distribution of styles as the only cultural variation. That is, such research will demonstrate diversity in percentages of secure, avoidant, or resistant attachment styles within a cultural context but fail to question the philosophical and cultural appropriateness of its application. Keller underlined:

> Inge Bretherton (1992) rightly found these cultural explanations as persuasive on the surface but not based on systematic assessments of parental beliefs and culturally guided practices. Moreover meta-analyses of cross-cultural studies showed that intracultural variation is far greater than intercultural variation (van IJzendoorn & Kroonenberg, 1988). Bretherton (1992) recognized the need for systematic studies of cultural differences when she concluded that attachment researchers need to develop ecologically valid, theory-driven measures, tailored to specific cultures and based on a deeper knowledge of parents and children's folk theories about family relationships. Folk theories about socialization and development are based on cultural conceptions of the self (Keller, 2007). (p. 181)

Perhaps what was most amiss in the attachment literature was precisely this, a recognition of cultural conceptions of the self and the assumed universality of conceptions of the self. Keller stressed that Bowlby's psychology "defined independence from others as a requisite of healthy human development" (p. 181) and that this "moral ideal" (p.181) formed the "ideological foundations of attachment theory" (p. 181), an ideology that has implications for both the goals of raising children and for what entails 'good' parenting. What is preferred in secure attachment are the "culturally valued qualities, such as self confidence, curiosity, and psychological independence" (p. 181) that constitute mainstream North American ideals and that have implications for what is considered well being and consequently, mental health and mental illness.

Keller accentuated that this moral ideal has become a judgement on "maternal adequacy" (p. 181). The "good mother" (p.181) in attachment discourse was one who "acknowledges that her baby has his/her own will . . . respects her baby's anger and evaluates the baby's needs as a separate autonomous person" (p. 181). Further, the sensitive mother needed to respond in a timely manner to the infant's signals, encourage a sense of efficacy and competence over his/her social environment, and follow the baby's lead rather than control or direct. Within this discourse, Keller emphasized, "the highly interfering or intrusive mother is regarded as one who has no respect for her baby as a separate, active, and autonomous person, whose wishes and activities have a validity of their own" (p. 182). Such attributes, Keller highlighted, was culturally specific and was not the norm of good parenting within many non-Western societies:

> For example, mother-infant symbiosis or triangulations belong to the clinical repertoire in the Euro-American middle-class culture, whereas it is the cultural standard and the valued practice in many non-Western contexts, which actually compose the majority of the world (Kagitcibasi, 2007; Yovsi, Kärtner, Keller, & Lohaus, 2009). (p. 182)

Keller underscored that one of the central differences in parenting across cultures is that the "monotropic bond between one caregiver and one infant is the exception rather than the normal case for human populations" (p. 182). In many cultural environments, alloparenting, a social system where several members of a community help to raise and support children, is the norm. Additionally, Keller explicated how from an evolutionary perspective that infants needed more than one caregiver in order to survive.

The assumption of attachment discourse as monotropic has implications for the current research. The theoretical underpinnings of the current research conceptualized the therapist/ client dyad as similar to what occurs in the infant/caregiver relationship:

> Like Hegel (1807/ 1977), Stern (1985), Benjamin (1988), and Mitchell (2000) [who] view intersubjectivity as a developmental achievement of coming to acknowledge the existence and value of the internalized other, a dynamic that readily applies to the mother–infant dyad and the therapeutic encounter. Daniel Stern (1985) has focused repeatedly on the internal experience of the infant's burgeoning sense of self as an agentic organization of somatic, perceptual, affective, and linguistic processes that unfold within the interpersonal presence of dyadic interactions with the mother. (Mills, 2005, p. 5)

The reader is reminded of Stern's (1985) description of the mother-infant attunement as "an unbroken line." What Keller (2013) highlighted is that this attunement occurs within an attachment relationship that is monotropic and reflective of white western notions of attachment discourses.

Several of the common themes in the current research exemplified this monotropy, in particular, the descriptions of "attunement as we're in this together." Participants suggested that there are "gradients" of attunement and chronicled a deeper level of attunement as a sense of "we-ness." Participants employed descriptions such as "being with me and with each other," "a secure base" and "we're in this together" to articulate their experience of we-ness. They described this attunement toward togetherness as being real and being in the moment. As well, participants referred to attunement as the "good enough other" in their descriptions of "we-ness." This experience was illustrated through portrayals such as feeling "motherly" or as being a "good enough caring other."

What was evident in the data was that therapists privileged the relational, that is, the therapist/ client dyad. This orientation is in line with both the theoretical foundations of AEDP as well as with the historical relational turn in psychology (see Chapter Two). Mills (2005) underscored:

> Post- and neo-Freudians form a marginalized community within North America in comparison to contemporary relational and intersubjective theorists, who emphasize the phenomenology of lived conscious experience, dyadic attachments, affective attunement, social construction, and mutual recognition over the role of insight and interpretation. Despite the rich historical terrain of theoretical variation and advance, many contemporary approaches have displaced the primacy of the unconscious. (p. 155)

Sugarman and Martin (2005) in their writings on psychological hermeneutics ask us to consider the sociopolitical and cultural contexts within which a contemporary relational and intersubjective psychology is constituted and how this constitution orients us as human beings. What Keller (2013) stressed was that the emphasis on the dyad and the development of attachments styles has been both monotropic and centred in a white western tradition of individualism. Carr and Battle (2014), while recognizing that attachment theory has the potential to reconceive social structures toward well being and social justice, cautioned against attachment theory becoming a social mechanism to shape neoliberal human behaviour of "individualism,

performativity and production"(p.16). Finally, because ADR has been informed not only by attachment theory but also by affective neuroscience, it is imperative to discuss the sociocultural assumptions about the brain when considering the context in which relational psychology is situated.

Bott, Radke, and Kiely (2016) in their discussion on psychologists' employment of neuroscience asserted that with a plethora of research emerging on neuroscientific understandings of behaviour, the "2000s saw a concomitant increase in the brain's role in human behaviour and was dubbed the 'decade of behaviour' by the American Psychological Association (APA)" (p. 321). Research in neuroscience, specifically affective neuroscience, has been fundamental to AEDP and to the theoretical underpinnings of ADR. To briefly recap, affective neuroscience contended that attachment developed in the infant/caregiver dyad through right-brain to right-brain communication of affective states (Schore, 1994; Siegal, 1999). Clinicians such as Siegel (1999) and Schore (2003) underscored that a process of attunement, disruption and repair was the mechanism by which affect regulation occurs within the infant/caregiver dyad and similarly, within the therapist/client dyad. Additionally, research in mirror neurons (Gallese, Eagle, & Migone, 2007) lent support to the notion of right brain to right brain affect regulation both in the infant/ caregiver dyad and similarly between therapist and client.

Within the data, the conceptualization of right brain to right brain affect regulation emerged in participants' description of attunement to vitality affects and in their employment of the language of affective neuroscience to describe their experiences of ADR. There was a palpable sense of vitality affects in the synchronized breathing, gazes, and silences depicted in the data that capture the biological rhythm, coordinated state and neural synchronization that Schore (2003) and Siegal (1999) distinguished. Moreover, participants employed the lexicon of affective neuroscience, that is, of attunement, disruption and repair in their descriptions of their interactions with their clients, including concepts of cross-modal matching, and models of self. Additionally, affective neuroscientific notions of dyadic regulation weaved throughout participants' phenomenology of ADR.

Investigating the sociocultural assumptions about the brain in relational psychology necessitates a discussion of biological reductionism. The polarizing debate in psychology between psychosocial models of behaviour and biomedical models has been longstanding. Biological reductionism asserted that human behaviour can be broken down into its biological

components and that mental illness can be explained and resolved by genetics, biology and the neurosciences. With the profusion of neuroscientific literature in the 21st century, Bott et al. (2016) cautioned against the "tidal wave of neuroscience research popularity and momentum" (p. 322). The authors maintain that neuroscience research findings have been misrepresented by the media and frequently distorted by individuals including psychologists. They quote a 2008 study by Weisberg, Keil, Goodstein, Rawson, and Gray that found that for those with little expertise in neuroscience, psychological explanations "with logically irrelevant neuroscientific information" (p. 322) tended to be more "persuasive" (p. 322) than explanations without a neuroscience component. Bott et al. (2016) underscored:

> More recently, Weisberg, Taylor, and Hopkins (2015) performed a triad of follow-up studies demonstrating that in comparison to explanations without neuroscience information, explanations of psychological phenomena that contained neuroscience information were judged more satisfying and were considered "good explanations," regardless of whether the neuroscience information was presented simply or with extraneous neuroscientific jargon. This effect has also been documented within categories of neuroscience evidence. Munro and Munro (2014) found that "hard" scientific evidence (MRI) was evaluated more favourably when compared to "soft: evidence (cognitive testing) in rendering psychological opinions. (p. 322)

Such research gives us pause and invites us to critically view the rise in the importance of the brain in popular culture and within psychology. When applied to this dissertation, such research additionally stresses the need to view the role of affective neuroscience on ADR and on the theoretical foundations of AEDP with a discerning eye.

Pitts-Taylor (2010) echoed the assertions by Bott et al. in her description of the rise in the importance of brain in popular culture. She maintained that the translation of scientific knowledge of the brain into popular culture has resulted in "neurocentrism, where the brain is conceived as foundational of many aspects of human nature and social life and where the ability to know key truths about the self and the social are dependent upon developments in neuroscience" (p. 635).

Pitts-Taylor affirmed that the discourse on the brain presents a biological view of the body and self as well as biological roots of mental illness and raises questions about biological determinism. In response to criticisms of biological determinism, researchers have pointed to

brain plasticity, that is, that rather than being hard-wired, the development and functioning of the brain is influenced by the environment. To this, Pitts-Taylor has countered that although brain plasticity has been "framed through postmodern, poststructural, queer, or progressive understandings of subjectivity and social life" (p. 639), there has been little accounting of the "power relations involved in seeing ourselves as neuronal subjects." (p. 639). In this respect, she argued that the "development of plasticity discourse is highly compatible with the neoliberal pressures of self-care, personal responsibility, and constant flexibility" (p. 640) and suggested "the need for further investigation into the lived experience of having/being 'embrained' (embodied) in the current social context" (p. 640).

The "embrained" conception of selfhood that emerged in the data when investigating ADR is a self whose early childhood attachment experiences have resulted in interpersonal and intrapersonal models of self, models of other and styles of attachment, and where attachment styles impact the ability to regulate one's affect and maintain secure relationships. Where negative early childhood attachment experiences result in 'ruptures' or 'disruptions' in affect regulation, they can be 'repaired' through replicating the right brain to right brain biological rhythm of the attuned infant/ caregiver dyad and engaging the neural circuitry of coordinated states. This notion of 'repair' is a relational process but also alludes to the idea that something, a physical phenomenon, is broken and needs to be 'fixed.' The idea of neural circuitry also leads to the notion that psychological phenomena can be 're-wired' if there's a short (i.e., a rupture or disruption). Such notions as 'repair,' 'neural circuitry,' 'ruptures,' 're-wiring' are mechanistic terms. In this vein, ADR risks echoing elements of biological determinism.

In summary, interpreting the data within a historical, sociocultural and political context situates ADR within postmodern and neo-liberal values of individualism and within a white western culture of monotropy. As well, in as much as ADR is defined by affective neuroscience, ADR risks being reduced to biological determinism. The findings in the current research offered several positive implications. The findings informed the processes of dyadic affect regulation and the development of secure attachment and helped further operationalize attachment theory. They provided a deeper understanding of how ADR transpires within the therapeutic process, have implications for training clinicians on both dyadic affect regulation and rupture repair, and contributed to our understanding of how change occurs in therapy. What a hermeneutic perspective invites us to consider is the broader historical, sociocultural and political scope

within which such research and findings are contextualized, that is, culturally specific to postmodern values of individualism and situated within a white western culture of monotropy.

Limitations

There are several limitations to this study. First, the most salient limitation to this research was that only therapists were interviewed. This study fell short of investigating the experience of ADR as an intersubjective process in the dyad. Notably, the research proposal was initiated with the intention of interviewing both therapist and client. Unfortunately, despite numerous attempts at recruitment, including offering monetary incentive, recruitment of clients failed. It is possible that clients had concerns and/or felt too vulnerable to discuss their experience of disruptions in therapy, especially if they were continuing to seek services from their therapist. Additionally, the IPR interview protocol is lengthy and can take up to 4 hours to complete. It's possible that clients were not able to commit this amount of time. Because of this, commonalities and differences in how therapists and clients experienced ADR was not investigated.

A second limitation arose with the purposive sample from which I recruited participants. Therapists were required to be trained in AEDP and employ AEDP as their approach to therapy. One limitation was that I studied the phenomenon of ADR in a purposive sample of AEDP trained therapists and therefore my interpretations may be limited to this population. I would caution about generalizing any understandings about how this phenomenon might manifest in other therapeutic approaches.

A third limitation was choosing what iterations of ADR to investigate. As noted in the theoretical literature review, a session consists of multiple iterations of ADR, most of which occur at a micro level and many of which occur out of awareness. Investigating every ADR that occurred in a session was beyond the scope of this research. As well, participants in this study self-identified a session that they felt was inclusive of ADR. There may have been bias in the selection of the session to investigate. For example, therapists may not have felt comfortable showing videotapes of disruptions they failed to address adequately.

Fourth, the current research viewed ADR as a co-constitutive process. Investigating each phenomenon (e.g., attunement, disruption or repair) individually in separate studies might yield more knowledge and copious descriptions of each component.

Fifth, the number of participants in this research may be viewed by some as low and lacking in the robustness of a large sample. However, the reader is reminded that this dissertation

utilized a qualitative research method which entails deep, case-oriented analysis. Unlike quantitative research that entails large sample sizes and has outcome as a goal, the research herein employed a phenomenological qualitative methodology that investigated the therapist's experience of attunement, disruption and repair and gained a richly woven comprehension of the phenomenon.

Sixth, there were limitations in the Interpersonal Process Recall (IPR) approach to the interviews. IPR interviews normally occur within 48 hours of a client session to facilitate more accurate recall. As noted in Chapter 3 under Procedures, the research herein diverged from this criteria. There was no specified length of time specified as a requirement between the client session and the interview in the recruitment of therapists. This may have impacted therapist recall of their experiences in the client session. In some cases, the video recording that was used as a basis for the IPR interview was previously shown to other colleagues, a factor that may have influenced how the therapist made sense of the session.

Lastly, the lack of cultural diversity of participants limited the current study. At the time this research project was initiated, there were few advanced practitioners of AEDP in Vancouver, BC and I needed to travel elsewhere to recruit participants. The lack of immediately available AEDP clinicians in my vicinity limited the diversity of participants who volunteered for this study. Participants were of Caucasian origin, four were female, two were male, two identified as lesbian and one participant as gay. Among the clients in the videotaped sessions, five were Caucasian and female, one was of South Asian origin and male, and all were able-bodied and heterosexual. Diversity of participants in research is important because the perspectives of marginalized groups have been traditionally underrepresented within research (Sue & Zane, 2006). Additionally, cultural variables have been shown to influence clinical needs (Sue & Zane, 2006). Although the aim of the current phenomenological research was not to generalize across populations but rather, to gain an in-depth comprehension of participants' experiences, nevertheless, one might ask how might the comprehension of the phenomenon within the research herein have differed if there had been greater diversity among participants?

Implications of the Findings for the Field of Counselling Psychology

AEDP is a contemporary therapeutic approach that has been developed in the last few decades and has been informed predominately by clinical theory. There have only been two previous studies directly on AEDP (i.e., Schoettle, 2010 and more recently Iwakabe and Conceicao, 2016). One of the strengths of the current study is that it adds to the empirical literature on AEDP. AEDP is

one of the first therapeutic approaches to operationalize attachment theory into practice. As such, the findings on ADR in this study inform the processes of dyadic affect regulation and the development of secure attachment and help further operationalize attachment theory into practice.

As explicated in Chapter Two, the prevailing conception of ADR has emerged from a confluence of domains of inquiry: infant development research, psychotherapy, and affective neuroscience. The theoretical literature within these domains conceptualized ADR as a fundamental vehicle for change in the therapeutic relationship. However, to date, there had been a dearth of empirical demonstrations examining ADR. The findings in this study addressed this gap by providing a deeper qualitative understanding of how ADR transpired within the therapeutic process.

The findings on attunement in this research presented attunement as a spiraling down through successive changes or degrees of attunement with increasing resonance. This understanding of attunement as successive degrees is critical to affect regulation and to assisting a client to experience core affect. This notion of gradations of attunement has not been addressed in the literature and as such, informs and advances the theoretical literature in attachment and affective neuroscience. Additionally, this finding has implications for training clinicians in dyadic affect regulation, a process to which attunement is fundamental.

The finding that disruptions were both relationally experienced and relationally resolved regardless of with whom the disruption originated, lends supports to Safran and Muran's (2006) research efforts on the role of relational factors in the change process and the investigation of mutual regulation between therapist and client. Moreover, understanding disruptions as a relational phenomenon within the therapeutic dyad has implications for how clinicians are trained to track and resolve disruptions within the therapeutic process. This is especially significant in light of Soygüt and Gülüm's (2016) recent research that demonstrated that psychotherapists tended to cite the client's contribution as the cause of the rupture, were less likely to suggest relational resolutions, and lacked the attuned moment-by-moment monitoring ability to be aware of rupture moments. In light of the findings on disruptions as a relational phenomenon within the therapeutic dyad and attunement as degrees of attunement with increasing resonance, it may be helpful to train clinicians in attuned moment-to-moment tracking and monitoring of the therapeutic experience.

The findings on repair illuminated this phenomenon as involving diverse components and may assist clinicians to become more aware and skilled in how to address and repair disruptions when

they transpire. The diverse components of repair, if implemented by a therapist, would not only deepen the therapeutic relationship but also assist clients in having a more complete experience of rupture resolution, a greater sense of self, and an a more in-depth awareness of interpersonal patterns.

Within the literature on affective neuroscience, the repair of disruptions has been conceptualized to involve the re-establishment of right brain to right brain coordination at a 'higher' level (Schore, 2001). It has been conjectured that a heightened and expansive transformation ensues when a repair occurs. The present findings on attunement in the repair and post-repair elucidated this phenomenon of 'coordination at a higher level' and 'heightened' transformation. It may be helpful for clinicians within the field of Counselling Psychology to be trained to facilitate and assist a client to stay with this sense of heightened transformation when it occurs in the repair process as this may help consolidate change.

Finally, the findings in the current study contributed to our understanding of how change occurs in therapy. Piliero (2004) affirmed that what facilitates therapeutic change is processing deep emotional experiences "in the presence of an empathically attuned other" (p. 95). By utilizing a qualitative approach, the current study gained a deeper understanding of the experience of empathic attunement in the therapeutic relationship. The current findings on ADR in this research have further informed and illuminated the process of change in therapy by elucidating the process of attunement in the "empathically attuned other" (p. 95) and by providing a rich tapestry of how ADR transpires and is experienced within a therapeutic session. It appears that training clinicians in dyadic attunement to help facilitate deep emotional experiences with their clients would have positive implications for therapeutic change.

Future Research

As discussed, one strength and limitation of this research is that it investigated ADR as a co-constitutive process. Future qualitative studies exploring each component of ADR within separate studies might yield a broader understanding of each experience. While ruptures have been extensively researched (see Chapter Two) in the literature, qualitative research on attunement in the therapeutic dyad as well as qualitative research focusing on the repair process is lacking. For example, how might the notion of 'gradations of attunement' found in this study expand if this phenomenon were to be investigated with a larger number of both therapist and client participants? Likewise, how might the findings in repair expand to give a clearer picture of the reparative process

if this phenomenon were to be investigated with a robust sample of both therapist and client participants? Additionally, because ADR is an intersubjective experience, it is imperative that future studies investigate this phenomena with both therapist and client participants.

While the current research distinguished between attunement, resonance and presence, it may be helpful within future studies to sift apart what is attunement, what is resonance, and what is presence and how each of these are experienced with more depth and distinction in the therapeutic dyad. Currently, as explicated in Chapter Two, such terms are often utilized interchangeably without distinguishing each experience. The current research paints an initial picture of the interplay between attunement, resonance and presence. Future studies might investigate how each phenomenon (i.e., attunement, resonance, and presence) informs or contributes to dyadic affect regulation.

Finally, Iwakabe and Conceicao (2016) recently published a task analytic study to develop a model of metatherapeutic processing within AEDP. Given the generalized standard of developing rupture resolution models employing task analysis, future research might develop a model of rupture resolution utilizing task analysis within attachment focused therapies such as AEDP.

Conclusion

This research investigated the question, "How is attunement, disruption and repair (ADR) experienced by the therapist in an attachment-focused approach to psychotherapy?" The findings within this research has enhanced and addressed a significant gap in the existing empirical literature on ADR; contributed to our knowledge of the construct of ADR in the therapeutic process; informed the process of change within the therapeutic process; informed existing theory on affect regulation and attachment repair; and added to the body of research on AEDP, an attachment-infused experiential model of therapy.

In this research in-depth interviews were conducted with six participants. I undertook a thematic analysis of the transcribed interviews and derived three overarching common themes, attunement, disruption and repair, as well as several sub-themes. The findings involved qualitative explications and richly nuanced depictions of ADR as experienced by the therapist. Participants portrayed attunement as a spiraling down with augmenting resonance in successive degrees of attunement. The findings on disruption demonstrated that within the context of AEDP, where therapists are trained to be tracking and scanning for mutual coordination of core affect from the get go, disruptions are experienced as *miscoordinated states*. More specifically, participants within this study described these disruptions relationally as a loss of connection and

lack of in-syncness within the therapist/client dyad, regardless of with whom the disruption originated. Likewise, resolutions involved a response that was relationally and attachment focused. Repair was experienced as a re-coordination of affective states in the dyad and understood to be a "circular, repetitive, and nonlinear" process (Safran & Muran, 1996, p. 455). While it was not the intent of the current study to develop a model of rupture resolution, the finding of "processing repair to completion," portrayed an idea of what a rupture-resolution model might look like in an attachment-based therapeutic approach like AEDP.

The findings were additionally interpreted through a psychological hermeneutic perspective inclusive of historical and sociocultural contextual considerations (Sugarman & Martin, 2005). This situated ADR within postmodern and neo-liberal values of individualism, within a white western culture of monotropy, and in as much as ADR is defined by affective neuroscience, underscored the risk of being reduced to biological determinism. This hermeneutic interpretation of the findings has implications for cross-cultural applications of ADR and cautions against the "embrained" (Pitts-Taylor, 2010, p. 640) conception of selfhood within the current social discourse.

Overall, this dissertation provided a significant contribution to the understanding of ADR, a co-constitutive concept that has been under-researched but increasingly utilized to describe affect regulation, mutual coordination, and the development of secure attachment within the realm of emotion-focused and attachment-oriented psychotherapies. This has been particularly relevant given the historical turn away from psychology as an intrapsychic phenomenon that has stressed insight and interpretation toward a contemporary intersubjective experience that emphasized "the phenomenology of lived conscious experience, dyadic attachments, affective attunement, social construction, and mutual recognition" (Mills, 2005, p. 155). As Fosha (2000) evinced, attachment is the "fundamental human need to form close affectional bonds" and constitutes the "foundation of our psychological life" (p. 33). The current dissertation on attunement, disruption and repair within the therapeutic process has contributed to the understanding of one crucial aspect of our human psychological life.

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APPENDICES

Appendix 1

Email Advertisement for Recruitment of Therapists to AEDP Listserve

Researcher:
Enzula P. Tavormina
Tel: xxx-xxx-xxx

Research Supervisor: Dr. Marv Westwood
Dept. of Educational and Counseling Psychology and Special Education
2125 Main Mall, Vancouver, BC, V6T 1Z4
Tel: 604-822-6457

I am seeking Accelerated Experiential Dynamic Psychotherapy (AEDP) therapists preferably but not necessarily in the vicinity of Vancouver, BC or Seattle area to participate in a doctoral research study. The purpose of the study is to investigate "attunement, disruption, and repair" in the therapeutic dyad. To participate in this research, you must meet the following criteria:

1) Be an AEDP therapist that has attended the immersion level one AEDP training or equivalent (e.g., equivalent can be completion of the AEDP Essential Skills course or having received one year of AEDP supervision)

2) Be actively employing AEDP in your therapeutic work with clients.

3) Have a videotaped session of your work with a client where attunement, disruption and repair have occurred

4) Be available for a two to three hour initial interview and a one hour follow up interview once findings are complete.

As a recognition of your time this study, you will receive a $100 honorarium.

For futher information, please contact Enzula by phone at xxx-xxx-xxx or by email at xxx@xxxxxx.xxx.ca.

Appendix 2

Questions for Pre-Screening Conducted by Telephone With Therapist

1. Introductions

2. How did you hear about this study?

_____
_____
_____

3. Description of the study:

This research study investigates the experience of attunement, disruption and repair in the therapeutic process. The study will consist of a) having a videotape of one of your sessions with a client that is representative of attunement, disruption and repair; b) having permission from your client to use this tape for research, and c) one 2-3 hour videotaped and audiotaped interview in which we will both view the selected video-recorded session. During the interview, I will ask you open-ended process questions about your experience. The questions are meant to elicit your views, opinions and descriptions of your experience of ADR during the session. Once I have read over the transcribed interviews, I will be meeting with you in a follow up session to present the themes that have emerged and to seek your feedback for accuracy. As a recognition of your time for this study, you will receive a $100 honorarium.

4. Questions for participant selection:

a) Have you attended the immersion level one AEDP training?
Yes_____ No_____

If yes, ask when?_____
If no, proceed to question 4b.

b) Have you had equivalent training to the level one AEDP immersion?
Yes_____ No_____

If no, discontinue phone interview.

If yes, what training? Completed AEDP Essential Skills Course or Obtained One Year of AEDP Supervision? _____
If neither of these, discontinue phone interview.

c) Are you actively employing AEDP in your therapeutic work with clients?
Yes_____ No_____

If yes, continue with interview. If no, discontinue phone interview.

d) To participate in this study, you need to have a videotaped session with a client that is representative of attunement, disruption and repair. Do you have this?

Yes_____ No_____

If yes, continue with interview.
If no, discontinue phone interview.

e) Do you have permission from your client to use the videotape for research purposes?

Yes_____ No_____

If yes, continue with interview.
If no, discontinue phone interview.

f) Will you be available for a 2-3 hour interview?

Yes_____ No_____

g) Sometimes viewing a video-recorded session of your work can be discomforting. Are you willing and ready to view a recorded session of your work with your client and to discuss experiences of ADR while viewing the tape?

Yes_____ No_____ (If no, discontinue).

h) Let participant know that I will provide them with a list of resources to contact for support if needed.

i) Would you be available for a one hour follow up interview once I've analysed the data?

Yes_____ No_____

5. Review issues of confidentiality and inform the participant that he/she will be asked to sign a release form for our audiotaped and videotaped interview and for participating in the study. Check to make sure he/she understands, is comfortable with this procedure, and ask if he/she has any other questions.

6. Write down his/her contact information:

   Name: _____

   Contact Info: (tel)_____(email)_____

   Best time to contact you: _____

Appendix 3

Informed Consent Form for the Therapist Participant
Title: Attunement, Disruption and Repair in the Therapeutic Process

Researcher:
Enzula P. Tavormina
Tel: xxx-xxx-xxxx

Research Supervisor: Dr. Marv Westwood
Dept. of Educational and Counseling Psychology and Special Education
2125 Main Mall, Vancouver, BC, V6T 1Z4
Tel: 604-822-6457

This research is being conducted as one of the requirements for Enzula P. Tavormina to complete a PhD degree in Counseling Psychology. The purpose of this study is to investigate attunement, disrupton and repair (ADR) in the therapeutic process. You are being asked to participate in this study because of you are an Accelerated Experiential Dynamic Psychotherapy (AEDP) therapist.

To participate in this research, you must meet the following criteria: (1) have attended the immersion level one AEDP training or equivalent (e.g., equivalent can be completion of the AEDP Essential Skills course or having received one year of AEDP supervision); (2) be actively employing AEDP in your therapeutic work with clients; (3) have a videotaped session of your work with a client where attunement, disruption and repair have occurred where the recording includes both a visual of the therapist and client; (4) sign an informed consent to agree to be interviewed; (5) have permission from your client to use the videotape for research purposes, and (6) be available for a 2-3 hour IPR interview and a one hour follow up interview.

If you choose to participate, you will view your videotape with the researcher, pause the tape at intervals, and answer a series of questions during the viewing. The focus of the interview is your experiences of attunement, disruption and repair during the session. To assist you, a set of definitions has been attached to this informed consent (see page 5). The interview will be approximately 2-3 hours and will be audio and video recorded. The audiotaped interview and responses will be analyzed according to significant themes and patterns that may appear. Quotes from counseling sessions, quotes from interviews commenting on counseling sessions, or written descriptions of a video image will be used to support the identification of themes in the analyses and will be used in presentations/publications. At all times, strict confidentiality will be maintained through the use of pseudonyms. Additionally, video images may be used in presentations (e.g., for the dissertation defense or for a conference presentation). If an image is utilized, all identifying features will be blocked out (e.g., pseudonyms will be used, face and identifying features completely blurred or blocked out with a black square).

Further questions may arise and with your permission, may require additional telephone contact. At a follow up interview of approximately an hour, you will be asked to validate the data and analysis, and will be given an opportunity to clarify and/or offer any further information. The follow up interview will also provide the researcher with an opportunity to clarify any information. As a recognition of your time for this study, you will receive a $100 honorarium.

page 2 of 5…

All tapes and documents relating to this study will be kept in a locked filing cabinet to which only the researcher, the research supervisor, and a peer reviewer, will have access. The peer reviewer will review the transcripts and documents once findings are complete in order to validate the findings. The researcher will keep all tapes and documents for a period of five years. After this period, all data will be destroyed.

The following are possible risks from participating in this study:

- Participating in this study may impact the therapeutic relationship you have with your client.
- You may feel discomfort upon viewing video-recordings of your sessions.
- You may feel discomfort upon reviewing the findings of the study.

Your participation in this study is completely voluntary. You have the right to refuse to answer any questions and/or to refuse to provide any information. You also have the right to withdraw from this study at anytime.

There is an active re-consent procedure at the beginning, mid-way, and at the end of each interview. During these intervals, ongoing consent will be sought. This will entail reviewing the consent form with you prior to commencement of the interviews and answering any questions you may have. The researcher, Enzula Tavormina, will clarify that participation in this study is completely voluntary, that you have the right to refuse to answer any questions and/or to refuse to provide any information, and that you have the right to withdraw from this study at anytime. The researcher will seek verbal consent from you to proceed. The researcher, Enzula Tavormina, and the research supervisor, Dr. Marv Westwood, will be available to answer any questions concerning this study.

Our contact info is listed at the top of page one of this consent form. If however, you have any concerns regarding your rights or treatment as a participant, you may contact the Research Subject Information Line of the Office of Research Services at the University of British Columbia at (604) 827-5112.

A copy of this consent form and a list of resources for support if needed has been given to you for your own records. By signing below, you acknowledge you have read and understood this consent form, and that you have been provided a copy of this consent form as well as the support resource list.

Participant's Name: _____

Signature: _____ Date:_____

Definition and Examples of Attunement, Disruption and Repair

Attunement: Attunement is the act of focusing on another person to bring into awareness the internal state of the other. It includes the matching of a feeling or quality of the internal state of another person. One experiences attunement by resonating with another through empathy and through non-verbal affective communication such as gaze, tone of voice, rhythm, head nods. In the therapist/client dyad, attunement is additionally facilitated through the steady somatic (i.e. bodily) focus on a client's experience and his/her felt sense.

Disruption: Disruption occurs when the therapist and client are no longer resonating or attuned or "feeling connected." For example, disruption in the therapist/client dyad may occur when the client is experiencing painful or unpleasant feelings and is temporarily disconnected from the therapist, when the therapist is overwhelmed with the experience being shared by the client and is momentarily disconnected from the client, or when the therapist misattunes to what the client is feeling or experiencing.

Repair: Repair occurs when a therapist re-establishes a sense of mutual resonance and assists the client to cope with his/her feelings. As a result of this repair, the client may experience a newly expanded state that is marked by positive emotions. The positive emotions may include feelings that are coherent, relaxing and flow with the experience.

THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Education

Appendix 4

Informed Consent Form for the Peer Reviewer
Title: Attunement, Disruption and Repair in the Therapeutic Process

Researcher:
Enzula P. Tavormina
Tel: xxx-xxx-xxxx

Research Supervisor: Dr. Marv Westwood
Dept. of Educational and Counseling Psychology and Special Education
2125 Main Mall, Vancouver, BC, V6T 1Z4
Tel: 604-822-6457

This research is being conducted as one of the requirements for Enzula P. Tavormina to complete a PhD degree in Counseling Psychology. The purpose of this study is to investigate attunement, disruption and repair as experienced by the therapist in an attachment-focused approach to psychotherapy. You are being asked to participate in this study because you have clinical experience in the area of attachment and/or emotionally-focused therapy. To participate in this research, you must meet the following criteria:

1) Have more than ten years clinical practice

2) Have experience and knowledge in AEDP or emotionally focused therapy, attachment theory, and dyadic attunement.

If you choose to participate, you will read the transcriptions and the findings. You will be asked to judge the rigour of this study by its trustworthiness, resonance, pragmatic usefulness. To assist you, a set of definitions has been attached to this informed consent (see page 3). The data, analysis, and any conversation between yourself and the researcher are to be held in strict confidence.

page 1 of 3…

All tapes and documents relating to this study will be kept in a locked filing cabinet to which only the researcher will have access. The researcher will keep all tapes and documents for a period of five years. After this period, all data will be destroyed.

Your participation in this study is completely voluntary. You have the right to refuse to answer any questions and/or to refuse to provide any information. You also have the right to withdraw from this study at anytime.

The researcher, Enzula Tavormina, and the research supervisor, Dr. Marv Westwood, will be available to answer any questions concerning this study. Our contact info is listed at the top of page one of this consent form. If however, you have any concerns regarding your rights or treatment as a participant, you may contact the Research Subject Information Line of the Office of Research Services at the University of British Columbia at (604) 827-5112.

A copy of this consent form has been given to you for your own records. By signing below, you acknowledge you have read and understood this consent form, and that you have been provided a copy of this consent form as well as the support resource list.

Participant's Name: _____

Signature: _____ Date:_____

Definition and Examples of Attunement, Disruption and Repair

Attunement: Attunement is the act of focusing on another person to bring into awareness the internal state of the other. It includes the matching of a feeling or quality of the internal state of another person. One experiences attunement by resonating with another through empathy and through non-verbal affective communication such as gaze, tone of voice, rhythm, head nods. In the therapist/client dyad, attunement is additionally facilitated through the steady somatic (i.e. bodily) focus on a client's experience and his/her felt sense.

Disruption: Disruption occurs when the therapist and client are no longer resonating or attuned or "feeling connected." For example, disruption in the therapist/client dyad may occur when the client is experiencing painful or unpleasant feelings and is temporarily disconnected from the therapist, when the therapist is overwhelmed with the experience being shared by the client and is momentarily disconnected from the client, or when the therapist misattunes to what the client is feeling or experiencing.

Repair: Repair occurs when a therapist re-establishes a sense of mutual resonance and assists the client to cope with his/her feelings. As a result of this repair, the client may experience a newly expanded state that is marked by positive emotions. The positive emotions may include feelings that are coherent, relaxing and flow with the experience.

...page 3 of 3

Appendix 5

Definition and Examples of Attunement, Disruption and Repair

Attunement: Attunement is the act of focusing on another person to bring into awareness the internal state of the other. It includes the matching of a feeling or quality of the internal state of another person. One experiences attunement by resonating with another through empathy and through non-verbal affective communication such as gaze, tone of voice, rhythm, head nods. In the therapist/client dyad, attunement is additionally facilitated through the steady somatic (i.e. bodily) focus on a client's experience and his/her felt sense.

Disruption: Disruption occurs when the therapist and client are no longer resonating or attuned or "feeling connected." For example, disruption in the therapist/client dyad may occur when the client is experiencing painful or unpleasant feelings and is temporarily disconnected from the therapist, when the therapist is overwhelmed with the experience being shared by the client and is momentarily disconnected from the client, or when the therapist misattunes to what the client is feeling or experiencing.

Repair: Repair occurs when a therapist re-establishes a sense of mutual resonance and assists the client to cope with his/her feelings. As a result of this repair, the client may experience a newly expanded state that is marked by positive emotions. The positive emotions may include feelings that are coherent, relaxing and flow with the experience.

Appendix 6

Brief Summary of Accelerated Experiential Dynamic Psychotherapy (AEDP)

AEDP is a healing centred treatment approach which integrates experiential and relational elements within an affect-centred psychodynamic framework. AEDP is distinguished by the several criteria.

1) The attachment relationship between the therapist and client is key to healing and transformation. To this end, AEDP draws on research in affective neuroscience, emotion theory, infant development research and interpersonal psychotherapy. Specifically it references the attachment relationship between caregiver and infant to underscore the emotionally dyadic regulatory processes that occur between therapist and client.

2) There is an emphasis on the somatic experience of emotions. AEDP maintains that emotions are centred in the body. The experiencing of one's emotions "to completion" in the presence of a caring other assists clients to develop self-regulation and human relational capacity. The notion of experiencing an "emotion to completion" is akin to waves, they advance and they recede.

3) AEDP recognizes various states of affect that are conceptualized as spirals of transformation. There are four states within AEDP: (1) transformance and inhibitory affects; (2) the processing of emotional experience; (3) the metaprocessing of transformational experience, and (4) core state and the truth sense.

4) AEDP works with a client's defenses with the goal of accessing underlying core affect. The 'triangle of experience" depicts anxiety and defenses at the top of the triangle and core affect at the bottom.

5) A foundational concept is that the therapist and client are in this journey together and the therapist aims to foster a sense of "we-ness" in the therapeutic work. Pathology is defined as unbearable aloneness in the face of overwhelming emotions. The client is guided to places where he/she has felt unbearably alone and to re-experience their affect in the context of a safe and caring other. i.e., the therapist. At all times, the therapist works within the client's "window of tolerance" (Siegel, 1999).

6) The therapist's feelings are central to the therapeutic relationship and are shared to strengthen the dyadic relationship and develop human relational capacity. Some examples of common disclosures of affect expressed by the therapist in AEDP are:

"My heart feels warm in hearing you say that."
"I feel sad when you refer to yourself that way."
"What do you see in my eyes?"

7) One of the key tenets of AEDP is that the unit of intervention is what the therapist says and how the client receives it. To assess this, the therapist will ask intermittently questions like:

"How does it feel to hear that from me?"
"What's that like to know that I'm angry on your behalf?"

"What happens in your body when you hear my sadness for you? My joy for you?"

8) AEDP prioritizes the metaprocessing of healing affect. Metaprocessing is the processing a client's experience of what's therapeutic about therapy and about the therapeutic relationship. Within AEDP, it's not enough to experience one's affect but more so, to experience one's affect to completion in the presence of a safe and caring other. A therapist will assist a client to meta-process by asking questions such as:

"What's it like to experience this anger/sadness/joy?"
"What's it like to share this with me?"
"What do you notice as you hear yourself saying that?"

Examples of AEDP Terminology

Allying with the client against his/her defense: To be in alignment with the client by challenging his/her defense.

Consolidating: To strengthen an experience and make it more solid.

Core affect: Core affect are those that we feel first, as a first response to a situation. Thus, if we are threatened, we may feel fear. When we hear of a death, we may feel sadness. They are unthinking, instinctive responses that we have. A person's core affect is often synonymous with a version of the seven categorical affects (Panskepp, 2001): seeking, rage, fear, lust, care, grief/ panic, and play.

Corrective emotional experiences: To re-expose a client, under more favorable circumstances, to emotional situations which he/she could not handle in the past.

Deeper level of affect: Affect that approximates core affect.

Drop down: The experience of attuning to and embodying one's deeper level of affect or core affect.

Green light: The positive non-verbal or verbal signals a client demonstrates that shows he/she is ready to experience deeper levels of affect.

Metaprocessing: Processing a client's experience of what's therapeutic about therapy and about the therapeutic relationship. Metaprocessing helps a client make their implicit experiences more explicit and assists a client to concretize, solidify, increase awareness and consolidate what was learned and experienced.

Model of other: Internal working model of relationships with others based on adult attachment patterns.

Model of self: Internal working model of self, based on attachment style.

Pathogenic Affect: Unbearable aloneness in the face of overwhelming affect.

Tracking and scanning: To follow a client's affect, non-verbals and verbals closely to help the client attune to his/her experience.

Self-at-best: States where we feel safe, proud, close and joyful, where we feel we are our better selves.

To bypass a defense: To assist a client to become aware of and stay with the core affect that underlies a defense.

Transformance: The overarching motivational force driving positive change. Transformance is a central concept in AEDP that denotes an adaptive self-righting striving toward vitality, authenticity, genuine contact and healing.

Underlying affect: The deeper level of affect or core affect that is at the root of an experience and/or defense.

Window of tolerance: Refers to a zone of autonomic and emotional arousal that is optimal for emotional regulation (Siegel, 1999).

Appendix 7

AEDP State Transformations

Appendix 8

Visual Summary of Findings on Attunement, Disruption and Repair