

Mind the Gap: AEDP Interventions Translating Attachment Theory Into Clinical Practice

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There has been a gap between the prolific attachment theory and research literature and a relative paucity of guidance about how to apply attachment theory to clinical practice. AEDP (Accelerated Experiential-Dynamic Psychotherapy) explicitly fills this theory/practice gap. This article will explore three aspects of clinical practice that foster secure attachment bonds, and will also address what kind of therapist an attachment therapist is. It will outline the importance of nonverbal communication; it will start to catalogue what I call experiential language: specific words and interventions that are evocative of experience and emotion. Finally it will assert that self-disclosure is an essential attachment-creating intervention, and it will explain the importance of metaprocessing and Metatherapeutic processing to titrate therapeutic interactions moment-to-moment in session and to promote meta-cognitive thinking as well.

Keywords: AEDP, experiential language, self-disclosure, metaprocessing, attachment creating interventions

... clinicians must scour all these sources [recent books on attachment] for the occasional contributions that address attachment theory's implications for adult psychotherapy. More often than not, these contributions are ... tantalizingly brief ... (Obegi & Berant, 2008, p. 1).

The more we as clinicians use attachment theory to understand all our therapeutic relationships, the more we are all trying to hone the effectiveness of our interventions to facilitate right-brain-to-right-brain growthful experiences with our patients. Now that we more fully understand that the attachment system is a neurological, biological, and evolutionary wired-in adaptive system, we are faced more and more with the clinical questions: How do we work to bring about secure attachments in all of our very different therapeutic dyads? How do we foster attachment experiences moment-to-moment in

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session? How do we utilize the new neuroscience that is stating loud and clear that it is the new experiences in session and session to session with the therapist that change the neural pathways and internal working models of our patients?

It is the interactions within the relationship that bring about change. These interactions take place nonverbally and verbally, in milliseconds and over extended periods of time. They involve all of the senses and our whole bodies. As much as we need to work on the techniques of the nonverbal, we all need to learn what are the more evocative, embodied words and interventions that help create securely attached patients. This is an intrapsychic and interpersonal endeavor: some words and interventions do this much more effectively than others. It is essential we start cataloguing what I call *experiential language* and right-brain evocative techniques so that we can intervene as effectively as possible.

It is a frustrating read to search the psychoanalytic literature for clinical material explicitly using or explicating attachment theory. It turns out that literature that describes how to form a secure attachment relationship is difficult to find (Cassidy & Shaver, 1999; Mukulincer & Shaver, 2007; Rholes & Simpson, 2004; Simpson & Rholes, 1998). There is a dearth of “specific guidance about what and when practically to say and do from moment-to-moment in the consulting room, and how such interventions relate to theory.” (Holmes, 2008, p. 491). AEDP (Accelerated Experiential-Dynamic Psychotherapy) does explicitly fill in this theory/practice gap with an extensive, detailed clinical practice. AEDP, as its name suggests, is an assimilation of both experiential interventions and psychodynamic theory. It integrates and uses to clinical advantage mother-infant research, affective neuroscience, developmental models, transformational studies and, of course, attachment research and theory. If we begin by allowing mother-infant interactions and research to guide our clinical practice, which AEDP already does, then we need to rethink how we intervene and the language we use. The explication of a therapeutic stance, a particular language for our talking, a way of using the self, and reflecting together on all of that will, I hope, go a long way toward filling the “endemic theory-practice gap” (Holmes, 2008, p. 491) and spelling out how we can engender secure attachment in psychotherapy.

This article will explore three aspects of clinical practice that foster secure attachment bonds with our patients, and address what kind of therapist an attachment therapist is.

1. In the first section as I describe the stance of the attachment therapist, I will also outline different areas of nonverbal communication.
2. Some words and interventions are more evocative of experience and emotion than others. In the second section I will put forward some examples of the language of the right brain or what I call *experiential language*: the

language of the body (and by this I don't mean body language, but rather the *language* of the body or *embodied* language) or the right-brain is a different lexicon than the language of the left-brain and thinking. Experiential, evocative language strengthens attachment bonds. This section contains six different types of interventions or aspects of therapeutic action that engender attachment security.

3. In this third section, I will show how self-disclosure is an essential attachment-creating intervention; it is *the quickest way to deepen an experience between two people* (Prenn, 2009). It will articulate two different areas within self-disclosure: (a) self-involving self-disclosure, which is most usually considered self-disclosure of the process, the here-and-now, and which includes therapist vulnerability, errors, and so forth; and (b) self-revealing self-disclosure of actual experience (similar or dissimilar) or therapist lived history (Linehan, 1993). Lastly, I will explain the importance of metaprocessing (Fosha, 2000b; Fosha, 2006; Prenn, 2009; Russell & Fosha, 2008) to reap the relational benefits of self-disclosure and to titrate therapeutic interactions moment-to-moment in session and to promote metacognitive thinking in our patients as well. Metatherapeutic processing is an explicit exploration of a particular piece of work on a macrolevel: "What is it like to have done this piece of work with me today?" while metaprocessing is a way of fine-tuning moment-to-moment interactions on a more microlevel: the standard intervention is: "What is it like to do this/hear this?" (Fosha, 2000b). To be clear: In AEDP, metaprocessing with a small "m" is used to refer to moment-to-moment processing of small disclosures or small rounds of work while Metatherapeutic processing with a capital "M" is used to refer to the larger exploration of how a session or piece of experiential work or successful treatment has been experienced by the patient (Fosha, 2000b).

SECTION 1. THE ATTACHMENT PSYCHOTHERAPIST

In this first section I want to address the stance of the therapist and some important nonverbal interventions.

The research states again and again that it is the quality of the relationship with the therapist that is the greatest predictor of successful treatment outcome (Mones & Schwartz, 2007; Stricker & Gold, 2006; Wampold, 2001). What should the optimal stance be? Diana Fosha writes:

Establishing the trust needed for deep affect work requires that the therapist's sense of self be engaged . . . AEDP's clinical stance demands at least as much from the therapist as from the patient: the patient cannot be expected to rapidly open up to a therapist who remains hidden and shielded. The emotional atmosphere should be one in which the patient feels safe and the therapist brave. The patient's sense of safety

within the therapeutic relationship is enhanced in part by the therapist's risk taking (Fosha, 2000a, p. 213).

Attachment is about safety: what kind of therapist is a secure base? What kind of therapist offers the patient a safe haven (Bowlby, 1998)? What can a therapist consciously and explicitly do to create a sense of safety for the patient? The attachment literature talks about the therapist as attachment figure: this therapist is wiser, stronger, brave, and kind. An attachment therapist is emotionally engaged, is affectively competent and confident and self-discloses affect and personal history in the service of the patient. She says: "me too;" "we are all in the same boat" (Yalom, 1995, p. 6). She initiates repair and is attuned, receptive, and responsive. She is motivated to stay emotionally engaged which means when she gets things wrong or is misattuned, she strives openly to correct the misattunement. She is explicitly helpful, she leads the way, and can also wait, not intrude, and without interrupting follow the patient's lead; she makes "the implicit explicit" (Fosha, 2000a, p. 219). She is validating, affirming, authentic, spontaneous, present and empathic. It is probably radical to spell this out, but this sounds like a "good-enough" mother (Winnicott, 1965). All of these characteristics are ways of being explicitly loving and caregiving. These are ways mothers explicitly act with their children, ways that engender attachment security.

Ferenczi (Ferenczi, 1933) spelled it out: "(the patient responds to) . . . maternal friendliness: without it he feels lonely and abandoned in his greatest need, i.e. in the same unbearable situation which at one time led to a splitting of his mind and eventually to his illness" (Ferenczi, 1933, p. 160). If we unpack Ferenczi's "maternal friendliness" from what we now know about mother-infant dyadic synchrony (Schore, 2003; Tronick, 1998; Fosha, 2001), then therapist and patient must sit face-to-face and not too far away, the therapist must be attuned to gaze and notice gaze aversion, she can delight in the patient and let the patient know it. She can exaggerate her affective response, she can enjoy herself with the patient, and tell her so. This kind of therapy feels good and right to both parties. I want to clarify:

The work is not about the promotion of 'happy' experiences and trying to get the patient to feel them. Rather, it is about the spontaneous emergence of these positive affects in the course of work with intense emotional experiences . . . In dealing with negative feelings, and fully processing them in a dyadically constructed atmosphere of support and help, positive feelings and adaptive resources are liberated (Fosha, 2004, p. 38).

AEDP takes many lessons from mother-infant interactions and although it certainly works through the trauma and pain in a patient's life, it also makes room for amplifying and expanding the positive. Sharing affect from smiling and tearing up to occasional belly laughing together, and the nodding and

gazing that ensue, is wonderful right-brain-to-right-brain communication that increases safety and makes room for delighting in each other and real pleasure. Like a good mother, the AEDP therapist privileges the positive and metabolizes negative affects quickly. The permission to be self-disclosing about emotion and reactions one has to the patient make for an ease and flow in the interactions. Letting the patient know s/he exists in our “mind and heart” (Fosha, 2000a, p. 219), for example, “I thought of you when I saw that movie you recommended,” “I tried the almond croissant you say you always eat at the cafe across the street,” helps a patient feel attached and cared for in a continuous way.

I want to add Fosha’s description of moment-to-moment interactions:

If the therapist’s internal state can meet the patient’s and the therapist’s own hopefulness and openness can come to the fore, allowing her to feel free to be as therapeutic as she is capable of being, something profound can happen: *in that moment*, the therapist has the opportunity to go beyond being good enough, to actually be downright good” (Fosha, 2000a, p. 214, my emphasis in italics).

In adult treatment, we are working with patient’s who already have more than one internal working attachment model laid down, and who often have primary attachment figures in their adult lives: spouses, parents, children, close friends. I would argue that we are not striving to be the primary attachment figure for all of our patients (although for some we will be), but *in the moment*, in the new experience in session, the patient will look to us for help to experience previously unbearable affects. She will seek our help, she will meet our gaze for reassurance in the moment, she will protest if we are unavailable or misattuned in that very moment, but if we are available she will dare to face with our help whatever has been unendurable alone. Then in that moment we will be what Fosha calls a “true other,” an attachment figure right in the here-and-now (Fosha, 2000b; Fosha, 2005): “The true other . . . has nothing to do with idealization; it has to do with responsiveness to need” (Fosha, 2005, p. 531).

Nonverbal Communication

Before I start to catalogue actual words and phrases that I think are most likely to facilitate secure attachment I want to address the all important issue of nonverbal communication. Reliability, dependability, predictability are the building blocks of psychotherapy and good enough parenting: we meet at appointed times, we start on time, we are consistent in appearance, response, and manner. Therapists communicate a great deal without words: nodding, mmming, sighing, wrinkling brow/frowning, laughing, smiling, delighting, tearing up, crying, sneezing, yawning, trying not to yawn. In our “face(s), voice(s), gaze, posture and gesture” (Tronick, 1998, p. 293), we are saying a lot. Add into the mix

emotion contagion and the work of the motoric mirror neurons (Rizzolatti & Craighero, 2004) and we are in the land of dyadic attunement. We literally enter the “regulatory system” of our patients (Tronick, 1998) as mothers do. We take each other in with all of our senses: with our gaze, with our touch, with our hearing, with our sense of smell, with our movement, and posture. For example, a patient who found herself feeling dysregulated while I was away on vacation bought herself the same lemon soap I always have in my office restroom. This familiar smell had helped her feel connected to me in my absence. This is a vivid example of a patient turning to me, her therapist, as a safe haven at a time of distress and finding comfort in much more than just our verbal interactions (Geller & Farber, 1993).

Rhythm, Intonation, Pacing, Pitch; Not So Fast

As we speak words in session we need to pay attention to our voice: our tone, pitch, and pacing are all very important aspects of creating attachment experiences in session. To enter into the rhythm of the patient is important. Often patients move at a fast, conversational pace and so to slow patients down and help them get in touch with their internal experiences is one of the first tasks of an AEDP session. To slow a patient down, one has to slow down the pacing of one’s own voice and lower its pitch. At times this involves only slowing down a little, a little more than the patient: matching and attunement with patients mean that slow and low are relative and dyadic in nature.

This is a good place to talk about matching and attuning. If a patient talks very fast and cannot slow down, it is important not to be mismatched and not to try to slow down too much. That would give the implicit message: you are not doing this right, you are moving too fast. Matching tone, pitch, pacing, depth of emotion, and rhythm are essential. Validating a patient who tends to speak quickly, finding a way to join with them and be on the same page meets them where they are and can be a good starting point: “We are well matched. A part of me loves this banter . . . and yet, another part of me wonders what would happen if we both slowed down a little.” “Parts” language is always a good way to hold two sides of the equation: to affirm it is all right to be where we are and to anticipate where we might go together (Schwartz, 1995). Whether one can slow down or not, there are some words and phrases that are more right-brain activating, that orient the patient toward experience and feeling rather than toward the intellect and thinking. The kinds of phrases we can say to communicate this stance to our patients is the subject of the next part of this article.

SECTION 2. EXPERIENTIAL LANGUAGE

This article has sprung from my own experience learning an experiential treatment (AEDP) and now my efforts to articulate how to teach AEDP to clinicians who have often been trained in more insight oriented psychotherapy models. In this section, I will focus on specific AEDP interventions and its experiential language. Although much clinical attention is currently and quite rightly being focused on the body and the nonverbal in psychotherapy, the vehicle of adult treatment is words.

In their article on clinical practice in one of the more recent books on attachment theory, research, and clinical practice (Obegi & Berant, 2008), Mallinckrodt, Daly, and Wang say that therapists are reluctant to give specific interventions to demonstrate the working through phase of therapy. They say that readers will be disappointed that there will be no “cookbook” (p. 254) of what to say clinically. As an avid gatherer of actual live interventions, I hope this article will satisfy those of us who love the actual words of actual interventions and I hope that it will pave the way for many more articles filled with versatile interventions that we can share and dialogue about. Although I am about to catalogue actual interventions and ways to intervene and a stance to take that I believe fosters, facilitates, and encourages secure attachment in patients, I want to be very clear that like in a manual or cookbook the cook makes a difference. And to take this metaphor maybe a little too far, we may have dinner guests with anything from mild preferences to severe allergies. We need to be responsive to them and adjust our interventions and ways of intervening accordingly. So, I am not suggesting there is a one-size fits all intervention by any means. To the contrary, dyadic attunement creates uniqueness, but this does not preclude cataloguing those words and interventions that are more likely to orient the patient and therapist to particular aspects of experience. Again I am not saying, “If the client does X, the therapist should respond with Y” (Mallinckrodt, Daly, & Wang, 2008, p. 254), but I am saying: “important” as an experiential word works better than a more insight oriented word like “interesting.” Judith Nelson give us a tantalizing taste of this: “. . . ‘touched’ . . . (a connected, attachment-caregiving word in itself)” (Nelson, 2008, p. 343). This is what I am talking about. Are there other “connected, attachment-caregiving” words out there? I think there are. I call it *experiential language*.

Experiential language tries to help make the shift from the left brain to the right brain, from thinking to feeling, from the language of the mind to the language of emotion rooted in the body, from talking about experience to actually experiencing and being in an experience together. To promote embodied, emotional experiencing in session, there needs to be a shift in language from:

- big words to small words,

- from interpretations to short interventions (one at a time if possible),
- from speed to slowness and waiting,
- from vagueness to the particular, and
- from linear and logical to emotional and imagistic.

Cataloguing a vocabulary for experiential work is a crucial next step in integrating mother-infant research into adult treatment. Words lead us places, words keep us on track, words facilitate a body based “felt sense” (Gendlin, 1996) experience in session and words help us talk about, metabolize, and metaprocess (Fosha, 2000a, 2000b) that experience afterwards. Clinicians are constantly faced with the gap between mother-infant/parent–child dyads and what to do and say in session with their adult patients.

The use of experiential language, specifically, and of the various interventions I am describing here, is aimed at filling this research, “theory-practice” gap. AEDP uses a language and a protocol (Prenn, 2010) that contributes to patients feeling understood, recognized, and attuned with: through moment-to-moment tracking and a variety of interventions, the AEDP therapist creates safety so that the patient can explore and experience previously warded off emotions.

The first essential skill in experiential work is slowing down. For patients to get to know their internal experience, we slow down. This is no ordinary conversation. Words that start this process are: “Let’s slow this down;” “let’s take a breath here;” “we have time;” “let’s pause here;” “mmm . . . a lot here;” “let’s go back;” “let’s stay here;” “let’s stay with this;” “can we . . .?”

Notice the words are short, often monosyllabic, and the interventions are short. Interventions that indicate the collaborative, relational aspect of the work do double duty: they continually say, “I am here to help,” and “You are not alone,” “we” are in this “together.” “We” highlights the attachment relationship. The active, directive stance places the therapist as an attachment figure in the moment. I am saying explicitly and implicitly that I know how to help: “I know the pace is too fast,” “let’s slow down.” I know what to do, I am actively helping and wanting to help. Statements are often more effective than questions. Language is simple and repetitive; I repeat as a mother does with her infant or child. It is perhaps an adult version of “motherese” (Schore, 2003, p. 13).

The second foundational skill is moment-to-moment tracking with its “notice and seize” (Frederick, 2005) focus.¹ The AEDP therapist tracks the patient moment-to-moment; she is acting as a reflecting and observing ego to

¹ This is step one of the AEDP Protocol. For the six steps of the protocol and more interventions for each step of the way, and a transcript illustrating this work, please see Prenn 2010.

the patient's experience and physical communications just as in early infancy the mother is the child's "auxiliary cortex." The patient cannot know or stay with his or her experience yet because she has not learned to be mindful/aware of her experience: she is an "inexperienced experienter" (Fosha, 2001). To get started the AEDP therapist draws the patient's awareness to her nonverbal communications and connects there. Ron Kurtz calls these "contact statements" (Kurtz, 1990, p. 81; Ogden, Minton & Pain, 2006²). An AEDP therapist unobtrusively tracks the experience of the patient as s/he sits in session: "Tracking and focusing provides a window on the state of the individual at that moment" (Fosha, 2000a, pp. 271–272), and if there is a shift or some glimmer of feeling/affect coming up in the patient the therapist reflects that back. Moment-to-moment tracking is an ongoing skill of an AEDP therapist. The words/interventions that help the patient focus on tracking and paying attention to his or her internal experience are: "what do you notice inside?" "what's coming up?" "what are you experiencing in your body/physically?" "a lot of feeling here;" "something shifted;" "there are a lot of feelings/pain here;" "I see tears/mmm . . . tears/a lot of tears;" "a big sigh/smile;" "so much here;" "a lot of feeling here;" "what do you notice in the moment/in this moment?" "you made a fist;" "your legs tensed;" "you are breathing rapidly;" "you look full of feeling."

A general rule of thumb is to *keep interventions short, intervene with one intervention at a time, and wait*. We do not know what patients are experiencing: by tracking, staying with, and exploring with the patient, we facilitate an emotional experience in session. To help insight oriented clinicians move to a more experiential way of relating, the guideline is: *don't explain, explore* (Lipton, personal communication, 2005). As Frieda Fromm-Reichmann so rightly said: "the patient needs an experience not an explanation" (Friedman, 2000). As the patient is oriented to the focus of internal/experiential work the therapist is:

- always *affirming*: "you are doing great"
- always *asking the body to help*: "what do you notice physically/inside?"
- always *exploring and expanding*: "is there more?" "what else?" "say more"
- always *asking permission and collaborating*: "is it all right for us to be with this/to stay with this a little longer?" "can we . . .?" "let's . . ." "can we together . . .?"

² Both of these books contain actual interventions and explicate in detail ways of working. Their goals are different than AEDP's, but the initial contact and the language to get there are the same. I recommend them both to anyone on the lookout for actual examples of interventions. See also Wachtel (1998).

Notice the “we” from the very beginning and repeatedly throughout the work. This continually makes explicit that the patient is not alone and creates a secure base in each moment.

Learning to Stay

Mindfulness is currently center stage in psychotherapy; there is more and more integration and incorporation of meditation, breathing techniques, Buddhism, and spirituality into adult psychotherapy (Chodron, 2001; Epstein, 1998; Kabat-Zinn, 1994; Linehan, 1993; Safran, 2003). AEDP asks the patient to focus inside, notice and stay with whatever is there: the words that do this most effectively are: “let’s stay here;” “stay with it;” “can we stay here?” “can you/we be with it?” “stay;” “is it ok to stay with this?” AEDP uses the body and the “felt sense” (Gendlin, 1996) as a starting point. The AEDP therapist always asks patients to try to stay with their physical somatic experience: the body holds traumatic memories, the body tells a story, “the body remembers” (Rothschild, 2000).

Therapist Vagueness and Curiosity; Patient Specificity

In experiential, emotion centered treatments, we want to open up as much space as possible for the patient to have their own internal experience. Vagueness on the part of the therapist makes room for the patient’s experience. Words that communicate this are, for example: “I see pain;” “there is a lot of feeling here;” “something here;” “a lot here.” The patient knows what the emotion/experience is or may need help exploring what the emotion is before she can put it into her own words. The obverse of therapist vagueness is asking the patient for specificity. The details of the experience are extremely important: we always want to explore whatever the experience in as much detail as possible: “say more;” “can we add more texture?” “let’s fill that out.” The specifics of a particular example deepen the work and are more emotionally evocative (Pally, 2000).

Before leaving the topic of experiential language and its specific interventions, I will include two more interventions that are useful to have in one’s tool box:

The Interruption (The Right-Brain, Emotion-Focused Version)³

A key intervention for all experiential therapists is what I call ‘the interruption.’ Very often we start to say something, and as we begin, the patient has a reaction to us: arms cross, legs jiggle, eyes glaze over, breath is held or starts to be more labored. It is essential to track these phenomena, and interrupt ourselves because what is happening with the patient is almost always more important than what we are saying! David Wallin references this: “. . . I frequently find myself rethinking my clinical judgments and adjusting the “depth” of my intervention virtually in midsentence” (Wallin, p. 333). Christopher Bollas writes about his experience of this intrapsychically, as he relates to his own subjective states:

For example, when in the midst of an interpretation to a patient I may suddenly realize that I am slightly off base, and I will stop myself and say something like, ‘nope, that’s not it, I can’t quite find what I want to say.’ If I realize that I am wrong, I will say so and state something like, ‘no, I think what I have just said, as plausible as it is, is just not right’ (Bollas, 1987, p. 207).

Bollas is offering a view of his self-reflective functioning (Fonagy et al., 1995) intrapsychically and as he goes on to say very often patients will jump in and try to help him get closer to their experience.

The “interruption” is an attachment-creating intervention because it shows the therapist like an attuned mother being responsive to the patient in the moment and moment-to-moment. Nonverbal cues are happening with lightning speed all the time as one can see in both the videotapes of mother-infant and therapist-patient interactions. The interruption says loud and clear: I am attuned to you. I see you and am prioritizing your experience. The interruption is always in the service of the patient’s experience. I should add that sometimes we have to say something that a patient will react to and it is important to finish what we need to say. As with all of these interventions there is no one-size fits all but being attuned means being able to change course and prioritize the patient’s experience.

The Platform

Up until this point the experiential language has focused on interventions that address right-brain-to-right-brain intervening, but there is still of course a place for the left hemisphere.

The platform is a place in AEDP where the therapist speaks in order to

³ This is not the same as the use of interruption to challenge defenses in short-term dynamic therapy approaches. Both the tone and the intent are very different.

organize the patient's experience (Fosha, 2008): "this is what I am thinking . . .;" "here is what I am seeing . . .;" "so let's see if I am getting this . . .;" "it's meaningful;" "this is meaningful" (Fosha, 2008).

"Platforming statements are verbal attempts to capture the emotional experience that precedes them" (Fosha, 2008, p. 192.). This is a place to pause and reflect on experience, often experience that has just been lived through in session or over a series of sessions. The platform is a place to upload right brain experience into left brain language.

SECTIONS 3. SELF-DISCLOSURE AND ITS METAPROCESSING: THE RELATIONSHIP IS ALL

Elsewhere, I have advocated that "self-disclosure take its place as an essential, integral, teachable part of the fabric of every treatment and that we question why we didn't disclose as much as we have traditionally examined why we did!" (Prenn, 2009, p. 98). Radical although that may sound, I think it does not go nearly far enough or explicate accurately how *essential* all kinds of self-disclosures are to creating secure attachment in session and session to session. I used to think of AEDP as a series of corrective emotional experiences (Alexander & French, 1946) within an attachment relationship. Now it seems clearer to me that corrective emotional experiences create a secure attachment relationship. The tide is turning from viewing self-disclosure as the beginning of a "slippery slope" into boundary violations to seeing self-disclosure as an intervention "option" (Wallin, 2007, p. 185). This needs to be taken further: Self-disclosure is crucial. Self-disclosure is the attachment-creating intervention par excellence. What follows below is the next step in that elaboration.

Self-disclosure is an essential part of the fabric of every AEDP treatment. It is a hugely versatile intervention:

- it undoes aloneness;
- it makes the implicit explicit (Fosha, 2000a);
- it increases safety and bypasses defenses;
- it puts the relationship front and center stage;
- it creates an experience;
- it makes active use of the AEDP therapist's engaged, active, empathic, open, risk-taking stance;
- it allows for the use of the therapist's experience of the patient's impact;
- whenever possible it needs to be followed by metatherapeutic processing.

The metaprocessing of self-disclosure is profoundly therapeutic and teaches the patient that experiences can be talked about and reflected upon both intrapsychically and interpersonally. In AEDP the unit of intervention is never self-disclosure alone; it is always (or whenever possible) followed by metaprocessing, that is, literally what the experience of the disclosure was like for the patient: “what was it like to do this piece of work with me?” “What is it like to know this?” In this way patient and therapist can negotiate and titrate their relational closeness; they can stay in sync or repair ruptures while having experiences together and reflecting upon them.

What Is Self-Disclosure? What Am I Talking About?

There are two main kinds of self-disclosure: There is self-involving self-disclosure and self-revealing self-disclosure (Linehan, 1993):

a) self-involving self-disclosure: “saying all of it” (Greenberg & Watson, 2005) and “speaking for” the patient (Hughes, 2007).

Self-involving self-disclosure is the most crucial kind of disclosure: it is the self-disclosure of the therapist’s affect and process as it unfolds in the session, and session to session. In many ways all of our interactions reveal us: when we notice a patient is sad, we reveal we are the kind of person that notices and feels comfortable noticing and talking about sadness. If we are silent in the face of our patient’s sadness, we are revealing as much, but different information about ourselves.

In this category there are two specific techniques to self-disclose our process effectively: there is what Greenberg and Watson describe as “saying all of it” (Greenberg & Watson, 2006, p. 128): it is not enough to say we feel angry or delighted or distanced by a patient or close, we need to “say all of it” and tell the patient the specifics, what the content is, and what our process is. And there is what Dan Hughes calls “speaking for” a patient (Hughes, 2007, p. 204): if we are stumped by a patient because they do not know or cannot articulate what is going on for them, we can guess, we can imagine: “I wonder if . . .” and we can also give them an out: “If this isn’t right or isn’t helpful, please just put it to the side.”

A recent example was a patient numbed out and not communicative in a session after we had seen each other on the subway. I wondered out loud if something had happened for her seeing me outside of the office for the first time. I disclosed feelings of my own when I saw my own therapist at a restaurant. I was not exactly right, my feelings were different than hers, but it allowed her to consider that our running into each other on the train was significant and was in fact contributing to her experience in the session.

b) Self-revealing self-disclosure is the disclosing of actual life experi-

ences, triumphs (Wachtel, 2008, pp. 254–261), uncertainties, dilemmas. They are often extremely helpful for patients to know about: they help undo aloneness and increase what Yalom calls “universality” (1995, p. 6); we are all human and struggle with similar things; “welcome to the human race” (Yalom, 1995, p. 6). In the research it is thought that self-involving/process/here-and-now self-disclosures are the most helpful (Farber, 2006). That said, numerous patients anecdotally state that disclosures of my personal experiences have had the greatest impact on them.

Self-disclosure is a secure attachment creating intervention. *The quickest way to deepen an experience between two people* is by one of them saying something personal or vulnerable. Therapist vulnerability is an invitation to patient vulnerability. If “disclosure begets disclosure” (Jourard, 1971, p. 16), it makes sense that the judicious, thoughtful, mindful use of therapist self-disclosure creates safety and establishes more security in the moment. And yet I want to stress that therapist self-disclosure does not only and simply beget patient disclosure (Jourard, 1971); it achieves much more than that. I agree with Philip Bromberg (2006) when he says that self-disclosure is not only permissible it is essential, but I disagree with him when he says that self-disclosure fails if it is used prescriptively: if I do this, then that will occur, the patient will do that (Bromberg, personal communication, December 2008). While it is of course true that we can never know when we self-disclose what the patient will do, we do know that if I do x, that is, self-disclose, something will occur. I would go so far as to say that if I self-disclose, something productive will almost invariably happen: the self-disclosure will either give us more information about the patient relationally, or will move us into something experiential happening between us. There will be experience, movement and information.

Because these are high-risk and intense interventions, the therapist must continually monitor herself . . . The patient’s reactions to the therapist’s self-disclosures must be attended to all the more carefully. If the patient feels burdened, intruded upon, or disgusted by the therapist’s disclosure, or if the patient reacts with numbing, blocking, or anxiety, *those reactions become the focus of the therapeutic work*. The same is true if the patient reacts by feeling strengthened, moved, or deeply valued and valuable. This sheds yet *new light on the patient’s experiences in interpersonal relationships* (Fosha, 2000a. p. 232; my emphasis in italics).

In terms of attachment style, self-disclosure often serves to gather attachment information about the patient. A securely attached patient will probably be able to talk coherently about what is happening interpersonally between patient and therapist. An avoidant/dismissing patient will probably predominantly avoid or dismiss the self-disclosure; a preoccupied/ambivalent patient may be fully in the experience, but less able to reflect upon it. Either way there will be an experience happening in session between patient and therapist that both will have an experience of first hand.

Self-Disclosure and the Importance of Its Metaprocessing

I want to lay out two examples taken verbatim from two authors I greatly admire to illustrate how important metaprocessing is as the second integral part of any self-disclosing intervention and to explore how an understanding of patients attachment styles can inform how one understands the moment-to-moment work in session.

Karen Maroda: “I have seen my own clients do this [work hard to overlook therapist faults and self-indulgence] yet at the same time their obvious discomfort when I disclosed something they were not seeking, not to mention the pervasive ‘tell’ of looking at their watches informed me that what I was saying was an intrusion” (Maroda, 2009, p. 27).

David Treadway: “The key element of assessing self-disclosure is to watch like a hawk for the outcome of your sharing. Does the client respond well? Does it seem to intrude on the session? Does it help change the tone or feeling of the session in a positive way? Or do people glance at their watches or come back with ‘Well, what I was saying . . .’ But self-disclosure is always an experiment. If the client doesn’t respond, don’t take it personally. Just move on. Try something else” (Treadway, 2009, pp. 278–279).

Metaprocessing is exploring the patient’s experience of an intervention or intervention; “What is usually the endpoint of the therapeutic road is [a] starting point” in AEDP (Fosha, 2000b, p. 72). Someone looking at their watch is an *entry point*, a place to metaprocess and self-disclose my interest in their reaction to my self-disclosure. It is as much an entry point as a flash or anger, a patient choking up or a fleeting smile. The truth is that we do not know what meaning patients looking at their watches has until we metaprocess and inquire. “I notice you looked at your watch. You are having a reaction to my saying that?” If I have disclosed some emotion my dismissing/avoidant patient may be uncomfortable. Is this a mistake? I think of this as a golden opportunity. And if in fact it is a ‘mistake,’ then we have some repair to work on and again this is a golden clinical opportunity. We have an interpersonal *experience* happening between the two of us; I have firsthand experience of the patient’s reaction to me: we are not talking about an interaction, we are having an interaction together. The attachment style of the patient and their ongoing efforts to interact in a habitual, procedural way will inevitably come to the fore. We are in rich mutative territory (Gold & Stricker, 2011; Safran & Muran, 2000; Stricker and Gold, 2006; Wachtel, 1998, 2008).

If the patient does feel misattuned to, we have an opportunity to repair this obvious disruption. This is another place rich for thickening attachment bonds. For many patients the cycle of *attunement, disruption, and repair* is a new world: for so many children with their parents there has been no possibility of repair so in fact our moments of misattunement and repairing

are healing and secure attachment creating in and or themselves (Lewis, 2000; Safran & Muran, 2000; Schore, 2003; Tronick, 1998). In terms of promoting growth and in terms of fostering secure attachment, mistakes/disruptions and their repair are often more fruitful than periods of attunement. Something is happening! Save me from treatments that hum along smoothly. Again Ferenczi: “. . . the admission of the analyst’s error produced confidence in his patient. It would almost seem to be of advantage occasionally to commit blunders in order to admit afterward the fault to the patient” (1933, p. 159).

Back to the “tell” of the glancing at the watch: it could be the patient is having an emotional response and is making sure she has time to be emotional and get herself back together before she has to leave; it may be that she is uncomfortable with my emotion: she may be an avoidant/dismissing patient and my vulnerability or emotion or realness has had an impact. If I am being dismissed this is important attachment material not to be missed: a place to work on changing the internal working model of the patient. This is not a social conversation. This is not “indulgence” (Maroda, 2009, p. 22): this is a crucial part of the change process in psychotherapy.

“The patient is strongly encouraged to articulate what he notices about the therapist’s nonverbal communication, and how it makes him feel. To encourage the patient’s engagement in this process, the therapist might ask, ‘What do you see when you look in my eyes? . . . How does that make you feel?’ In this way, patient and therapist collaborate on constructing an intimate relationship . . . The therapist might follow a comment she makes about what is happening between the patient and herself by saying, ‘This is how I see it? What’s your take on this?’” (Fosha & Slowiaczek, 1997, p. 239).

If we learn from reflecting on experience and not just the experience itself, we need to metaprocess. Alternating waves of feeling and reflecting expand the emotional/affective repertoire of a patient and promotes self-reflective functioning (Fonagy et al., 1995; Fosha, 2000a; Fosha, 2000b).

Will this eventually mean that the patient will get good at noticing when we respond with a “tell” of looking at our watches, for example? Yes, but this is good news: we are modeling that we are in relationships of constant flux and change, that we can talk about our experiences and we can inquire as to the meaning of experiences that happen between us and together: “You looked at the clock. Is time up?” “Are you bored?” I may be checking to see we have enough time to metaprocess something and the patient may read it as me being bored or in fact I may be feeling disconnected and this will be an opportunity to explore and metaprocess together whatever is happening between us. In the same way that we track the shifts and emotions of our patients in session so too our patients read and track us. Often this goes unprocessed unless the therapist helps metaprocess it: “I teared up. What was that like for you?” Our patients learn to accurately read us and to be able to

talk about it. This is all good attachment news. On a larger scale, Metatherapeutic processing towards the end of a session or at the end of an emotional piece of work or at the end of a successful treatment is important relational glue: it helps the patient reflect on the experience of being helped and on the relationship within which this help occurred. What is usually an endpoint in psychotherapy is the beginning of another phase of treatment in AEDP (Fosha, 2000b, p. 72). The standard intervention: “What is it like for you to have done this with me?” guides the patient to reflect on their experience, give left brain meaning to this experience, get to know explicitly and with visceral texture what the success or change is like and do all of this in the context of the relationship with the therapist. Often the experience of the therapist’s delight, pleasure, and pride in the patient’s accomplishments leads to more emotional rounds of work: there is often grief for what the patient has not received previously in her life: “mourning the self;” and/or an expansion of the sense of the patient’s self-efficacy, what Fosha calls the “mastery affects” (Fosha, 2000b; Russell & Fosha, 2008; Prenn, 2010).

Self-Disclosing The Patient’s Impact on The Therapist

The importance of the stance of the AEDP therapist as self-disclosing of affect and process is crucial: “It stands to reason that if emotional exchanges, or lack of, create affective patterns that a person creates over and over again, that only new emotional exchanges could facilitate the altering of old affective patterns” (Maroda, 1998, p. 83). In the same way that there is no such thing as an infant, only a nursing couple (Winnicott, 1958), so too there is no such thing as a patient: as Tronick puts it: “To rephrase Descartes, I interact, therefore I am.” (Tronick, 1998, p. 296). And he means this literally: “. . . the patient and the therapist create dyadic states of consciousness. These states of consciousness emerge from the mutual regulation of affect between the patient and the therapist. When these dyadic states are achieved, the state of consciousness of the patient expands and changes.” (Tronick, 1998, p. 298). Maroda calls this “completing the affective cycle.” (Maroda, 1998, p. 65). Why is this affective cycle or dyadic regulation of affect so important? I think it is for two reasons: first because emotions must be felt interpersonally before they can be felt intrapsychically (Maroda, 1998; Schore, 2003); and second that intolerable feelings need to be projected before they can be integrated (Schore, 2003, pp. 58–107): “The therapist’s empathic ability to receive, resonate with, and amplify the patient’s often ‘shimmering,’ transient states of positive affect facilitates the interactive generation of higher and more enduring levels of

positively valenced states than the patient can autogenerate” (Schoore, 2003, p. 79).

Self-disclosure of affect and process and of the patient’s impact on the therapist is necessary to expand the patient’s emotional repertoire. Emotional interactions with the therapist create a corrective emotional experience and not only help the patient attach to the therapist interpersonally, but create intrapsychic portable change for their other relationships. The internal working model changes. The still-face experiment is such a good example of what happens to the infant or patient when the mother or therapist does not show emotion, does not complete the affective cycle: “The little girl detects the change . . . almost immediately. She begs her mother . . . to respond to her. She throws things and eventually hits the mother.” (Tronick, 1998, p. 296). Maybe this explains so much of the negative transference in psychoanalytic work! It may explain why separations for toddlers are so hard: “. . . an experience of diminution-literally, a sense of becoming less coherently organized.” (Tronick, 1998, p. 297). This may be part of what Bromberg means when he writes, “Help! I am going out of your mind.” “This right to exist fully as a self can only be actualized when the “other” is alive to one’s own subjective experience, recognizing it and cognitively engaging it, creating as Enid Balint (1989, p. 102) put it ‘a state of eager aliveness in two people’” (Bromberg, 1998, p. 321).

What are some of the words that communicate our affect/their impact on us to our patients? “I feel moved or touched (by what you have told/shown me);” “Oh! how awful/how terrible;” “I feel sad hearing this/feeling your pain/aloneness.” And then of course metaprocessing: “What is it like to hear how angry this makes me?” “You have a reaction to my being moved by you?”

Like a good mother, sometimes we simply reflect the emotion: “how sad;” and sometimes we amplify: “I feel so angry on your behalf.”

Fine-Tuning: More or Less Disclosure; Same or Different Self-Disclosure

Can we develop guidelines about whether to disclose more or less to patients according to their attachment styles? Should we disclose different things to different patients according to their internal working models? Dismissing/avoidant patients may profit from the therapist self-disclosure of similar experiences and emotional experiences. Perhaps in order to create more separateness in preoccupied patients’ working models might it not be useful to disclose ways that we are in fact different? I would also argue that

one might reveal more ways that we are similar in the early phases of treatment and disclose differences later in treatment as an important developmentally appropriate boundary making series of interventions. And then we would metaprocess: “what is it like to know we are similar/different in this way?” In terms of maturation, Lewis writes about married couples that (a) “Respect for subjective reality increases the likelihood of greater self-disclosure.” (b) “With greater self-disclosure, there is increased opportunity to appreciate similarities and differences.” (c) “Appreciation of similarities and differences leads to both increased closeness and augmented individuation” (Lewis, 2000, p. 1377). I raise these questions and yet I think we probably all work this way intuitively. Again to both make explicit and then explicate what we are doing and start a dialogue is my intention here.

CONCLUDING COMMENTS

In this article I have started to fill in some gaps between attachment theory and research and its clinical practice. I have put forward what attachment therapy’s language sounds like, and what kind of therapist an attachment therapist might be: what she says, how she says it and then what she does. I hope that all of these actual interventions will spark more manuals and cookbooks of psychotherapy so that there can be a dialogue about what works effectively with whom and when. As I end, I think of the struggle facing clinicians every day and every hour to translate mother-infant research into clinical practice: we all know what we are trying to do: we are trying to promote right-brain-to-right-brain interactions; we are trying to regulate affect, and repair ruptures and misattunements; we are trying to be caregiving and helpful so that patients will seek us out in stressful times and be comforted by our presence; we are trying to reflect together on as much of what is taking place between us as we can. I could go on; it is a lot to hold in your heart and mind everyday! So to end with a thought: every day I try to remember to be what Daniel Stern describes as “bilingual:” “at seven,” he says, “I was at a pivotal age. I knew the infant’s ‘language’ but also knew the adult’s. I was still ‘bilingual’” (Stern, 1985, p. viii). We too are at a pivotal age: we have focused extensively on the adult’s language and interpretation, and now we must all pool our resources to relearn the “language” of the infant, and the stance of a “good-enough” mother and try to give “good enough care” (Winnicott, 1965, p. 49). AEDP has a lot to offer in terms of the specific interventions of clinical practice. For those looking for an attachment psychotherapy, AEDP may well be it.

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Correction to Prenn (2011)

In the article “Mind the gap: AEDP interventions translating attachment theory into clinical practice” by Natasha Prenn (*Journal of Psychotherapy Integration*, Vol. 21, No. 3, pp. 308–329), due to mistakes in the production process there was an error printed in the fourth sentence of the block quote on page 323. The fourth sentence should have read, “In this way patient and therapist collaborate on constructing an intimate relationship.” The online version of this article has been corrected.

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