META-THERAPEUTIC PROCESSES AND THE AFFECTS OF TRANSFORMATION: Affirmation and the Healing Affects

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ABSTRACT

When successful therapeutic experiences themselves become the focus of therapeutic inquiry and work, it becomes possible to deepen and broaden the treatment's effectiveness. The systematic exploration of phenomena associated with therapeutic change --through exploring the patient's experience of having a therapeutic experience-- activates *meta-therapeutic processes* associated with characteristic *affects of transformation*. The aim is to raise the consciousness of therapists of all orientations, *a fortiori* those interested in integration, of the therapeutic potential inherent in the exploration of such non-denominational processes. First, three meta-therapeutic processes -*acknowledging mastery*, *mourning-the-self,* and *receiving affirmation*- and their respective affective markers -*joy, emotional pain*, and the *healing affects*- are identified. Then, the focus is on the dynamics of the affirmation process and the phenomenology of the healing affects. Therapeutic benefits of and possible sources of resistance to receiving affirmation -in both patients and therapists- are discussed. In the last part of the paper, a transcript of a clinical vignette illustrates integrative therapeutic work with the response to affirmation and the experience of the healing affects.

INTRODUCTION

As therapists, bringing about change is our *raison d'être*. In our different orientations, we conceptualize mutative agents variously, and then, through our interventions, seek to activate them in order to bring change about, thus alleviating suffering and helping our patients lead fuller, richer lives. What I am interested in exploring in this paper is what happens when we achieve our goals, i.e., what happens once the patient has been substantially helped, once significant change for the better has occurred. What happens when patients *do* experience our empathy and *do* feel understood? What happens when patients *are* able to overcome a phobia and (re)gain a sense of freedom in their lives? What happens when, through deep experiencing of previously unbearable affects, patients *are* able to achieve mastery and work-through traumatic pasts? What happens when --through treatment-- depressions lift, anxieties are mastered, personality restrictions are overthrown, symptoms disappear, maladaptive patterns are replaced by adaptive ones, and previously feared situations become opportunities for demonstrating mastery? What is usually the endpoint of the therapeutic road is the starting point of this investigation. This is the beginning of a new phase where *meta-therapeutic processe*s and *the affects of transformation* that are their markers can come into operation, providing an opportunity to deepen and broaden the treatment's effectiveness.

In considering meta-therapeutic processes at what is often taken to be the end of the therapeutic road, I am also, of course, putting forward a particular view of what constitutes an essential therapeutic process that I have elaborated elsewhere (Fosha, 1995, 2000; Fosha & Osiason, 1996; Fosha & Slowiaczek,

1997). Suffice it to say here that this view of therapeutic change, like many integrative experiential therapies (see Gold, 1996, Chapter 6), places the experience of affect in the context of an emotional relationship at the center of its understanding of psychic development and therapeutic process; it does so within a development-informed psychodynamic conceptual framework. This article concludes with a brief overview of this psychotherapeutic approach, Accelerated Experiential/Dynamic Psychotherapy, in the context of presenting an illustrative vignette with a moment-to-moment analysis of the clinical material from a therapy session.

Regardless of the therapist's model, in any therapy that is going well, the patient (and the therapist too, it is important to add) experiences a sense of accomplishment. Successful therapeutic experiences --be they in the moment or the cumulative results of a course of treatment-- provide the opportunity for the next round of therapeutic work. The focus shifts to the patient's experience of having a therapeutic experience, thus the name *meta-therapeutic processes.* These processes themselves are associated with characteristic affects, which I have called the *affects of transformation*, as they are the markers for processes of therapeutic change. *Acknowledging mastery, mourning-the-self* and *receiving affirmation* are the three major meta-therapeutic processes.

• In the process of *acknowledging mastery*, the patient is in contact with his success in overcoming obstacles that stood in his way before. This *a fortiori* applies to patients' active and successful efforts at change (Bohart & Tallman, 1999a; 1999b; Gold, 1994, 1996; Hubble, Duncan, & Miller, 1999). The affective markers most common to mastery and its acknowledgment are the categorical emotion of *joy* and the feelings of *exuberance, pride* and *happiness* (Kissen, 1995; Perls, 1969; Tomkins, 1962).

• In the process of *mourning-the-self,* the therapeutic experience activates the patient's awareness of what he didn't have, what he lost and what he missed. Similar to the work of mourning (Freud, 1917; Lindemann, 1944; Volkan, 1981), the work of mourning-the-self involves facing and working-through the impact of the painful reality that resulted in the patient's psychic suffering. The affective marker associated with the process of mourning-the-self involves the experience of *emotional pain*, which is a grief whose object is the self (Fosha, 2000).

• The process of *receiving affirmation* is the other side of the coin of the mourning process. It involves fully acknowledging, feeling and working-through the emotional reverberations of therapeutic experiences, i.e., those experiences that led to the alleviation of the patient's suffering and to engendering his nascent and growing sense of well-being. The affective markers associated with being the recipient of affirmation are *the healing affects,* of which there are two main types: (a) feeling moved, touched or strongly "emotional" within oneself; and (b) feeling gratitude, love, tenderness and appreciation toward the affirming other.

Alternating Waves of Experiential and Reflective Work

The essence of making use of the meta-therapeutic processes lies in the experiential processing, patient and therapist together, of the patient's reaction to changing and to having been helped in a useful and meaningful way. Patient and therapist together become involved in tracing the affective contours of their successful collaboration. The exploration involves alternating waves of experiential (Greenberg & Safran, 1987; Greenberg, Rice & Elliott, 1993) and reflective (Fonagy *et al*., 1995) work, in a manner akin to good public speakers who are advised to "tell them what you're going to do, do it, and then tell them what you've done." What's involved here is (a) facilitating a therapeutic experience, (b) naming and acknowledging it as such, and then (c) exploring the patient's experience of the therapeutic experience. In ordinary language, what is being suggested is feeling and talking about feeling, and feeling what it's

like to talk about feeling, and so on. This way, it is not only that the patient has been successful and has been helped; he also deeply knows *that* he has been able to have a success and that he has been helped, which contributes to self-efficacy and capacity to trust. The patient also has access to *how* he experiences that success and help and to *what* they mean to him. The process of change itself is thereby identified and marked for the patient as a coherent experience and thus becomes an accessible part of his affective-cognitive-behavioral repertoire. Experience, reflection and meaning-construction --all in a relational context-- are all integral aspects of meta-therapeutic processing.

Therapeutic Opportunities Residing in the Therapeutic Exploration of the Meta-Therapeutic Processes.

How is the focus on the meta-therapeutic processes and their associated affects of transformation clinically useful? Why draw attention to them? There are several reasons:

First, by explicitly elaborating the meta-therapeutic experiences, rather than allowing them to operate silently, we give our patients the opportunity to process, and thus learn about, the nature of experiences that are helpful to them, experiences where they have already been successful. This furthers the transfer of therapeutic learning to experiences outside of treatment; these processes then become something patients can reflect on. As the work of Fonagy *et al*. (1995) and Main (1995) has powerfully demonstrated, the capacity to reflect on one's own experience, as well as on that of others, is powerfully related to resilience and psychic health.

Second, the acknowledgment of and focus on the impact of positive therapeutic experiences gives rise to specific clinical phenomena that themselves have enormous therapeutic potential as they tap the psyche's natural healing forces. This dual process is reflected in the two meanings of *healing affects*: they are markers for processes that are healing, and, they are affects which are healing in and of themselves. Experientially focusing on them leads to ushering in a state transformation where deeper resources are accessed, which include some of the following:

• general awakening of the adaptive action tendencies released by the full experiencing core affects (Darwin, 1872; Frijda, 1986; Greenberg & Safran, 1987; Lazarus, 1991; McCullough Vaillant, 1997; Safran & Segal, 1990);

• increased confidence and self-esteem;

• access to states of well-being, calm, ease and relaxation

• access to 'true self' states and experiences of aliveness, liveliness and authenticity (Ferenczi, 1931, 1933; Gendlin, 1991; Perls, 1969; Winnicott, 1949, 1960);

• deepened capacity for intimacy and closeness (Davanloo, 1990)

• true insight, i.e., deep knowing and clarity about the nature of one's needs, difficulties, as well as a felt sense of one's resources in being able to overcome them (Greenberg, Rice & Elliott, 1993)

• increased empathy and self-empathy (Alpert, 1992; Jordan, 1991; Kohut, 1984; McCullough Vaillant, 1997).

Third and finally, having -and acknowledging having-positive affective experiences with the therapist

help patients recover memories of positive relationships, vital to their psychic survival, but often forgotten or dismissed as unimportant. For example, work with a patient had focused on her deep grief and anger about her father's failure to understand, nurture and appreciate her (i.e., the process of mourning-the-self). In the course of doing the work, the patient was deeply moved by what she experienced as my loving interest in her, an experience she was encouraged to explore and articulate. Her experience with the therapist de-repressed long-forgotten memories of her father when he had been both very loving and very proud of her. She remembered a nickname he had had for her, which she had not thought of in years, and she remembered how proud she had been of his interest in her writing when, at the age of 6, she had declared herself an 'authoress.' The recovery of these positive memories allowed us to better understand her dynamics. She had had her father's love up until she lost it irrevocably and inexplicably during the latency years (the loss appeared related to the birth of another child, who became father's favorite, as well as to the patient's turning nine, the exact age at which her father had lost *his* father). While the loss of her father's love and subsequent starkness of her relationship with both parents shaped her adult personality and concerns, the recovery of early memories of her father's love solidified her core sense of herself as good and worthy of love and understanding. It also shed light on the origins of her incapacitating fears of loss, which had inhibited her growth and development. These consolidating memories of a good past relational experience might never have been recovered without the meta-therapeutic focus on present relational experience.

The working-through of the meta-therapeutic processes and their accompanying affects of transformation is a major source of healing and one which, to my knowledge, has not been fully acknowledged in any other major therapeutic approach. This work can be seen as building on several strands characteristic of integrative therapy work. These include, but are by no means not limited to, work that recognizes the importance and therapeutic effectiveness of :

• the patient as active healer (Bohart & Tallman, 1999a; 1999b), agent of change (Hubble, Duncan and Miller, 1999), and psychotherapy integrationist (Gold, 1994, 1996), thus emphasizing the importance of the recognition of mastery experiences through being attuned to and fostering "the clients' perception of the relationship between their own efforts and the occurrence of change" through therapists' drawing attention to and showing interest in the "client's role in changes that occur during treatment" (Hubble, Duncan and Miller, 1999, p. 411);

• affirming and valuing of the patient (e.g., Rice & Greenberg, 1991; Rogers, 1961; Wachtel, 1993);

• being change- and strength-focused, rather than pathology-focused (e.g., Fosha, 2000; Gold & Wachtel, 1993; Greenberg, Rice, & Elliott, 1993; Hubble, Duncan and Miller, 1999; Rogers, 1961; Wachtel, 1977, 1993);

• relational process factors in psychotherapy, for example, to only select a few, empathic attunement (Greenberg, Rice & Elliott, 1993; Stern, 1985), corrective emotional experiences (Alexander & French, 1946), disconfirmation of pathogenic beliefs (Reeve, Inck & Safran, 1993; Weiss & Sampson, 1986); repair of therapeutic ruptures (Safran & Muran, 1996; Safran, Muran, , & Samstag, 1994; Safran & Segal, 1990)

The experiential and reflective exploration under consideration here occur *after* these types of successful therapeutic experiences -be they patient-focused, therapist-focused or process-focused- have made their impact; possibly, the dyadic, mutual exploration of meta-transformational processes is a beginning of a methodology for exploring the mechanism of "magic" so gracefully evoked by Gold (1996, p 213-216).

FOCUS ON THE PROCESS OF AFFIRMATION AND THE HEALING AFFECTS

In this section, first the concept of the *true other* as a counterpart to the concept of the *true self* will be introduced; then the process of receiving affirmation will be explored in detail, and the phenomenology of the healing affects described.

On the Concept of the '*True Other*', the Relational Counterpart of the '*True Self*'

Winnicott's (1960) 'true self,' aside from its extraordinary importance as a construct for both patients and therapists, captures a certain essential quality of experience that is rarely encountered in pure form; nevertheless, it does exist experientially at those times we call *peak moments*. An experience-near construct, it is deeply meaningful for the experiencing self.

The 'true other' is the relational counterpart of the 'true self.' Like the notion of the 'true self,' the notion of the 'true other' describes a subjective experience: on those occasions when one person can respond to another in just the right way, that person becomes experienced for that moment as a 'true other'. The action of the other is "true" to what is emotionally necessary in the situation, necessary being defined in the terms of the experiencing individual. The sense of the 'true other' has experiential validity, and it is important to both conceptually identify it and validate the individual's experience of it. It is related to Bollas' (1987) concept of the "transformational object."

For the most part, optimal functioning is characterized by the 'true-enough' self, a mixture of 'true self' stuff with some defenses, conscious (i.e., socially necessary) or unconscious (i.e., psychically necessary) thrown in. However, there are moments of experience and self realization when we have pure 'true self' experiences. These have been described as *peak experiences*, being *in the zone*, being in a state of *flow* , etc. Similarly, in relational optimal case scenarios of the responsiveness of the other, we have that other wonderful Winnicottian construct, the good-enough m/other. In the relational realm as well, there are peak moments throughout the life cycle when a particular other responds to one's self in such a way as to provide exactly what is needed, even when there was no awareness of the need prior to its fulfillment. These are *peak relational moments*. The phenomenon refers to an essential responsiveness, to a deep way of being known and understood, seen or helped, which is meaningful, attuned, appreciative and enlivening.

Therapeutically, it is not something to strive for, for it can only be genuinely spontaneous. But it is extremely important to be aware of and recognize the patient's experience of the other as a 'true other', for the therapeutic potential residing in such experiences is enormous. By being with a 'true other,' the individual can more readily evoke and experientially connect with his authentic 'true self.'

It is important to localize the 'true other' experience in the experiential moment and not mistake it for a claim of the perfection of the other or any other thing that smacks of idealization. The 'true other,' as I am using it here, has nothing to do with idealization; it has to do with responsiveness to need. It captures an experientially-accurate, in-the-moment assessment, given the impact of the other on the self at that given moment in the particular emotional predicament. It is real, actual, deeply felt, unmistakable. Idealization, which by definition implies distortion, would enter the picture only if the

patient then went on to assume that 'trueness' is an invariant feature of the other, i.e., assumed the other to be in her everyday life an always-and-across-the-board true other, rather than a human being with frailties, faults, etc. Like its counterpart, 'true self' experiencing, 'true other' experiencing takes place in a state of deep affective contact. Unlike idealization, it is contingent, not rigidly fixed.

A wonderful example of how the sense of the 'true other' captures an experientially accurate assessment that bears no relation to idealization occurs in the movie *Scent of a Woman*. Colonel Frank Slade, played by Al Pacino, could not be a more frayed and contaminated individual. Narcissistic, arrogant, alcoholic and abusive, his blindness, isolation and alienation are the tragic consequences of a life-long severe character disorder. Charlie Simms, the other lead character played by Chris O'Donnell, is a young prep school boy with an endearing mixture of innocence and integrity. Through the vicissitudes of plot, a bond grows between the two, though Charlie has no illusions about Slade. There is a moment when Charlie faces a situation with a potentially disastrous consequences. It is at this precise moment that Slade comes forward for Charlie, and does so very effectively. Deeply understanding what Charlie needs, he provides it: he is there, he is effective when it counts and completely counteracts Charlie's excruciating and poignant aloneness. At that moment, a lifetime of narcissistic pathology notwithstanding, Colonel Frank Slade is a 'true other' for Charlie Simms.

Now we are ready to consider the reception of affirmation. This meta-therapeutic process captures the experience of core affect of a 'true self' in relationship with a 'true other' (Fosha, 2000).

The Process of Receiving Affirmation and the Healing Affects: *Having* and the Processing of Good-Enough (and Then Some) Emotional Reality

In experiences that are deemed healing or therapeutic, suffering is relieved and well-being is brought about. While healing or therapeutic experiences by no means occur only within the confines of spaces formally deemed to be therapeutic, it is hoped that they more reliably occur within such spaces, which, after all, are designed to provide them. When they do occur within the therapeutic setting, it is crucial that they are recognized and that the most is made of their therapeutic potential.

Less familiar than the mourning process, the process of receiving affirmation can be a major pathway of therapeutic resolution. In contradistinction to the process of mourning-the-self, it involves processing the positive emotional consequences of 'having' (as opposed to 'not having'. The *process of receiving affirmation* is activated by and involves the experience of having an important aspect of one's self affirmed, recognized, understood and appreciated. The affirmation can apply to a deep recognition of one's achievements or of one's transformation; or it can inform and underlie the other's actions toward the self.

Change for the much better is an essential aspect intrinsic to the affirmation process. A deep transformation occurs within the self as a consequence of being with another --*a fortiori* with a 'true other-- rather than alone; of being seen, loved, understood, empathized with, affirmed; of being able to do that which was too frightening to do before; of being in touch with the aspects of emotional experience that were previously feared to be beyond bearing; and so on. As a result, one is closer to one's true, essential self, the self one has always known oneself to be. As one patient put it: "thank you for giving me back the self I never had."

Being the recipient of deep affirmation elicits a highly specific affective reaction which has two aspects: feeling moved, touched, and strongly "emotional", on one hand, and feeling love, gratitude, and

tenderness, on the other. There exists no single word in the English language for this emotion, yet it has all the features of a categorical emotion (Damasio, 1994; Lazarus, 1991): a specific phenomenology (with presumably a distinct physiological profile), specific dynamics, a state transformation taking place and adaptive action tendencies being released upon its being experienced. Being a marker for therapeutic experiences, the label of *healing affects* seems apt. Its crucial elements are captured in the well-known hymn "Amazing Grace":

"Amazin' Grace

How sweet the sound

That saved a wretch like me

I once was lost, but now I'm found

Was blind, but now I see"

The healing affects arise specifically in response to the alleviation of emotional suffering, to being seen or responded to just as one has always wished, as well as to one's recognition of oneself as --in that moment-- expressive, authentic and true to oneself. The healing affects register a change in oneself --"I was blind, but now I see"-- a strongly welcomed one. This change is either witnessed and understood by the other, and/or actually reflects the impact of the other upon the self.

The two types of healing affects differentiate two reactions that arise in response to feeling affirmed: Feeling *'moved,' 'emotional,'* or *'touched'* appear intimately linked with the recognition of transformation of the self toward greater authenticity; feelings of *love, gratitude, appreciation,* and *tenderness* specifically arise toward the affirming other. Darwin (1872) discusses the various aspects of what I call the healing affects, in a chapter titled "Joy, High Spirits, Love, Tender Feelings, Devotion."

The Phenomenology of the Healing Affects

The physical, physiological manifestations of the healing affects include a trembling, shaking voice associated with trying to contain emotion and hold back tears. The eyes are clear, light-filled and usually moist with gentle tears. The gaze tends to be uplifted. There appear to be internal state changes related to gaze direction. It is my sense that gaze up and gaze down are linked to internal state transformations of an affective nature: gaze down seems to be the affective marker for grief and experiences of loss, while gaze up is the affective marker for the healing affects and experiences of affirmation. The experiential correlate of the uplifted gaze is often a sense of "something rising," a "welling up," " a surge," or feeling "uplifted." Whatever the words used by a given individual, there is an upward direction to the sense experience.

The expression of feeling moved, touched or emotional, as well as that of deep love or gratitude is usually accompanied by tears, though patients make it very clear that they are neither *primarily* sad, nor *primarily* in pain; at times, they actually report feeling happy or joyful. When, at other times, the reaction is mixed with sadness or emotional pain, the individual embraces and accepts the pain as one that is well worth feeling, without being frightened and trying to avoid it. My daughter, alerted to its existence by a Sesame Street episode, dubbed the phenomenon "happy crying" (Lubin-Fosha, 1991). Weiss (1952) has written about one aspect of this reaction, speaking of it as "crying at the happy

ending" phenomenon. A patient referred to tears of being moved as “truth tears.” Gendlin beautifully captures the essence of these tears:

"Tears can be about life now, and not only when it is sad. A certain kind of tearfulness comes with the stirring of one's need for living *now*. There are also quiet, gentle tears. The deepest tears are not always uncontrollable sobbing. Very gentle tears can be deeper still. They can come when people are deeply touched, or when they touch a deep part of themselves. Tears can come when something new stirs, and comes alive for a moment" (Gendlin, 1991, p. 274).

The experience of change which emerges in the face of full self-expression and intense, validating relatedness, has a particular quality. The healing affects possess a quality of simplicity, clarity, innocence, freshness, sweetness and poignancy. The individual is in a state of openness and shimmering willed vulnerability which is free from anxiety and defense. A sense of ease, relaxation, simplicity and clarity prevails. There is often a gentle, almost shy smile. The mood (or primary affective state) surrounding the healing affects can be either solemn, poignant and tender, or else joyous and filled with wonder. William James referred to what I call the healing affects with characteristic eloquence and phenomenological precision as "the melting emotions and the tumultuous affections connected with the crisis of change" (James, 1902, p. 238). Overall, the quality of the healing affects is sweet, innocent, light, soft, melting (cf. the musical phrase accompanied by the words "how sweet the sound" in ”Amazing Grace”).

"Perhaps you could say I did very little with my life, but the *douceur*, if that is the word, Talleyrand's word, was overwhelming. Painful and light-struck and wonderful" (Brodkey, 1996).

Contrast is an integral aspect of the experience of the healing affect: this is the joy experienced by someone who has known pain, the light experienced after years of darkness, the experience of feeling understood after having felt misunderstood. Darwin (1872) speaks of the tears that accompany the healing affects as tears of joy which gain their emotional charge by virtue of being in contrast to the emotional pain which preceded them:

"The feelings which are called tender are difficult to analyze; they seem to be compounded of affection, joy, and especially of sympathy. These feelings are in themselves of a pleasurable nature.... They are remarkable under our present point of view from so readily exciting the secretion of tears. Many a father and son have wept on meeting after a long separation, especially if the meeting has been unexpected. No doubt extreme joy by itself tends to act on the lachrymal glands; but on such occasions as the foregoing vague thoughts of grief which would have been felt had the father and son never met, will probably have passed through their minds; and grief naturally leads to the secretion of tears.“ (p. 214-217).

This is the essence of crying at the happy ending (Weiss, 1952), of re-union triumphing over the grim specter of loss and its attendant grief.

In the next passage, the contrast is in terms of darkness and light. (The metaphor of light -- see also *Amazing Grace*:, “was blind but now I see” and Brodkey above, “painful and light-struck and wonderful”-- is particularly apt, given its connection to the uplifted gaze and the predominance of *photisms,* i.e., light-seeing phenomena, James (1902) speaks about.) Also added is the phenomenon of paradoxical recognition with which new experiences are met: encountering for the first time what one has always known:

"It seemed to him that he recognized the place in some way that he did not quite understand, as though

it were a place he had been looking for without knowing it, like the perfect house one dwells in sometimes in dreams. *Standing in the dark at the border of light*, he felt an ache building inside him, a sweet, incomprehensible pain he yearned to hold to him, to probe, to understand, as if, grasping it, he might then become oblivious to pain, to loss, to death, to everything that might touch him save the occasional raindrop kiss." (Preston Girard, 1994, p. 240; italics, added).

Finally, there is also a sense of heightened sensations and new perceptions, which define the sense of being intensely alive. There is a "sense of clean and beautiful newness within and without" (James, 1902, p. 248).

In the next two quotes, all the elements of the phenomenology of the healing affects come together. First, here is Casanova's description of what he experienced after a narrow escape from the confinement of prison and persecution:

"I then turned and looked at the entire length of the beautiful canal, and, not seeing a single boat, admired the most beautiful day one could hope for, the first rays of a magnificent sun rising above the horizon, the two young boatmen rowing at full speed; and thinking at the same time of the cruel night I had spent, of the place where I had been the day before, and of all the coincidences favorable to me, I felt something take hold of my soul, which rose up to merciful God, exciting the wellsprings of gratitude, moving me with such extraordinary force that my tears rushed in an abundant stream to soothe my heart, choked with excessive joy; I sobbed and wept like a child..." (quoted from Casanova's *Histoire de ma vie* in Flem, 1997, pp. 66-67).

The elements we have been describing are all here: the contrast between narrowly avoided tragedy and the currently joyful circumstances; the sense of the new state taking hold; the upward surge, and the heightened sensations and perceptions; the healing affects, first the experience of being moved, then the 'happy crying', weeping with tears of "excessive joy;" and the feeling of gratitude toward the affirming, deeply holding other, in this case, "merciful God".

The last quote is from a patient, a man in his thirties, who had lately mastered the fear and self-loathing associated with traumatic memories of being scapegoated, ganged-up on and threatened by a bunch of his schoolmates. Some weeks prior to the writing of the note I reproduce below, as he remembered and re-lived the torment and terror of those times, he also recovered a memory of a place of safety: he remembered sitting under the shade of one particular tree, and finding soul-soothing solace there. The feel of the tree trunk against his back, the cool air, and the welcome solitude all made him feel peaceful and grounded. On a recent visit home, he decided he felt up to going to the schoolyard. To his surprise, there was no nausea in his stomach, nor fear in his chest: the school yard, the site of childhood dreads, seemed so small. A couple of sessions later, he spoke about how anxiety-free and self-confident he had been feeling. He mentioned that the previous evening, as he was "just hangin' around" at home, he felt the impulse to write, and did so (in itself a very unusual occurrence for this patient). Moved and pleased by what had come out of him, he brought me what he had written and gave me his permission to include it in this article:

"When I remember me as a little kid, a smile comes across my face, it starts down somewhere around that belly button space. it starts first as a thought, then there's a moment where it's caught in a white noise, silent place. Then, like it came, the silence breaks and it rushes up through my chest, my head and then falls into place. It is what's defined, as I said, you know, a smile. It comes to my face. The thought brings joy and feelings stir. A warmth crosses my skin, a feeling so large and present and yet, you could never see a thing. Love hits this way, peaceful and soft and Right. It gives me a certain

courage that strengthens a Dimming light. I sit and in an instant, a tear is in my eye, the stinging kind, not the sad tears when I really sit and cry. It's all a bit confusing, and I am left woundering (sic) why a smile, a loving thought, then an emotion, should Bring a tear to my eyes. Then I think, one step deeper, and just one second will pass. I think of me as a little boy once again, and happiness at last" (spelling, underlining and capitals in the original).

The phenomenology of the healing affects is unmistakable: happiness now at the sight of past torment; the sense of the experience coming, unbeckoned, rather than its being sought or willed; the intense sensations, including the upward surge ("the silence breaks and it rushes up through my head and chest"), and the sensation of warmth; the tears of being moved, explicitly differentiated from sad tears; the feeling of love; the gentle but certain quality of the feeling "peaceful, soft and Right;" the sense of a yet even deeper state transformation following the state transformation in which the healing affects occurred ("one step deeper"); and finally, the next wave of positive experiences/phenomena that follow the experience of the healing affects: along with "a certain courage that strengthens a Dimming light," the patient, going "one step deeper," experiences "happiness at last."

Reaping the Therapeutic Benefits of the Affirmation Process

It is important to describe the phenomenology of the healing affects because their presence alerts the therapist that the therapeutic process is going well. Their presence also tells the therapist that in this moment, in this configuration, she is different from the past figures with starring roles in the development of the patient's difficulties. This is especially important for psychodynamic therapists who have a low threshold for perceiving the repetition of the bad-and-old and a high threshold for perceiving evidence of the good-and-new. For instance, it is essential that 'happy crying' tears not be confused with sad tears: with 'happy tears' or 'truth tears,' the patient's experience is not about loss, but about finding, not about deprivation, but about having. Since the negative state is always there implicit in the contrast, the patient will often go easily to the negative state or to emotional pain, if the therapist so guides the process. But then a valuable therapeutic opportunity is missed: dealing with meta-therapeutic processes involves tolerating experiences of having as a consequence of being in an affect-facilitating relationships rather than in affect-inhibiting ones. The individual has to tolerate, process and take in good stuff such as love, appreciation, understanding, and recognition, the stuff that makes psychotherapy work (Hubble, Duncan, & Miller, 1999; Orlinsky, Grawe, & Parks, 1994). However, good stuff can be as scary as bad stuff, sometimes even scarier by virtue of being new and unfamiliar, causing patients to feel scared of feeling helpless or inadequate; "What do I do now?" is a common refrain from patients who feel vulnerable and out of control in the face of the unknown. Patients often feel an urge to retreat into painful, self-destructive but infinitely more familiar modes of non-being and non-experiencing. When that happens, another round of work is activated, fostering further working-through.

Another difficulty lies in the fact that positive experiences are often linked with painful ones; *having* only highlights the painful starkness of *not having*. To experience the positive is to risk being immersed in painful feelings. Patients rely on their defenses to prevent the experience of both. Other fears of experiencing and fully owning positive experiences include the fear of making oneself vulnerable to loss, which becomes even more unbearable in light of the realization of how good good can feel: "I could get used to this," muttered a patient whose traumatic experiences made the prospect of relaxing defenses and taking in good stuff the stuff of nightmares. Finally, issues of guilt and unworthiness often also need more rounds of working-through before the affirming process can be fully integrated.

By acknowledging and owning healthy functioning, resources, and emotional capacities, patients gain access to solidly-based self-confidence in being able to handle emotional situations, even score occasional triumphs in the face of emotional adversity, without fear of being overwhelmed. They grow confident that they can participate in creating positive relational experiences, and that they can readily identify such situations when they arise. Confidence in one's abilities (the opposite of helplessness) and belief in the possibility of meaningful, mutually satisfying relationships, are important underpinnings of interpersonal relating. The healing affects themselves promote trust, hope, and confidence.

Finally, by alternating experiencing and reflection, patients can take ownership of the process of transformation. As one patient said, "one begins to know the process of being healed, to believe in it, not just as a temporary aberration, or a fragile moment, but as an owned aspect of experience, as something one can do."

Resistance to Receiving Affirmation

Patients' difficulties in acknowledging the impact of receiving recognition, love and empathy are not as well understood by clinicians as difficulties resulting from being deprived of love and recognition. In part, this is an artifact of the neutral stance of traditional analytic therapists. Difficulties accepting and receiving love --much as it is craved when it is not available-- more readily come into view with a loving therapist who can initiate a loving exchange, than with a therapist who withholds responsiveness (Coen, 1996). Difficulties in owning emotional competence, resourcefulness and other strengths become evident more rapidly and more pointedly when the focus is on the patient's strengths, rather than on his pathology. Finally, there is a difference between benefiting from empathy, love and recognition implicitly and experientially acknowledging and elaborating those experiences: only in the case of the latter, is the full extent of difficulties in taking in good stuff apparent.

A major factor responsible for the relative dearth of clinical attention the meta-therapeutic processes have received is, I believe, the discomfort this work evokes in us therapists. For instance, Safran's work on meta-communication (Reeve, Inck & Safran, 1993; Safran & Segal, 1990) focuses on unhooking from the pull to enact maladaptive interpersonal scenarios responsible for the patient's pathology. Better trained in processing negative reactions toward us, we squirm with unease at being recognized, appreciated, and loved. The patient's defenses are not the main culprit, here, for the healing affects occur when patients' defenses are in abeyance. The problem lies with our discomfort: we seem to be at a loss as to how to deal with positive patient responses toward us, such as our patients' love and gratitude for being good at what we're supposed to be good at, i.e., helping them change and feel better; we often use modesty --often false modesty, I would claim-- to cover up our personal difficulties with being thanked for doing exactly what we most value. It is ironic that we have such struggles with these feelings, as most of us became therapists out of profound wish to alleviate suffering, and have a transforming impact on others.

On one side, psychodynamic practitioners, well-versed in investigating the depths of the patient-therapist relationship, are much more comfortable focusing on and working through negative experiences, frustrations and disappointments.

"Development in psychoanalytic theory is always described as a process in which, at each stage, the child is encouraged to relinquish something with no guarantee that what he or she is going to get instead will be better. *This is a hard school and we might wonder what it is in us that is drawn to*

stories of renunciation, to ideologies of deprivation, whether they are called the symbolic, the depressive position, or Freud's description of the resolution of the Oedipus complex" (Phillips, 1997, p. 744; italics, added).

Experiential and client-centered approaches, on the other hand, which do emphasize actively empathizing with and appreciating the patient (e.g., Bohart, 1991; 1993; Greenberg, Rice & Elliott, 1993; Rice & Greenberg, 1991) have stayed away from the deep exploration of the dynamics of the affective/relational aspects of the patient/therapist relationship, i.e., what the patient feels toward the empathic, validating therapist, or in turn how the therapist feels in response to the patient's love and gratitude. Here too, theoretical oversights have been further exaggerated by the discomfort of clinicians with patients' explicit positive feelings towards them.

For instance, gratitude often arises in a therapy which is proceeding successfully; its importance lies in its being the patient's emotional acknowledgment of being helped by the therapist. Taking in such deep appreciation can make us feel quite vulnerable: insecurities about personal worth or competence, fears of loss or humiliation, feelings of being overwhelmed or at a loss as to how to deal with something so yearned for are only some of the more common disturbing responses stirred in us. In the face of genuine acknowledgment, our defenses kick up; we tend to shy away from dealing with the material as we would with any other that came up in therapy. False modesty, minimizing the magnitude of our contribution, a low threshold for inferring negative motives and a high threshold for positive ones interfere with meta-therapeutic processing. Aside from being a lost opportunity for growth for the therapist, it is a huge loss for the patient.

In working-through the meta-therapeutic processes and the affects of transformation, it is necessary to focus on and explore positive therapeutic experiences as thoroughly and as systematically as we explore negative experiences. It is important for therapists to learn to tolerate being the focus of love and gratitude and avoid modesty as a defense. Viewing videotapes of sessions has a major role in helping practicing therapists develop a competence in this area. It allows for growing familiarity with the moment-to-moment phenomenological unfolding of the healing affects. Also, as Davanloo used to say (1986-1988), repeated exposure to videotapes of emotionally-charged material (one's own work and that of others') systematically desensitizes the therapist's unconscious. Ultimately, like with any other initially daunting type of therapeutic work, knowing that something works, and the pleasure that ensues from contributing to effective interactions, are powerful reinforcers that help motivate therapists to overcome their resistances. Personal explorations of one's difficulties in this area, and biting the inside of one's cheek to keep from grinning foolishly, sometimes also greatly help.

AFFIRMATION AND THE HEALING AFFECTS AT WORK: A CLINICAL VIGNETTE

While meta-therapeutic processes come to the fore in the course of any successful treatment, regardless of orientation, the clinical work that led to my awareness of and allowed me to elaborate these processes occurred under the aegis of a particular integrative model. Let me first briefly describe Accelerated Experiential/Dynamic Psychotherapy --AEDP from now on-- (Fosha, 1995, 2000; Fosha & Osiason, 1996; Fosha & Slowiaczek, 1997). The clinical vignette that follows zooms in on a therapeutic moment when the patient's response to receiving affirmation and the healing affects are in full view.

Accelerated Experiential/Dynamic Psychotherapy (AEDP)

AEDP is an example of an integrative therapy in action. The treatment is conducted within a psychodynamic matrix for understanding clinical processes and phenomena. It developed out of the rich tradition of the experiential short-term dynamic psychotherapies (Alexander & French, 1946; Alpert, 1992; Coughlin Della Selva, 1996; Davanloo, 1980, 1990; Fosha, 1992; Laikin, Winston, & McCullough, 1991; Magnavita, 1997; McCullough Vaillant, 1997; Sklar, 1992). AEDP strategies of therapeutic action, integrating *psychodynamic* (Malan, 1976, 1979; Wachtel, 1993), *relational* (Ferenczi, 1931, 1933; Kohut, 1977, 1984 ; Mitchell, 1988; Shane, Shane & Gales, 1997; Winnicott, 1965, 1975) and *experiential* (Davanloo, 1980, 1990; Greenberg & Safran, 1987; Greenberg, Rice & Elliott, 1993; Safran & Greenberg, 1991) technical elements, aim to promote direct affective experience and to minimize the impact of defenses and resistance. The stance of the AEDP therapist, informed by recent developments in the attachment and mother-infant interaction literatures (Beebe & Lachmann, 1994; Bowlby, 1969, 1973, 1988, 1989 ; Fonagy et al., 1995; Main et al., 1995; Stern, 1985) is actively empathic, highly expressive and emotionally engaged. The use of the therapist's in-the-moment emotional experience is crucial to the clinical enterprise (Alpert, 1992). This stance arose out of the effort to (a) minimize the impact of the patient's defenses against affective and relational experience, and (b) reduce the anxiety and shame that fuels those defenses (Alpert, 1992; Fosha, 1992; Fosha & Osiason, 1996; Fosha & Slowiaczek, 1997; Sklar, 1992). AEDP's stance and therapeutic techniques are all in the service of bringing about the state-transforming experience of affect in the context of an emotionally-alive patient/therapist relationship; it is this aim which has guided the integration of techniques from different approaches.

In therapy, the aim is to help the patient experience and process emotions that were previously off-limits and thus (re)gain the integrity and richness of his inner life; the therapeutic stance fosters the patient's sense that he is *not alone;* that he is actively understood, appreciated, and valued; and that the other is willing to help. AEDP's quintessential therapeutic processes --the deep experiencing of core affective and relational experiences with an emotionally-engaged other-- bring about a state transformation within which the repair of the emotional damage that brought the patient such suffering can begin. Focusing on the patient's experience of getting better and feeling helped activates the meta-therapeutic processes and their accompanying affects of transformation. The individual registers, affirms, acknowledges and processes his reactions to the therapeutic experiences he has just been through. If the patient does not do so spontaneously, the therapist directs the patient's focus in order to experience the full impact of meta-therapeutic work.

The affects of transformation -joy and exuberance, emotional pain, and the healing affects- are core affective phenomena, and as such, are highly mutative. Here, AEDP's specific therapeutics is most evident: once these core affects emerge, they are privileged, focused on, enlarged and explored with the same thoroughness and intensity as any other core affective experience. This is part of AEDP's experiential aim to minimize the impact of defenses and resistance and to enlarge the scope and depth of core emotional experience.

Moment-to-Moment Analysis of a Clinical Vignette

The patient is a 30 year old single woman who, despite a history of severe depressions since at least adolescence, had never sought treatment before. She felt "stuck and stagnant" in her work, and in her personal life. The crisis that led her, despite major reservations, to enter therapy culminated in her

bursting into sobs at work and not being able to stop crying. The patient entered therapy feeling somewhat hopeless and extremely helpless. She felt humiliated by having "fallen apart," by needing help, and by not being able to resolve her problems on her own.

The following vignette comes from the last fifteen minutes of a two-hour initial evaluation, which had gone very well. Much of the work preceding the vignette had focused on exploring the patient's self-reliant defenses and exposing their consequences, i.e., their having led to her emotional isolation and loneliness. Throughout, the understanding of the patient's defenses, as well as of all other clinical material, was framed within an adaptive/empathic perspective, emphasizing how they reflected the patient's best efforts to take care of herself. Both in her account of her current and past life, and in exploring the phenomena of the evolving patient/therapist relationship, the patient's strengths were noted and affirmed, as were her therapeutic efforts on her own behalf. The therapist was empathic, expressive, and supportive of the patient, emotionally self-disclosing and highly encouraging of the patient's affective and relational experiencing. As a result, resistance was relatively low; despite the patient's characterological tendencies toward mistrust and self-reliance, a lot of emotional work was accomplished in a warm, mutual atmosphere. As Mann & Goldmann (1982) note, in-depth explorations from a stance of empathic attunement to the patient's pain tend to not elicit resistance, but instead, foster patient openness, trust, and the welcome experience that the therapist is "beside and inside" the patient.

N.B.: Parentheses are used to describe non-verbal aspects of the clinical material, italics reflect the emphasis of the speaker, and brackets and text in bold are used for moment-to-moment analysis of the clinical material.

Pt: And I also always thought like 'alright I could do it by myself. I don't need anybody. I don't need anybody's help'. That's always been my thing 'Don't help me, I can do it' And that's why in the past even though I thought 'OK, maybe I should talk to somebody, a therapist or somebody,' another thought would come 'No, I don't need to, I don't have to' **[patient is openly describing self-reliant defenses; high therapeutic alliance in operation]**

Th: See, I was realizing that I focused a lot on how hard it is for you to stay close to your feelings. But (speech slows down here) I am also so struck how open you've been with me. And so direct. **[affirmation of patient's therapeutic efforts on her own behalf]**

Pt: (nods head, swallowing hard) **[beginning of experience of feeling moved]**

Th: And I appreciate it all the more because I'm learning more and more what it takes for you to do that. That it's not just your reflex (snaps fingers) to do that **[more recognition]**

P: (voice shaking a bit, some tears) Right... Yeah. Definitely I wouldn't say that it's in my nature, to just, like, tell people things...**[more affect]**

Th: You have a feeling about my recognizing this about you? **[in response to incipient healing affects, meta-therapeutic inquiry: making affirmation explicit and inquiring about patient's experience of it]**

Pt: Do I have a feeling about it? (swallows hard) Ummm...I feel that... Well, I'm glad, I mean (smiling broadly and shyly)

Th: (very sympathetic tone) Uh huh

Pt: I'm definitely glad you can see it (rueful, soft laughing).

Th: (empathic, non-verbal affective resonance) Mmmmmm

Pt: I don't know what else I feel... I kind of feel like, uh, ... relieved (moved, voice starting to shake, talking through tears) in a way, you know like, wow, maybe, like I'm glad that you can understand what I'm trying to tell you. **[healing affects in response to feeling understood]**

Th: Tell me what that sense of relief feels like ... Once again, you start to talk and it touched something deep **[eliciting deeper experiencing of healing affect, through inquiry and empathic mirroring and labeling]**

Pt: Hmmm, let's see

Th: (empathic, non-verbal affective resonance) Mmmm

Pt: I'm trying to like...

Th: Don't try, just tell me

Pt: OK, I don't know if I can... I don't know

Th: It's alright

Pt: Ummmm... It does feel good to like be able to you know get it off my chest, like...

Th: (deeply empathic tone) You've been carrying so much, so much.....

Pt: But like you know, I think that I have..... I think... When I called you last week I think that's what I was feeling too, like (emphatic, determined feelingful tone, crackling with withheld tears) 'yeah, you know what? Like, *it's time*,' you know, (her voice breaking, starts to cry) **[takes in and owns empathic acknowledgment of her psychic suffering; deepening of healing affects: affirms validity of her own needs]**

Th: (feelingful, emphatic and tender) *It's time for you*

Pt: (shakes her head in affirmation, cries; gaze down, voice breaking, sobs for a while) ... I do feel like... Yeah, like I do really like push down a lot. And I feel like 'No, OK (vigorous arm motions with hands in fists of pushing down), I'm just gonna go, I can deal with that, I can just move on,' but maybe I don't allow myself to kind of, I don't know, 'indulge' myself .... I don't know if that's the right word, but... Maybe like... feeling like... not so much that I come last, but maybe that I'm the last one I want to deal with or something **[emotional pain, mourning-the-self; detailed, specific description of her defenses and felt sense of their negative consequences; starts to make emotional space for basic needs and yearnings, the very experiences she customarily defends against]**

Th: Like you feel that you can take it

Pt: Yeah, like I feel that I can take it

Th: What about this sense that you're the last one that you want to deal with?

Pt: Yeah, like I think maybe that's it. I think I was kind of like afraid to really see.... you know.... like

what is behind... my persona, that people see me as, like at work. People see me as a certain way. And like.....

Th: What else is there?

Pt: Yeah. Like, I don't know, I was afraid to deal with what was inside. Like it's unknown, like 'Oh, oh, it could be too scary, I don't know if I want to do it, so let's just pretend like I don't have a problem or that I can deal with it or that it will go away, or it'll get better somehow' or whatever, even though I don't know how it will, but somehow it will, you know. Or maybe 'OK, really, I don't want to deal with it now, I'll deal with it some other time'. (voice very moved) But I think like now, it *is* the other time (shakes head affirmatively) **[deeper description of defenses leads to a deepening of the material and patient articulates her fears; with deepening affect, she spontaneously affirms and validates the 'rightness' of seeking help]**

Th: Yes

Pt: Because I feel like I can't really move on, like I feel really stuck and stagnant. And even though I've felt stuck for a really long time, now this whole thing [crisis which brought her to treatment], like this is the thing that's like pushed me to do it. Because of this situation, it is forcing me to do it, which is a really good thing.... Like it took this to do it **[patient clearly and without ambivalence declares her motivation for treatment]**

Th: To shake things up

Pt: Yeah. Like I just felt that I know something's gonna happen, I don't know what, it's going to be scary, it...

Th: It has to do with *you* and *growth*.... **[affirmation]**

Pt: (moved) Yeah. Yeah. **[receptive affective experience]**Th: And taking care of something.

Pt: Yeah. (Light giggle). That's what's been happening **[end of one wave of work]**.

Th: What's it been like to talk together, for you to talk to me? You have sense of me? **[<u>Therapist-initiated transition</u>: the end of one wave of work coming to a satisfying resting point, the therapist makes the decision to elicit patient's relational experience of the therapist and of the patient/therapist connection; this work is particularly important for a patient who uses defensive self-reliance; she has just allowed herself to get help from someone, it has worked and it is important for her to register and experientially process that this is so; regardless of whether this line of inquiry evokes defenses or core affects, this a significant opportunity; thus, beginning of relational meta-therapeutic processing]**

Pt: I guess it's felt like I've wanted to let you know where I'm coming from and maybe in talking to you like... Do you feel like it's something that I can.. maybe because of your experience, do you think that we can work together? Is there a way.. to help? Or something? **[bare, vulnerable, undefended expression of her yearning to be helped, despite her fears; a long way from defensive self-reliance]**

Th: Ohh (very tender, somewhat surprised tone, touched), I feel I can say a lot more than that, you know. That I really have a lot of feeling for you, and what you're telling me and for what you're going through. And that you've been able to be so open with me, it's.... very touching to me, actually.

[patient's vulnerability elicits tenderness in therapist, who starts to respond directly to patient's bare statement of need through more affirmation of the patient and affective self-disclosure of her own healing affects evoked by the patient]

Pt: (feeling touched; mouth quivering) **[receptive affective experience; healing affects]**

Th: There's something about that, about how you've been with me.... that I appreciate. **[more self-disclosure of therapist's experience of the patient and her own healing affects in response to patient]**

Pt: (feeling moved) Uh huh.... I feel like it's been easy to talk to you

Th: (appreciative) Mmmmmm

Pt: Like, you really, you've listened to me. You've really... Like...like... OK.. like I was going to say, like even when I talked to you on the phone

Th: Uh huh

Pt: Uh, there's something about like... your tone (moved, holding back tears) in your voice that like, it feels good, you know... it feels like warm... and kind of like, I don't know, embracing or something...So like I feel that I can kind of like talk to you and I can kind of just... (soft crying, gentle smile) like cry... if I want to... you know **[patient articulates her experience of affirmation process and accompanying healing affects; breakthrough of experience and expression of yearnings for relational contact and core affective expression]**

Th: (tender tone) Mmmmmm

Pt: So that's kind of like the feeling that I get, you know.... like uh, (crying softly) you know, concern, something like that.. **[healing affects]**

Th: (warm voice) Where are these tears coming from?

Pt: (mmmm) I don't know (holding back bigger crying)

Th: (very tender) Mmmm

Pt: I just feel that..(Very definite gaze up, eyes uplifted)... like I feel that I wanna be... uh, able to just like relax and, you know that feeling.... of just being able to, kind of if you wanted to ...to be embraced and feel like... warm and feel safe, you know, and I guess maybe that's maybe some of the feelings that I feel like that makes me wannna... cry, you know.....'cause I feel like I want to be not so strong all the time, that I just wanna be able to let it all out, (vulnerable) to... **[healing affects (note the gaze up); further breakthrough of experience and expression of yearnings for relational contact and core affective expression]**

Th: ... to let go

Pt: Yeah, like let go and just kinda like feel comfortable enough to do that.... Kinda like falling back and havin' somebody to catch ya, you know, being able to do that. I feel like... I keep having this image in my mind of like... you know that experiment where, you know, where two people stand up and you have to let yourself fall back...

Th: ... without putting your hands down to

Pt: .... yeah, and having somebody catch you, I've always wanted to do that and I don't think that... I don't think I can or I haven't been able to.... **[continued elaboration of core affect: experience and expression of yearnings for relational contact, accompanied by healing affects]**

Th: Mmmmm

Pt: So when I talk to you I kinda feel like maybe I am on the way to being able to do that... or something (blows nose; calm now, peaceful) **[end of another wave of affective work; state transformation and experience of new phenomena in the wake of affirmation and the experience of the healing affects: trust, hope, relaxation]**

Th: (moved) That's such a deep thing to say to me...I really, I mean...

Pt: (laughs softly and girlishly, a little shy, with evident pleasure)....

Th: Uh, thank you. Thank you. **[acknowledgment of patient's impact on the therapist through declaration of therapist's gratitude toward the patient]**

Pt: (a bit shy, pleased, open) So that's kind of like the best way I can describe the feeling.

Th: Oh, it's very eloquent. It's very eloquent. You know, and I think that's what makes me feel hopeful, very hopeful about our working together. I think it's a sense of connection, you know, I mean you've just expressed it to me in a very deep way, and I have felt it as well with you. And I think that there's something about your trust, and again, trust, particularly when trust doesn't come easy.... **[using the evidence of the meta-therapeutic experiences and accompanying affects they just shared, as well as her growing understanding of the patient resulting from the patient's increasing openness and expressiveness, the therapist addresses the patient's question and expresses her own hope and confidence in their capacity to do good therapeutic work together]**

Pt: Yeah

Th: ...that's very meaningful.

SUMMARY

Meta-therapeutic processing, i.e., acknowledging and owning the emotional capacities involved in therapeutic successes, creates the foundation underlying the sense of confidence in one's effectiveness (the opposite of helplessness) and the belief in the possibility of meaningful, mutually-satisfying relating, a very important underpinning of the capacity for trust, intimacy and closeness (the opposite of hopelessness). Furthermore, the visceral experience and empathic elaboration of the healing affects brings in its wake trust, hope, ease, clarity, empathy and self-empathy, as well as the ability to risk believing that goodness is possible and that the self can be resilient when optimal conditions do not obtain.

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