Mind the gap: AEDP interventions translating attachment theory into clinical practice

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"...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 new 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 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 now 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. 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, trauma studies, body-focused treatments and, of course, attachment research and theory. If we begin by allowing mother-infant interactions and adult attachment 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 this 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). Based on the emerging research on how relationships operate in and affect the brain, I argue that experiential, evocative language strengthens attachment bonds. This section contains six different types of therapeutic intervention that engender a secure attachment bond between therapist and patient.

3. In the 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). I will articulate two different areas within self-disclosure: i. self-involving self-disclosure, which is most usually considered self-disclosure of the process, the here-and-now, and which includes therapist vulnerability, errors, etc. ii. self-revealing self-disclosure of actual experience (similar or dissimilar) or therapist lived history. Lastly I will explain the importance of metaprocessing and Metatherapeutic processing (Fosha, 2000b, 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 metacognitional thinking in our patients as well. Metatherapeutic processing is an explicit exploration of a particular piece of work on a macro-level: "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 micro-level: 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 an attachment 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 of an attachment

therapist 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, follow the patient's lead. She makes "the implicit

explicit" (Fosha 2000a, p. 219), She is validating, affirming, authentic, spontaneous, present, and

empathic. Sounds like a "good-enough" mother (Winnicott, 1965)**, right?** All of these

characteristics are ways of being explicitly loving and care giving. These are ways mothers

explicitly act with their children, ways that engender attachment security.

      Ferenczi 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. Here 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 ensues, is wonderful right-brain-to-right-brain communication

that increases safety and allows 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), e.g., "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 bold). In

adult treatment, we are working with patients 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, 2005): "The True Other…has nothing to do with perfection: 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, and 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 (Gallese. Fadiga, Fogassi & Rizzolatti, 1996) 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 helped regulate her distress and 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 that 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.

Matching tone, pitch, pacing, depth of emotion, and rhythm are essential. Validating a patient

who tends to be speedy, finding a way to join with them and be on the same page is meeting

them where they are and can be a good starting point, e.g., "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 often 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/content of the next part of this paper.

Section 2. Experiential language.

This paper 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 most adult treatments is words. In their article 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 is no "cookbook" (p. 254) of what to say clinically. As an avid gatherer of actual live interventions, I hope this paper 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 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 a little farther, we may have dinner guests with anything from mild preferences to severe allergies. We need to

be responsive to them and adjust our interventions 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, and Wang, 2008, p. 254). I am saying that "important" as an experiential word works better than a more insight oriented word like: "interesting." Judith Nelson gives us a tantalizing taste of this when she writes: "...'touched' .." and then says that this word is "(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 words 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 statements or questions (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 attachment research and theory 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. The use of experiential language, specifically, and of the various interventions I am describing here, is aimed at filling this "theory-practice" gap. Moment-to-moment tracking and experiential language are important methods with which the AEDP therapist attempts to create 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 not 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; 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. The AEDP therapist tracks the patient moment-to-moment; she is

acting as a reflecting and observing ego to 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. 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, 2006[1]). 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, 2000, p. 271-2), 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/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, 2005). As Frieda Fromm-Reichmann is reported to have said: "the patient needs

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[1] 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 look out for actual examples of interventions.

an experience not an explanation." (quoted in Friedman, 2000, p. 42). As When 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 e**xploring and expanding**: "is there more?" "what else?" "say more"

• always a**sking 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...?"

Notice the "we" from the very beginning and repeatedly throughout the work. This continually makes explicit that the patient is not alone. The therapist offers help and invites collaboration 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 (Linehan, 1993; Epstein, 1998; Chodron, 2001; Kabat-Zinn, 1994; Safran, 2003). AEDP asks the patient to focus inside, notice and stay with whatever is there: some words that do this 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 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).

Transcript

A short piece of transcript from the first twelve minutes of a second session with a patient will illustrate some of this experiential language and some of these "skills" in action. The patient is talking about the defenses she knows she will see herself using when she watches the tape. She says she gets fidgety and smiles when she has painful or difficult feelings. The transcript that follows is verbatim. In parentheses are my comments on the interventions.

PT: All my personal power comes from my... my speech and my ability to figure things out and to talk about them and to ya so like to literally to protect it, you know, I guess (beautiful laying out of her defenses: she is very good at talking and figuring things out to protect 'it;' notice cognitive disruption around traumatic subject matter)

NP: And as you are saying that **what are you experiencing physically**? (I start to try to move to her bodily sense of her feelings)

PT: Well, I am always a little embarrassed to talk about something that I am proud of in a way. Like I am proud that I am really smart (big laugh), you know. And um I'm also embarrassed that that is something that I would have problems admitting.

NP: That brings tears to your eyes to say that you are embarrassed of something that you are proud of (moment-to-moment tracking; noticing and reflecting back)

PT: Ya. 'Cause I am not as embarrassed as I am that I am embarrassed that I am embarrassed.

NP: It is like it is layered.

PT: Ya.

Three minutes later. I keep trying to help her focus inside so that she describes her physical experience. We are nodding and matching each other in tone, pacing and intonation. We are getting in sync. I am pulling a little bit to slow down a little and drop down a little by lowering my voice and slowing my pace a little. The patient is talking about her parents as we rejoin the session:

PT: ...they just laughed a lot and...(patient's voice cracks)

NP: And this touches something? (tracking her experience; letting her know I see her feeling here; this is a notice and seize moment)

PT: Ya...

NP: Ya. Stay with what is happening **physically**. I see so much feeling coming up around this. (starting to entrain somatic focusing)

PT: It is just...It is so much in my childhood...(not quite getting to the physical, but it is emotional)

NP: And where do you feel it? **Physically**, if you just describe...just notice. **Physically**, right...(I keep asking about the somatic piece)

PT: **Physically**...Well, it is like, I don't know how to explain it, when I get nostalgic, when I get homesick or whenever it is like hard to be in New York City, and, I just, I think about that as such a great time in my life...yeah.

NP: And so much came up, right? (again educating that feelings come up inside, and letting her know I notice)

PT: (laughs) Ya.

Three minutes later, her body starts telling its story, we notice it together and the patient gets it.

PT: ...I was never one of those little girls that the mother was like, "Let's brush your hair, put you in a dress. You're really cute. Don't you look pretty today?" It just wasn't in our vocabulary. From my dad it was really not in our vocabulary 'cause he would never say, "You look pretty." He was always saying, "You should look prettier." (makes a fist and bangs armrest of chair). So I just...

NP: Mmm...and something shifted when you said that: a lot of feeling about that. (tracking a shift, and seizing upon it as a target of our work: notice I do not know what she is feeling)

PT: Ya.

NP: Again what do you notice just physically, you know, because I...(asking her to focus on her somatic experience)

PT: Clench up a little bit...

NP: Ya.

PT: Get a tighter throat (she gets it: she begins to describe what she feels physically). I have a hard time breathing sometimes.

NP: Mmm,

PT: Ya...

NP: Mmm... and if you just stay with that: that a lot of feelings comes up around this. What do you? If you just let it be. (vague invitation)

PT: Be there...(she makes it more specific for me; this is in a very quiet almost childlike voice)

NP: Ya. What is that feeling inside? ....Tightness and...?

PT: Well, it is funny that you should ask me because it's...This is the stuff that bothers me so much that um physical tightness that leads to anxiety attacks and stuff like that. (this is a pivotal moment; a lot of feeling in her statement; her body is telling its story)

NP: Mmm.

PT: And it always seems to come from someone just being mean (laughs), you know?

NP: And you laugh, right? When you say someone just being mean. (defense recognition)

PT: Yeah.

NP: Yeah.

PT: And I've noticed at work sometimes even... when someone in the line will speak to me like I am an idiot or like, you know, because there are some very, very ritzy people calling in.

NP: What happens inside, ya?

PT: It really makes me tighten up ....feel really like I want to defend myself, but I am not supposed to.

NP: Mmm.

PT: You know? Which is how I felt at my Dad's house...all the time. He would always say, "You should be prettier." (she makes the connection)

NP: And when you say that you make a very strong hand gesture. (bringing her back to the specific example she gave)

PT: Ya.

NP: You get this tightness. And, if you stay with that.

PT: It was just such a mean thing to say to a kid.

In these very first minutes, I am asking the patient to stay with her physical experience and we rapidly get to a traumatic memory stored in her body. As the session progresses, we will find together that this tightness in her throat that leads to anxiety and panic attacks is several things: a remembering of trauma with her father, a sexual assault in college, and what has brought her into treatment a fight with her current boyfriend. By using simple, repetitive language, a soft, gentle holding, yes, tender tone of voice, and focusing our attention on her physical experience as well as staying with her experience, we learn about her past dynamics from the present moment with me.

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)[2]

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[2] 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.

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, 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. Non-verbal 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 intervention, 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 organize the patient's

experience (Fosha, 2009): "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, 2009). "Platforming

statements are attempts to verbally capture the emotional experience that precedes

them." (Fosha, in press). 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 (Fosha, 2000). It is a hugely versatile intervention:

• it undoes aloneness;

• it makes the implicit-explicit;

• 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 metaprocessing.

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 (Fosha 2000a); it is always (or whenever possible) followed by metaprocessing, i.e., literally what the experience of the disclosure was like for the patient: "what is it like to know this?" "your reaction to my sharing this with you?" 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:

a) self-involving self-disclosure: "saying all of it" (Greenberg and 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 our selves.

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 and Watson, 2005, 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**

Self-revealing self-disclosure is the disclosing of actual life experiences, triumphs, 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 my 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; 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 bold). 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, p. 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). A patient looking at their watch after my self-disclosure 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 of 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 first hand 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, 2001; Stricker & Gold, 2006; Wachtel, 1998, 2008: Safran & Muran, 2000).

If the patient does feel misattuned to, we have an opportunity to repair this obvious disruption. 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 of themselves (Safran & Muran, 2000; Schore, 2003; Tronick, 1989, 1998; Lewis, 2000). 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 afterwards the fault to the patient." (1933, p. 159).

Back to the 'tell' of the glancing at the watch. It could be that 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 own 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. In short, there is often grief for what the patient has not received previously in her life: "mourning the self;" an expansion of the sense of the patient's self-efficacy, what Fosha calls "acknowledging mastery;" and relational, attachment work between patient and therapist: "receiving affirmation" (for a full explication of all of these see Fosha, 2000b).

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: firstly because emotions must be felt interpersonally before they can be felt intrapsychically (Maroda, 1998; Schore, 2003); and secondly that intolerable feelings need to be projected before they can be integrated (Schore, 2003, p. 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." (Schore, 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 classical 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 i. "Respect for subjective reality increases the likelihood of greater self-disclosure." ii. "With greater self-disclosure, there is increased opportunity to appreciate similarities and differences." iii. "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 my intention here is to be explicit and then explicate what we are doing and start a dialogue about how to do it more efficiently and effectively.

Concluding comments

In this paper 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 new right-brain-to-right-brain interactions; we are trying to regulate affect, and repair ruptures and misattunements; we are trying to be care giving 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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