

Psychotherapist REVEALED

Therapists Speak About Self-Disclosure in Psychotherapy

ANDREA BLOOMGARDEN

ROSEMARY B. MENNUTI

Editors



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chapter six

I second that emotion! On self-disclosure and its metaprocessing

Natasha Prenn

I assert not only that the analyst's self-revelation is permissible but that it is a necessary part of the clinical process. (Bromberg, 2006, p. 132)

In thwarting our patients in their quest for an emotional response from us, have we unknowingly been withholding that which could be most therapeutic? We might be tempted to rationalize our lack of overt emotional expression, on the old grounds that we will detract from the patient's experience, but this fails to address the change process. (Maroda, 1999, p. 84)

Not enough has been written about self-disclosure, and I think I know why: to write about self-disclosure involves self-disclosing! I feel my anxiety rise as I contemplate revealing myself. I feel like a new patient trying to decide how much or how little I want to say to you. I am back in a classical analysis: I am not sure how you are reacting as I write, and so I am anxious. This may be a little much for you already—we are just meeting. Can we track it together? I am wondering if I can write about my own tears and struggles as a patient and as a person. I am wondering how much I can dare to tell of my own thoughts and feelings as a therapist. It seems to be all right and accepted to talk about anger and hatred and frustration, but love and caring and closeness are less safe. So I feel like a patient, and I feel anxious. Maybe we can find a way to be in this experience of this chapter together. Maybe I can check in with you along the way to wonder how you are feeling as you are reading and I can tell you how I feel as I am writing.

Pivotal experiences

My first experience of psychotherapy was not as a therapist but as a patient. I know viscerally what it feels like to be sitting in the other chair or on the couch. I want to start by describing my two very different treatment experiences to illustrate what now so deeply informs my work as a psychotherapist. Karen Maroda writes that when she first started working as a therapist she could not understand why her patients felt humiliated by her not answering their questions. She was applying “right” technique. How come it felt so terrible? (Maroda, 1998). I know the humiliation personally: the shame of wanting to know and the double humiliation of being denied when I asked. In my first therapy, an analysis, I learned this “rule” the hard way, by feeling it, and, in the treatment itself, learned new areas of defensive exclusion (Bowlby, 1980).

Slinging my book bag across my shoulders, I stood up. “Are you going anywhere nice?” I asked casually. I was new to therapy. Mark, my therapist, was going away on vacation. He froze, put his hands in his pockets, and looked away from me. “What makes you ask that?” “Um ... I don’t know,” I stuttered.

And so began a process of tentativeness and hesitancy on my part as I tried to avoid making this kind of mistake again and the shame I felt at having gotten it wrong. I lost my spontaneity in this exchange and many other interactions like it. I didn’t ask Mark about the specifics of his life then and I didn’t ask about his feelings either. But I watched him, and I imagined what he was feeling and thinking, and the transference blossomed, but I did not change, and in some new ways I felt more constricted. I remember crying and looking up to see him silently looking away. I don’t think I have ever felt more alone or more ashamed.

Fast-forward to starting a very different kind of therapy. My new therapist, Claudia, had told me her schedule and I knew she was going to be away. She smiled, “I will see you in 2 weeks.” I broke eye contact, looked away and then down. “What just happened?” she asked. “You looked away.” I hesitated, but spoke up, “Can I ask you where you are going?” “Of course you can,” and she proceeded to tell me specifically where she would be over the next 2 weeks. Tears welled up in my eyes, and I felt my body relax in relief. I would not have to constrict my “self” in this relationship. And then she said, “I see tears.” “Yes, it is just such a relief to know, to have you answer me,” I replied.

Not only was the disclosure hugely important, but so was the conversation about the feelings that accompany the disclosure. This interaction literally freed me up to be myself and to talk openly and emotionally about things I had not allowed myself to think about for years. If she would let me into her world, I could dare to let her into mine.

Fast-forward again to my own office. I am the therapist. It is the end of the session. I am going on vacation. "I will see you in 2 weeks then," I say. "Where are you going?" Ellie asks. "I'm going to London," I reply. "That's where you are from originally, right?" "Yes, it is." We look at each other and smile. "What is it like to know where I'll be?" "Oh, it feels good. I can imagine you there." Ellie stands up, buttons and belts her coat, throws her backpack over her shoulder. She hugs me. "All we are doing will stay with me," I say. "I'll think of you and you think of me," she says. "Yes, I will," I say. Ellie is young, 22, and she has never been in therapy before. Should I ask her why she wants to ask me such a "normal" question? Should I shame her by not answering? Should I teach her that there are things that cannot be discussed in a talk therapy? That just doesn't make sense to me.

Becoming an AEDP therapist

As I began my career as a therapist I knew how I didn't want to be as a therapist and I thought I knew how I did want to be. I feel incredibly fortunate that as I searched for a theory and a way of working that fit with me, I found AEDP (Accelerated Experiential-Dynamic Psychotherapy), an experiential treatment modality, the work of Diana Fosha (Fosha, 2000, 2003, 2006). AEDP not only approved of self-disclosure, but required it and provided guidelines on how to do it effectively.

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, 2000, p. 213)

In AEDP self-disclosing is only the first step of the intervention and is always or whenever possible followed by exploring the patient's experience or reactions to the self-disclosing: *metaprocessing* the disclosure. Metaprocessing (Fosha, 2000) helps patient and therapist collaborate and titrate disclosures together. How doubly fortunate I am also to have begun my career at a time when affective neuroscience and mother-infant research were hugely impacting how we think about adult treatment. My children's infancies and toddlerhoods were fresh and alive in me; I felt

softer, more open, more connected to people and to the world. All of this informed how I wanted to work. Before I found AEDP I struggled through an analytic training program. My training paralleled my experiences in treatment.

Consider my first analytic supervisory experience: I am reading process notes to my supervisor. He tells me over and over again that “silence” is the best intervention. I should be silent? I think about what had worked and not worked for me in my own treatment, and I think and feel the rich mutual communication I have with my small children. And I read mother–infant research and Allan Schore (Schore, 1994), of course. And I think: silence? I remember the shame and mortification I felt at Mark’s silence and lack of response to me. I liken the experience to what happens to infants and children in the “still-face experiment” (Tronick, Als, Adamson, Wise, & Brazelton, 1978). They are confused, they try a number of strategies (some more extreme than others) to get their mother to react, and finally they give up. What is important is not only how anxiety-provoking it feels for the children but also how painful it feels to the mothers who are asked not to respond to their children/babies for just 3 minutes: a typical testimonial reads something like, “It was all I could do not to respond. I felt as if I were deserting my baby. I felt torn away from her, and I felt as if I were losing a part of myself. I felt sad, angry, and desperate in turns. I never want to do it again.” They go on to say that it was a “relief to be ‘real’ again.” In reuniting with their children/infants they often said: “Mommy is real again” (Brazelton & Cramer, 1990). Not responding does not feel good to patients or to therapists. Silence? How could that possibly be right? How could that help? I watched as my colleagues wrestled with themselves not to show their patients how much they cared about them. On more than one occasion I saw therapists crying because of their patients’ suffering and distress and their desire to help. I thought, if our patients knew how much we care and are invested in them, wouldn’t that help?

What a relief to start AEDP supervision. Robert, my supervisor, asks me how I feel about the patient in this moment. How do I feel? I feel delighted, I feel full of love, I feel protective of her. “Have you told her?” he asks. Wow! What a different experience.

Beyond the taboo—self-disclosure as a necessity

Can we check our Freudian superegos at the door, and look at disclosure not as a taboo but as a necessity? There is every reason to self-disclose to patients: “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). There are no good reasons not to self-disclose. If we step back from Freud, if we think about mothers and infants and let that inform our work, then of course we would disclose. And this is just the beginning, the minimum requirement.

If we reframe our thinking about self-disclosure so that it is an essential part of the fabric of every treatment, which I believe it is, then we have to figure out how to do it well. To my mind, it does not matter so exactly what you do and don't self-disclose (I have disclosed all kinds of things); it is what you do next that matters. Self-disclosure is neither good nor bad; *it is the quickest way to have an experience between two people*. Then patient and therapist have an opportunity to process together what that experience was like: an experience they have had together. We are not "talking about" experience. A lot has been written about impingement, intrusiveness, and overstimulation (mainly by men and predominantly by analysts), but I contend that if we ask what the experience was like for the patient we can figure out together with the patient how much of what and when they need from us to facilitate the work together. This exploration of the experience of whatever has happened is called metaprocessing in AEDP (Fosha, 2000). It is an essential tool in the change process and a crucial way to measure with the patient how disclosing, for example, is experienced by the patient. It also cements the interaction transferring a right-brain emotional experience into left-brain language.

Therapists, with noteworthy exceptions, are afraid to self-disclose and they are afraid to talk and write about self-disclosure. This is for a number of reasons. The first and most forbidding is that it has been considered taboo and the beginning of a slippery slope into boundary violations and acting out: "There is a correct analytic stance and ... this [self-disclosure] is not it" (Bromberg, 2006, p. 132). The consequence of this taboo and the second reason therapists are afraid to self-disclose is that therapists have not learned to use it well or effectively. The third reason therapists get anxious about self-disclosure is that it is not one therapist activity, but rather a number of different behaviors (Yalom, 2002). Let me be clear about what I mean.

I think there are three main activities that fall under the umbrella of self-disclosure: (a) there is the most crucial kind of disclosure: the self-disclosure of affect and process as it unfolds in the session and session to session; (b) there is the self-disclosure of actual life experiences which are often extremely helpful for patients to know about: they help undo aloneness and increase what Yalom calls "universality" (Yalom, 1995, p. 6): we are all human and struggle with similar things; (c) there is therapist vulnerability, errors, and anything that decreases therapist omnipotence and creates a collaborating partnership: we are a team

working on the patient. I have my psychological expertise, but you are the expert on you (Fosha, 2000).

Back to my first treatment

I arrive at the session with Mark. I have been needling him for weeks and I know it. I keep asking him if he is angry and he always replies, "Maybe you are angry." I read up on it: I am "projecting." But am I? Am I always? And what about him? Isn't he angry? How could he not be? I continue my needling. He finally erupts. "Fuck you," he splutters at me. I am simultaneously delighted and afraid. I am delighted because now I can relax: I have had enough of an impact on him for him to react like this. But at the same time, I am afraid because he was frightening; he was out of control. We take most of this session and the following sessions to regroup. But that moment is pivotal: I now know I exist for him. I exist enough to make him angry, but why was I provoking him? I was talking to him openly and emotionally every session, and I was getting no response from him. Did it need to be so hard and so extreme? I don't think so.

It is now some years later. I ask Claudia, my AEDP therapist, if she is angry. Yes, she is, she says, but she adds straight away, "I am angry with you, but I am not going anywhere." She lays out what she feels I am avoiding, and how painful it is for her to see me avoiding it. A very different scenario, but a similar feeling. It is not acted out, but it is talked through with some intensity.

Self-disclosure of emotions: Completing the affective cycle

These are two examples, big examples from my own experiences of what Maroda calls "completing the cycle of affective communication" (Maroda, 1998, p. 65). Why is the affective cycle so important? In a way, the first example is more illustrative because there was a huge intensity of feeling. It is in these times of affective exchange that change can take place. These are the moments of therapeutic action. Psychoanalysis calls the big moments *enactments*, and the writing on these is important. I want to add that the pressure of feeling that builds up by not being responded to is not only transference and not only enactment. The nondisclosing stance is in many ways pointing the finger and saying, "It is *you*." Mark swearing at me was such a relief because his anger told me, "It is *us*." Which it was all along, of course.

In my AEDP therapy not only did I feel I could read Claudia's emotions accurately, but her owning and disclosing her affect meant I wasn't shamed into thinking I was projecting, "It is all in your head!" I wasn't projecting, and I wasn't crazy; she was angry, and angry for a reason.

OK, not the end of the world. We had some stuff to deal with, and we did. This is also an example of “saying all of it” (Greenberg & Watson, 2005, p. 128). It is not enough to say we feel angry or sad or distanced by a patient; we need to “say all of it” and tell the patient why, what the content is, and what our process is.

There are lots of reasons for therapists to disclose actual life experiences and feelings embedded in life experiences. How very powerful to give an example of a feeling I have had and the context in which it happened for me. I often find that disclosure of some of my more “taboo” thoughts or feelings helps patients the most. This increases the sense that “we are all in this together” and nearly always creates momentum in the treatment. I think of this as introducing into individual therapy an aspect of the efficiency and effectiveness of group therapy where group members traditionally have had more latitude to disclose than individual therapists: “In the therapy group, especially in the early stages, the disconfirmation of a patient’s feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, patients report feeling more in touch with the world and describe the process as a ‘welcome to the human race’ experience” (Yalom, 1995, p. 6). I notice as I write that I am hesitating to be specific about the kinds of feelings I have disclosed to patients. This is one of those moments when writing about self-disclosure feels risky and yet I can’t help but feel that your knowing that I have felt full of love, bursting with pride, shaking with anger, and red-faced with embarrassment, just as you probably have, will make me a little more real as I write. Should I promote hiding?

This is not an easy task: I recently shared with a patient that sometimes I feel vulnerable and unsure. She lifted her chin and looked down her nose at me. “How can you help me if you feel vulnerable sometimes? How can you help me if you are weak?” was her initial response. We were able to really look at her feelings about me: her utter contempt for my “weakness” and disgust with weakness in herself. We were able to reframe her definition of weakness. I certainly don’t feel my uncertainty is a weakness: I think of it as one of my strengths. Did she shame me with my vulnerability? Yes, at first she did. Did it deepen the work and help her in the long run? Absolutely.

Self-disclosure: Facilitating corrective emotional attachment experiences

Midway through writing this chapter, I became aware that I am still fighting for self-disclosure and against the disclosure taboo: Freud/one-person psychology casts a long shadow. I realized while writing

that AEDP is such a different way of working, and I found myself reflecting on how much I self-disclose, and why I do it. If we believe, as I do, that (a) emotions must be felt interpersonally before they can be felt intrapsychically (Maroda, 1998), (b) intolerable feelings need to be projected before they can be integrated, and (c) most patients need more help figuring out what they are feeling than anything else, then we have to pay careful attention to our minds, emotions, and bodies in session and between sessions and communicate what we notice happening within us in our process to our patients. I think of therapy as a series of corrective emotional experiences in a corrective emotional attachment relationship. I will quote Maroda again: "Only new emotional exchanges [can] facilitate the altering of old affective patterns" (Maroda, 1998, p. 85). I repeat: Self-disclosure is essential, but in some ways a minimum requirement.

AEDP translates and synthesizes attachment research, emotion theory, developmental models, and affective neuroscience into transformative therapeutic action. AEDP takes seriously and literally the plasticity and fluidity of the mind as well as its constancy and continuity. If we can change dramatically for the worse in trauma, why shouldn't we also be able to change rapidly in therapy (Fosha, 2006)? In AEDP self-disclosure is one of many interventions employed to create patient safety and to swiftly bypass defenses (Fosha, 2000). The feelings I disclose are real, the experiences from my life are real, and my uncertainty and need for help are real. The relationship is real from the very beginning.

I read over and over again that one must wait until the patient is ready and that the patient will let you know when that time is. In AEDP, which is not a time-limited or even necessarily a short-term treatment modality (although sometimes it is), one is constantly on the lookout for what is most active or alive emotionally in the patient. We want to be at the leading edge of where the patient is. As a result, the AEDP therapist is active and often directive. Moment by moment, patient and therapist work to negotiate their relationship, and this begins from the first moment of the first session. In fact, the first session is "a unique opportunity" (Fosha, 2000, p. 189).

The relationship with the therapist evokes intense feelings: from the first minutes of the first session, the therapist declares that she wishes to relate to the patient. By focusing on the patient's feelings, asking for specifics, and responding empathically and emotionally to the patient, the therapist activates the patient's complex feelings about intimacy and

closeness. ... The emotionally charged atmosphere of the first minutes of the first session offers tremendous opportunities as the first set of dynamics that underlie the suffering the patient is seeking to remedy is exposed. (Fosha, 2000, p. 189)

My new patient arrives; she hangs her coat and arranges herself on the sofa. "What is it that brings you in today?" I want to capitalize on the precipitating event, the final straw that pushed her to find a therapist and dial my number. This is usually the most affectively alive in the patient. "How are you feeling telling me that?" I initiate our collaborative process from the very beginning. "I am feeling scared," she replies. "I am so glad you are telling me. It helps me a lot to know that. Can you tell me more about the scared feelings?" My stance is empathic, collaborative: I need her help, and I am appreciative of all she is doing. In this first session I want to be explicitly affirming: "You are doing a good job telling me; you are helping me." The focus on how well she is doing and how her efforts are helping me often leads to an affective experience of pride or mastery or hope (Russell & Fosha, 2008). In the rounds of work that follow, we begin to track our responses to each other, and I often use self-disclosure to open up patients' curiosity to their own internal experience. "I notice you came forward and then you seemed to withdraw or retreat a bit. Did you notice that?"

In AEDP the unit of intervention is not just the disclosure or intervention itself but rather the therapist's intervention *and the patient's response to it* (Fosha, 2002). The research is undecided about whether disclosing *per se* is essential in successful treatment or not, but what is essential to positive outcome is the therapeutic relationship; it is in the metaprocessing, the exploring of the intervention/interaction, that greater traction and intimacy in the relationship take place (Farber, 2006). Ehrenberg calls this place "the intimate edge" (Ehrenberg, 1992).

This is leading me to want to take what Maroda says about affective cycles and projective identification quite a lot further. If we put all of this into the framework of attachment, attunement, disruption, and repair, we are in the land of dyadic regulation of affect. Mothers and infants regulate their affect together: babies, toddlers, children, and adults need their mothers/therapists to calm them, to reflect them, to be excited with them. And the wonderful freedom of the cycle of attunement, disruption and repair means that we don't have to get it right all of the time; the moments that we get it wrong are as important if not more important than when we get it right.

This is very much so, working with depression.

Treating depression: Moving out of comfortably numb

An active, involved, leading, self-disclosing stance helps depressed patients. They have lost their vitality and need ours. They need to know that their depression is about something, and that we will understand what it is about and work together so that they feel better. This disclosure in session nearly always has an emotional impact on a depressed patient, and is a great example of how self-disclosure about the process is *the fastest way to an emotional experience* between two people. Educating patients that depression is not a primary or categorical emotion can be hugely helpful. Depression is a secondary emotion: It lets us know something is awry, but like a panic attack, it is not the thing itself (Fosha, 2000; Greenberg & Watson, 2005; Greenberg & Paivio, 1997).

Here I want to give some examples from a therapy that relied on my being in touch with my embodied feelings and sharing my emotional life in sessions with my patient. Gradually with me leading the way, he started to listen to his body and his feelings as they told his emotional story. We did rounds and rounds of work focusing on the categorical emotions of anger, grief, joy, and sadness. When we processed his feelings to completion (Fosha, 2000), he felt better and when we did not get to the other side of the depressed mood, he continued to feel depressed. So for him very clearly his depressive moods were “about something,” something coming up to be dealt with in treatment and something he needed me to feel before he could feel it himself. My feelings gave him permission to feel. I will call him Jay. (Patient is composite).

Jay arrives. He looks anxious. He is depressed. He tells me he can hardly get up off his sofa. He feels like he is free-falling into paralysis and inactivity. I feel connected to him and tell him so. I tell him I feel optimistic: He is in touch with his somatic sense of himself. I think I can help. We agree to roll up our sleeves and get to work together. We do. I am worried he will kill himself. I seek consultation. We start on a very interesting and at times for me uncomfortable treatment. He feels anxious and depressed or nothing much at all. We all have experiences like this in session: “How are you feeling?” “Dead.” “What are you feeling right in this moment?” “Numb.” “What are you in touch with inside?” “Nothing.” “What do you notice?” “Nothing!” And, as I think often happens with patients suffering from depression, I felt a lot: I felt sad and angry and hopeless and angry and irritable and frustrated. I felt a lot with Jay. He would come in feeling nothing and not much else. It is simplistic to say that as I paid attention to my feelings and shared them with him, he learned to name his feelings and let himself have them, but this is a lot of what happened. Eighteen months later,

equipped with a newly found emotional repertoire but no depression, he feels ready to graduate.

An early session

Me: How has your mood been?

Jay: I have been really depressed yesterday and today. This morning I could hardly get out of bed. I lay awake staring at the ceiling.

Me: Uh-huh. What has been going on?

Jay: Nothing I can put my finger on.

Me: What are you feeling now as you are talking?

Jay: Nothing.

Me: If you scan your body, are there places you feel more tension ... less tension?

Jay: I feel tight in my back.

Me: OK. Stay with that. What comes up inside as an image or sensation?

Jay: It feels as if I am being whacked.

Me: Stay with that. Let yourself focus there...

Jay: I feel as if I am being whacked. I got so angry at work this week. My boss asked me to stay late and I couldn't say no, and he was being such an asshole.

Me: Uh-huh...and you were angry?

Jay: Yeah, really angry.

Me: Are you feeling it now?

Jay: No, not now.

Me: What are you feeling as you are talking?

Jay: Nothing. Numb. Dead.

Me: And with your boss. How did you feel when he asked you to stay?

Jay: Furious. Mad.

Me: What did you say to him?

Jay: Nothing. I couldn't say anything.

Me: Oh, I feel so angry listening to this. He is always doing this. I'd like to tell him to leave you alone.

Jay: (silent)

Me: What is it like to have me feel so angry at him and want to stand up for you?

Jay: It's great. It feels good.

Me: What's it like inside ... physically?

Jay: It makes me feel bigger, filled out inside ... filled up. Bigger. I want to tell him to pick on someone else.

On another occasion tears well up in me as he tells me about how lonely he felt after his mother left his father when he was eight. He wrinkles his brow and tears come into his eyes. "Oh, it was sad. I am sad." He feels it now. In the metaprocessing, he says, "Your tears give me permission to have my own tears."

Very often patients feel that there was a manual given out to other people about how to live their lives and how to feel their feelings, and with no training from their parents they feel that they didn't get the manual. I think it is essential for them to know that there is no manual and that in many ways we are all in the same boat. For this reason, I very often disclose that I have been in my own therapy, and the different ways I know firsthand what it is like to be in the other chair.

Jay has asked to reschedule. He arrives at exactly the moment I am saying good-bye to my previous patient. He is unable to articulate what is wrong for the first half of the session. All attempts I make to figure out what is going on go nowhere. Finally I start to guess out loud what he might be feeling, including wondering if his rattledness could have anything to do with seeing a patient leave as he arrived for his session. At this, he let out a huge sigh and says maybe it was something to do with that. End of discussion. He cannot make eye contact and becomes more and more distant. He says he is feeling numb but that is about it. He is having a reaction to something, not wanting to have the reaction to it, feeling ashamed by having the reaction. I am asking him to talk about a reaction that is raw and alive and shaming. I decide to self-disclose about a time when I was in my own therapist's waiting room when another patient came out of her office. I talk about my fear that my therapist liked this patient better than me and how intense and important those feelings were. I wonder out loud if anything like this could be going on for him. I tell it like a story in a slowed-down, right-brain to right-brain kind of way. I say that if this doesn't fit or isn't helpful, he can disregard it, but that he can take anything that resonates and help me fill in the rest. I talk about my feelings and what I can imagine about his feelings. Dan Hughes calls this: "speaking for" a patient (Hughes, 2007, p. 202). He starts to cry. He has not thought these feelings were all right to have. Telling him about my intense feelings for my therapist allows him to have his about me.

I love you

Jay phones late at night. He is suicidal. He has talked for a long time about hating himself, feeling helpless, hopeless, desperate. Nothing is ever

going to change: “No one loves me; no one cares about me; I don’t make a difference. No one would miss me if I was gone.” How am I to respond? To his “I hate myself,” I have empathized and heard his pain: “I hear how you hate yourself right now.” There is a lot at stake. He is not with me; I can’t see him. He says he wants to die. Tone, pitch, and pacing of my words are as important as what I say; I need to regulate him. Slowly, deliberately, softly, and calmly, but with energy, I say, “I love you; I care about you. My life is considerably better for having you in it. I would miss you if you were gone.” This is a pivotal moment. In the next session we metaprocess what it was like to have me tell him how much I care about him, how he has impacted my life, that I love him. He reports that his mood changed dramatically after our phone call. He woke up the next morning feeling buoyant and exuberant. Knowing that I love him and that he impacts on my life changes how he feels about himself. He says that he did not realize how much he wanted to feel loved. In the metaprocessing I tell him specifically the things I love about him (“saying all of it,” Greenberg & Watson, 2005). It is in these details that I make explicit that my love is not erotic or sexual; it is a caring kind of love that has grown out of his letting me get to know him. It is because I really know him that my loving him matters to him.

I notice that I am leaving love to the very end of the chapter, and using a very extreme example as the context for writing about saying “I love you” to a patient. We are almost at the end. I want to avoid doorknob therapy. So let me say that if I feel loving feelings for a patient (and I think I feel loving as often as I feel, say, sad or angry) then why would I hide those feelings? Well, historically there are plenty of reasons to do so. But if I let mothers and infants inform me, why would I? So how does one decide? There is a feel to people in the room with me: if it feels sexual or noticeably asexual, I generally avoid saying, “I love you.” And I know there are patients male and female that I would not say “I love you” to for a variety of reasons. So how did I decide? I think it often has to do with feel and one’s sense of the patient’s developmental age or stage. Jay felt so young in treatment: he felt like a little boy needing to know he was valuable and lovable. This is what guided my feeling free to tell him how I felt. He needed me to teach him about feelings, feel his feelings, and reflect back to him who he was, and more than anything else he needed to feel loved. The late-night call was a turning point and was the first round of many cycles that revolved around his needing to know I loved him. And I did. And I do.

Final words

As I come to the end of this chapter, I find my Freudian superego kicking up. I hear whispered accusations of narcissism and gratification and my unmet needs. I hear you all, but what about detachment and silence and

the withholding of affect? I find more often than not if I am unsettled at the end of the day, it is because I wasn't brave with my feelings when a patient needed something emotional from me. I want to end by advocating 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! The goal is not to be perfect, but as Karen Maroda says, echoing Winnicott, let's strive to be "good enough" and learn to self-disclose as effectively as possible.

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