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Response to Commentaries on Combining Expressive Writing with an Affect- and Attachment-Focused Psychotherapeutic Approach in the Treatment of a Single-Incident Trauma Survivor: The Case of "Grace"

The Case of Grace: Strategic Rationales Underlying the Therapy Process

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ABSTRACT

This is a response to three commentaries to my case study of "Grace" (Pass, 2012), which utilized an integrative treatment for a survivor of a single traumatic incident. My therapeutic approach (the "AEDP-Writing" model) began with a foundation in Diana Fosha's Accelerated Experiential Dynamic Psychotherapy (AEDP) and then added Expressive Writing to the treatment in order for Grace to more directly process her trauma. Two of the commentaries are by practitioners and scholars of integrative treatment, Stanley Messer and George Stricker, and the third is by a pair of more empirically-influenced researchers, Kara Harmon and Michael Lambert. In the following response, I consider these thoughtful commentaries and offer my feedback.

*Keywords:*Accelerated Experiential Dynamic Psychotherapy (AEDP), Expressive Writing, psychotherapy integration, trauma case study, post-traumatic stress disorder (PTSD), case study, clinical case study

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Having the opportunity to present my work in the context of thoughtful and probing commentaries is rewarding, fascinating, and not a little nerve-wracking, as therapy can be such an intense and intensive endeavor. My work with "Grace" was an enriching, important training experience, conducted while I was a doctoral student in clinical psychology. I remain indebted to the excellent supervision I received—individual, academic, and peer—as well as to Grace herself, who proved to be a good fit for my approach. When Grace presented for treatment, her life had reached a point of chaos both interpersonally and intrapsychically in the wake of an intensely disturbing trauma. While she was suffering and seeking relief, she understandably remained frightened to delve into her fragmented memories of this trauma. Her ability to progress as much as she did over the course of treatment was inspiring and I was grateful to have the opportunity to know and work with her.

Because therapy can be an isolating experience, it has been invaluable to write about a case which felt so integral to my training and have others so respected in the field share their reactions and expertise. I was excited to have the opportunity to both learn from and contribute

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to Fishman's (2005) pragmatic case study approach, and I think the concept of learning in a qualitative manner about the richness of so many cases is a wise one. Humans are unique; the patients with whom we work are deeply complex individuals, and getting a glimpse into so many practitioners' styles and approaches is invaluable.

A GENERAL RESPONSE TO THE COMMENTARIES

In terms of the three commentaries on my case study of Grace, it is always helpful to have constructive feedback to help deepen the self-evaluation process when it comes to being a clinician. Messer's and Stricker's backgrounds and expertise in integrative work—both theoretical integration and assimilative integration—are especially helpful as this is the stance I take in my work as a therapist. I am always looking for ways to best connect with my clients and not remain wedded to one theoretical orientation in the process. As detailed in my case study, my theoretical approach is grounded in a relational model with attachment processes and affect exploration at its base, which is why I have gravitated toward Diana Fosha's (2000) Accelerated Experiential Dynamic Psychotherapy (AEDP) method. As noted in both Messer's (2012) and Stricker's (2012) commentaries, AEDP itself is an integrative model which borrows from both psychodynamic and experiential theories and applications.

Messer's and Stricker's discussion from an assimilative integration and/or local clinical scientist point of view helped to further crystallize my understanding of a truly integrative formulation and treatment. Messer's point (2012) that it is important to orchestrate integrative treatment artfully and carefully, as opposed to introducing something carelessly that might feel jarring or abrupt to a client, is well-taken. Of course, it is also important to remain flexible and open to new approaches throughout any treatment if they appear to be a helpful addition. I believe what is most important in this respect is maintaining rapport and communication with the client as well as some level of transparency on the part of the therapist so that the client is always aware of the reasoning behind the addition of a new approach or technique.

The final commentary of my case study of Grace, by Harmon and Lambert, comes from a more empirically-based place, utilizing more of a quantitative research model as opposed to the integrative, attachment-based model which informed my work. Lambert, the co-creator of one of the quantitative measures I used, the Outcome Questionnaire-45 (OQ-45), understandably has a firm grasp on the incorporation of outcome measures, as does Harmon, working within the United States Veterans Affairs (VA) system. While their approach is based in a different place than mine and that of the theories that inspired my work, it is always valuable to consider diverse points of view.

STRATEGIC REASONING BEHIND THE AEDP-WRITING TREATMENT PLAN

In my case study I discuss the fact that I would want to do more investigation with more clients before assuming I could generalize my findings to a client with complex PTSD and/or repeated trauma dating from an earlier age. As Stricker points out, Grace was a "relatively healthy young woman with a superimposed trauma" (2012, p. 119). Indeed she was, which likely enabled her to benefit from the AEDP-Writing approach within such a *relatively* short time span

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(40 sessions). This brings me to my next point: despite Grace being a relatively well-adjusted young adult, she was still endorsing several symptoms of Post-Traumatic Stress Disorder (PTSD) and describing ongoing episodes of severely dysregulated affect. My being flexible in her treatment as opposed to adhering strictly to a pre-determined method of working felt vital in order to establish trust and rapport. This felt important in light of her trauma, and is recommended in work with trauma survivors, who have often felt so vulnerable, alone, and without control (Fosha, 2002, 2003, 2006; Herman, 1992).

In their commentary, Harmon and Lambert (2012) express concern regarding the length of the treatment (40 sessions) and suggest that other, manualized approaches like Prolonged Exposure (PE; Foa, Hembree, & Rothbaum, 2007) and Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2008) place efficiency as a top goal and choose to tackle in-depth processing of trauma from the earliest sessions. In response, I would first note that I was assigned the case of Grace as the applied portion of a course I was taking in Short-Term Psychodynamic Therapy, and thus I planned my treatment within this realm by choosing one STDP therapy—that of Fosha (2000)—that is appropriate for clients who have undergone trauma.

Second, there are reasons why AEDP can involve a longer treatment than approaches like PE and CPT. AEDP is a phase-oriented, experiential approach and thus can be viewed as more holistic and frequently lengthier than PE and CPT. Working to establish a secure attachment within the patient-therapist relationship in order to build trust and process trauma in a deep and thoughtful way is a time-consuming process and was a guiding principle of my treatment. As Fosha says,

> [In AEDP,] the therapist seeks to create a safe and affect-friendly environment from the get-go, and to activate a patient-therapist relationship in which it is clear that the patient is deeply valued and will not be alone with emotional experiences. If this is accomplished, the patient will feel sufficiently safe to take the risks involved in doing deep and intensive emotional work (Fosha & Slowiaczek, 1997)…Trauma therapy in essence involves undoing the individual's aloneness in the face of overwhelming emotions. (2003, p. 245)

Below I present more of the rationale for the longer time frame that I utilized in the case of Grace.

Staying within the framework of a short-term dynamic therapy approach, the projected length of treatment was originally presented to Grace as 20-24 sessions, giving us some time to build trust and safety before intense trauma processing. She agreed to and was in support of this, as I described in my case study:

> Grace expressed relief at this idea, saying that she was glad to have some time to work toward processing the suicide instead of diving right in. This was in keeping with my plan of a phase-oriented model, which stresses the need for stabilization and safety before active trauma processing begins. (2012, p. 78)

At the time, this plan concerned my supervisor, a seasoned clinical psychologist with a specialty in work with trauma survivors who is also well-versed in working within a short-term model and

familiar with AEDP as a framework. Her main concern was that 20-24 sessions may not have been an adequate time to develop the necessary rapport and feelings of safety to adequately process Grace's trauma, which had altered her ability to trust others and left her feeling isolated and fearing she had lost control. As noted in my study, the treatment's actual 40 sessions did end up exceeding the original pre-determined amount of sessions. This was decided with the ongoing input from the patient as to how she was feeling about the treatment as well as her symptoms and overall functioning.

Reasoning to Be Strategic About Trauma Processing From an AEDP Perspective

Gleiser, Ford, and Fosha emphasize that

> Fundamental to AEDP is that its emotion-focused interventions are grounded in an experientially explored, attachment based therapeutic relationship. (2008, p. 345)

This quote is from an article which contrasts an exposure therapy (Prolonged Exposure, or PE) with an experiential therapy (AEDP) in the treatment of complex PTSD. While Grace was not presenting with a complex trauma history, she initially presented for treatment having extreme difficulty with affective regulation and did not seemingly yet possess the skills or willingness necessary to launch intensive trauma processing. She was ambivalent about therapy at this point, especially about feeling "sad" as a result of her traumatic memories, which she expressed to this writer (Pass, 2012). Gleiser et al. (2008) comment on several differences between PE and AEDP in the treatment of trauma, some of which I've included below.

- On the difference between therapist style: "Where PE therapists are directive and educative, AEDP therapists are fostering and collaborative." (p. 355)

- On the speed at which trauma processing is tackled: "Whereas in PE, the ability to trust the therapist and submit to inherent vulnerability is taken for granted, in AEDP, they are the focus of ongoing assessment, and explicit intervention." (p. 350)

- Also on trauma processing: "PE assumes that patients can respond on command to the prompt to narrate their traumatic memories in great detail, maintaining their own affective edge, and does not use emotional or somatic cues to track or modulate affect aside from subjective self-reports of distress." (p. 353)

- On the therapist's "toolbox" in treatment: "PE equips a trauma therapist with two basic tools, a structured approach to confronting fear-evoking memories and encouragement to the patient to persevere until anxiety dissipates. AEDP broadens this toolbox to encompass not only engagement with and desensitization to *all* adaptive emotional experiences and impulses, but also regulation, soothing, restructuring, transformation and meaning making." (p. 354)

Thus, AEDP is a more holistic, integrative approach, as opposed to the more laser-like focus of PE, one of the treatments mentioned by Harmon and Lambert in their commentary. Gleiser et al. also suggest that AEDP's dedication to forming a secure attachment between

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patient and therapist in itself can prevent potential negative client reactions such as "dropping out of therapy" or "passively or dissociatively complying with a more powerful other" (2008, p. 350). These are several of the reasons why I felt the AEDP approach, with its focus on the bond between therapist and patient and careful attention to potential ruptures in the rapport, was a strong choice for work with a traumatized patient. It also enabled me to be more flexible in treatment and operate according to what my patient was signaling as opposed to following the steps of a manual, which might not have taken into account the individual—with her own unique needs and history—who was in the room with me.

Reasoning to Be Strategic About Trauma Processing From a Client-Centered Perspective in the Case Of "Grace"

My client Grace was very anxious at the start of treatment. She expressed considerable ambivalence about accessing the traumatic memories that were leaking into her consciousness and causing distress. While I knew that we would ultimately have to access and process these memories, and that avoidance is a symptom of PTSD, my foremost goal was to remain attuned to Grace and respect what she was communicating to me about her readiness. She made it clear in our beginning sessions that while it was her ultimate goal to process the intense relational trauma she had witnessed, she was going to need some time to establish rapport and trust in me before she approached the material in this deep way. She shared in our first session that her only other foray into therapy (a group session for survivors of suicide held at a local hospital) had shocked and frightened her, and she had not returned. It was only after a close friend and her spouse urged her to try individual therapy did she decide to try again. As her therapist, I saw it as my role to help her approach this material in a way that felt safe rather than insist that we tackle it on day one, which would have possibly broken our bond. I am not discounting the success that clinicians using models like PE and CPT have had. But that is not the frame within which I was working, and that is not what this patient signed up for.

Again, coming from an AEDP perspective, my treatment approach was about establishing a safe space and building trust so that Grace could process an intense trauma, one that had shattered her ability to self-soothe and function in an optimal way across a range of areas (relationally, professionally, independently). When she expressed ambivalence, I honored that and asked her about it. I wanted her to feel both heard and seen. As treatment progressed, she struggled at times with the intensity of the subject matter and the level at which she was ready to access the deep trauma. There was considerable hesitation on her part. It was my job as her therapist to monitor this by checking in with her regularly about her experience, and to relay the message that she was safe in the treatment with me and that I wouldn't betray her trust in me.

At other times throughout the treatment, Grace expressed gratitude for my not insisting that we process the trauma intensively in every session. She also expressed, in session 15, that it had taken her a while to feel comfortable in sessions, but that she now felt more at ease and better able to trust me (Pass, 2012, p. 86). In addition, after Grace completed the first writing assignment to directly and explicitly address the suicide, she said, "This was probably the hardest thing I've ever had to do but I'm glad I did it" (p. 91). Thus, Grace was able to objectively comment on her subjective experience of trauma processing and acknowledge that while it was challenging, she realized its importance in her healing.

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Early in the treatment, I mentioned to Grace that I intended to eventually incorporate expressive writing exercises into the treatment as a way of processing her trauma, following the work of Pennebaker (1997, 2004). I told her that we would use a series of exercises to familiarize her with writing before we tackled the index trauma, and she appreciated this. Because the goals of the writing were also to help her establish time outside of the session in which she could spend time alone and become attuned to her thoughts and feelings, as well as to strengthen her personal voice, it was important to me that the writing was an ongoing process as opposed to singularly focused on the traumatic event (Pass, 2012). By the end of the treatment, Grace reported that she enjoyed having this time to herself, and she had learned how to carve out time and space for herself in a way she hadn't been able to before.

Finally, I'd like to address Harmon and Lambert's (2012) mention of Resick, Monson and Chard's (2008) article which states that a relationship is not necessary to process trauma and that if trauma processing isn't handled immediately in the treatment, the therapist may be "colluding" with client avoidance of traumatic processing. In my treatment of Grace, some of her traumatic memories were indeed approached and discussed early in treatment, in sessions prior to starting the writing exercises. When we did this, I monitored Grace's reaction and checked in with her about her experience. While the writing was intended as a more focused way to address and more fully process Grace's trauma, it was made clear from the start that processing her trauma in various ways was a clear goal of the treatment. I chose to approach this in a flexible way in which Grace was allowed some navigation and autonomy. She was challenged, but always through the lens of building a secure attachment, increasing affect tolerance and establishing safety.

TO MONITOR WEEKLY OR NOT: THAT IS THE QUESTION(NAIRE)!

Both the commentaries from Stricker and from Harmon and Lambert mention the concept of quantitatively monitoring client experience on a more regular basis than I did in my work with Grace. Harmon and Lambert (2012) discuss the "possible misleading characterization of the study as a pretest-posttest design" (p. 128) and I understand their concern. However, I want to reiterate that it was not my intention that this study be *interpreted* as a pretest-posttest design. I make it clear in my writing that I did not begin this treatment as a research-based study and it was only once the treatment was underway were outcome measures added. I am aware that my study is not a valid measure of quantitative results and if I had to do this again, I would administer the measures at the start and completion of treatment. Per Harmon and Lambert's response, my study is more in the vein of the "one-shot case study" design (2012, pp.129). I agree that it would be interesting, as they suggest, to conduct another treatment using the AEDP-Writing model and then compare the two cases. In fact, following Fishman's (2005) argument about the logic of pragmatic case studies, it would be important to do this with multiple cases.

I'd like to further address Harmon and Lambert's this idea of more regularly assessing client experience in two ways: first, with information about how AEDP tracks its clients' experience continually, although not with quantitative measures; and second, about possible ways in which more regular, standardized quantitative measures could be instituted in future

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treatments. I should also mention that each of my sessions with Grace was recorded on DVD—adding to the level of assessment of client experience from another source—each of which was reviewed in its entirety by a clinical supervisor who had a wealth of experience in the treatment of trauma as well as knowledge of the AEDP model. This aspect of my training was invaluable, as having another set of eyes both on me as the therapist as well as on Grace and her experience deepened my understanding of the case.

Tracking Clients Via AEDP

Tracking clients via quantitative measures *each week* historically has not been designed into an attachment model. Since the latter was informing my work, I did not build in having the client complete a questionnaire in every session. However, in keeping with AEDP, I frequently checked in with Grace verbally as well as monitored her nonverbal cues.

Harmon and Lambert (2012) stress the "advantages of session by session tracking" and their way of achieving this would be via the OQ-45 (the measure co-created by Lambert). I would argue that this could be seen as redundant within the framework of an AEDP treatment, in which the client is repeatedly asked by the therapist about his or her experience (see below, for a more complete description of "meta-processing"). As for avoiding "clinician guestimates" (Harmon & Lambert, 2012), there were several checks and balances in place throughout this treatment. Because I chose an AEDP approach in the first place—which values the relationship between clinician and patient and the importance of transparency on the part of the clinician—there were regular check-ins with Grace, both about her affective and relational experience at specific times in sessions and also about her overall experience of therapy and her ongoing functioning out of session. These check-ins were strategic on my part and weaved throughout sessions as opposed to only being read from a printed symptom questionnaire.

Along these lines, within AEDP as well as other experiential treatments such as emotion-focused therapy, the core focusing principles are not about recurrent concrete assessment of symptoms. Instead, the focus is more on the experience in the room and the importance of attunement on the part of the therapist to the client's experience. With that in mind, I strived to be attuned to Grace's experience throughout the treatment, to be the "good-enough" therapist (with a nod to Winnicott's "good-enough mother"). I encouraged her to share details of her ongoing functioning, both at work and at home. Her relationships—with her spouse, with her family, with her friends and co-workers—were important to Grace and we frequently discussed how they had been impacted by her traumatized state and how they were evolving as the treatment progressed. In each session, it was important for me to track her, both via my asking questions about her experiences and functioning and paying close attention to her affective state as well as observing what she might be communicating nonverbally.

Furthermore, AEDP has its own methods of assessing a client's experience of the therapy as well as his or her functioning both within and outside of treatment. For example, a main principle of AEDP is meta-processing, in which the therapist brings the client's attention to his or her experience in the session, encouraging the client to reflect on what is occurring for him or her in that moment, affectively and/or relationally (Fosha, 2000). These interventions can deepen patients' experience as well as increase their ability to objectively view themselves.

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When this concept of assessment was posed to a series of AEDP therapists, there was a question that if meta-processing is being done effectively and regularly then weekly monitoring via quantitative measure may start to feel redundant. For instance, the repeated question, "What's this like for you?", frequently posed to the patient in an AEDP-influenced treatment, can potentially garner more nuanced and layered data than can a survey. Depending on client response, it is up to the therapist to change course if necessary and then continue to pay attention to client experience via asking about it. Indeed, in his commentary, Stricker (2012) talks about his idea of what a Local Clinical Scientist is, including "displaying a questioning attitude" and changing "course whenever it was called for" (p. 121). This was exactly what I intended. I always want to remain flexible in my treatment, and meet the client where he or she is at. Of course therapists are not infallible and may miss things even when using meta-processing regularly. But this may happen regardless of the mode of assessment, whether it is via questionnaire or a dialogue in session.

Tracking Clients Via Quantitative Measures

On the other hand, I am open to seeing if tracking a client's experience and ongoing symptomatology via a standardized, normed questionnaire would have a significant impact on treatment. Stricker (2012) mentions the option of using shorter instruments than the ones I chose, and to use them at each session. He recommends the Duncan Outcome Rating Scale and Session Rating Scale, each consisting of four questions and administered at the start and end of each session; these would be a good place to start.

With regards to Harmon and Lambert's suggestion of using the longer OQ-45 each week, I wonder if this might start to feel redundant or like the client is being asked questions about areas not of concern to him or her every session. Since the OQ-45 includes a range of symptomatology, I agree that it is helpful at the start of therapy to get a fuller picture of the client's presentation. However, the questionnaire is not tailored to each individual case.

Another concern is about whether results are genuine once a rapport is formed. Might the client want to please her therapist at this point and so not be completely truthful when filling out a questionnaire? In dialogues we had in session, there was time to explore Grace's hesitation and ambivalence. Of course, the client can avoid certain areas of discussion in person as well as on a questionnaire. However, I think that in session, the therapist has the added benefit of being able to observe the client to see if affect or presentation matches the topic being discussed and gently challenge when necessary.

Also, Harmon and Lambert express concern about the clinician's decision-making needing to be informed by quantitative data. They encourage striving for efficiency and "shortening the length of treatment" (2012, p. 130) in general. Perhaps addressing these concerns via a standardized questionnaire is a cleaner, more automatic way of gauging this. In the example of my treatment with Grace, there was regular monitoring and checking-in about her subjective experience of treatment. We discussed the length of treatment at several points, and it was only when she expressed a desire to extend the sessions did that happen. When she expressed hesitation, I respected that all while maintaining movement toward deep processing of trauma,

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which she had not been able to do before. Throughout, there was collaboration and thought being applied to the trajectory of treatment.

THE IMPORTANCE OF SYSTEMATIC RESEARCH IN ANSWERING THE QUESTIONS RAISED BY HARMON AND LAMBERT

While I have argued above why the attachment-and-experiential-focused, AEDP-Writing therapy model I employed with Grace was justified in being longer than cognitive-behavioral therapies like PE and CPT, and why I did not see the need for additional, standardized quantitative monitoring in Grace's case, the counter-arguments offered by Harmon and Lambert are cogent and present important challenges to my model. Moreover, the empirical research and database behind the standardized use of the OQ-45 that they summarize is very impressive. Ultimately, I think they would agree with me that it will be through further, rigorous quantitative and qualitative research that we will be able to answer the questions raised: (a) whether the time required by AEDP therapy provides a genuine and particular "value added" over shorter therapies, at least for certain clients; and (b) what type of particular "value added" comes from the inclusion of standardized OQ-45 monitoring in therapies like AEDP.

SOME FINAL GENERAL THOUGHTS AND RESPONSES

Finally, I'd like to address some additional points raised by Stricker (2012). He mentions Shedler's (2010) article, "The Efficacy of Psychodynamic Psychotherapy," which includes the idea that psychodynamic psychotherapy often shows statistically significant gains post-treatment. I absolutely should have arranged to do a post-treatment assessment with Grace, to measure any gains or losses once the treatment was completed. This would have helped to solidify information about strengths or weaknesses of my integrative, AEDP-Writing treatment. (Furthermore, Shedler's article was an important step in showing that psychodynamically-influenced treatments do indeed have empirical support.)

Stricker also mentions that Grace's anger was not explored in depth. We did broach this at times, but it was not typically the prominent affect presented in session. Grace was less in touch with her anger toward her brother than with her grief, longing, sadness, and shock. I could have kept her with her anger for longer at times, yes. Perhaps this was not a direction I pursued intensively due to AEDP's inclusion of the importance of healing affects such as joy, hope, and gratitude (Russell & Fosha, 2008). On the other hand, AEDP would not recommend favoring one type of genuine, core emotion over another if there is unprocessed affect getting in the way of healing. It's an interesting point and one I will look into in future cases.

Stricker also mentions disappointment that there is not more attention paid to religious or cultural aspects, which were not an ongoing focus of my work with Grace. Again, I could have spent more attention on this. It was not something voluntarily shared by Grace in treatment; the information I did gather was that she grew up in a Christian, relatively non-observant home. I could have pursued this more, to see if religion or spirituality had provided comfort or grounding at any point, for either Grace or any of her relatives. Regarding the pseudonym of "Grace," I did

purposely choose it, but not necessarily for its religious connotations. Instead, I saw this patient as very brave and willing to trust in me when handling material that indeed felt sacred to her. I thought she handled this difficult process with beauty and elegance, hence the word grace.

To conclude, I am again grateful for this experience, both the treatment and the subsequent documenting and detailing of it. The experience of having my study commented on has helped me to process it in a deeper way and consider new perspectives.

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