

***Commentary on The Role of Exposure Therapy in Accelerated Experiential-Dynamic Psychotherapy: The Case of "Chris"***

**The Case of "Chris" through a Principle-Based and Alliance-Focused Lens**

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**ABSTRACT**

The case of Chris (Yunusova, 2023) details an 8-session Accelerated Experiential-Dynamic Psychotherapy (AEDP) treatment delivered in the context of a university clinic. Chris is a 30-year-old white male who had nearly completed a doctoral program at the time of treatment. He presented to treatment with the goals of addressing loneliness and depressive thought patterns in the context of the expectation that his emotions were overwhelming and noxious to others. The case illustrates the active role that avoidance and exposure can play in AEDP, with emphasis on affective exposure by way of AEDP's efforts to increase the patient's tolerance of their own emotions as well as those of others. The following discussion applies the integrative notion of principles of change in psychotherapy to the case of Chris, with an explicit focus on the therapeutic alliance and the emergence of alliance rupture markers in the development of the case.

*Keywords:* accelerated experiential-dynamic psychotherapy (AEDP); exposure; avoidance; psychotherapy integration; principles of change; therapeutic alliance; alliance rupture resolution; case studies; clinical case studies.

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**INTRODUCTION**

The case of Chris illustrates the point that the active mechanism of change in this particular treatment, facing previously avoided emotions, serves as an inherent area of overlap between AEDP and more traditional cognitive-behavioral understandings of exposure-based interventions. This commentary aims to zoom out from this point to focus on the broader application of the integrative theory of principles of change to the case to demonstrate the pathways through which Chris was able to make such significant change over the course of treatment. Given the transtheoretical nature of the framework as well as its relevance in this particular case, I will focus on the therapeutic alliance and the additive benefit of metacommunication as a therapeutic stance to address alliance ruptures. Ultimately, I hope to

demonstrate how the transtheoretical approach of metacommunication can add nuance to and create a deeper understanding of a case such as Chris' in the context of a larger integrative case conceptualization.

## **A PRINCIPLES-BASED APPROACH TO PSYCHOTHERAPY INTEGRATION**

Driven in large part by the psychotherapy integration impulse and a desire to break through the predominant jargon-laden psychotherapy approaches, Goldfried (1980) advanced the notion of "common factors" (i.e. those aspects of psychotherapy that are present across all therapeutic approaches (Rosenzweig, 1936; Frank, 1961)) by proposing a set of five principles of change thought to cut across the major psychotherapy orientations, including cognitive-behavioral, psychoanalytic/psychodynamic, and experiential-humanistic. These five principles were delineated on the basis that they exist within an "intermediate level of abstraction," in contrast to high levels of abstraction (i.e., theoretical frameworks) and low levels of abstraction (i.e., specific techniques) (Eubanks & Goldfried, 2019). Below, I summarize each of these five principles, and provide examples to illustrate how each were relevant to the case of Chris, with a particular emphasis on the therapeutic alliance as a critical factor for the success of the case.

### ***Principle 1: Fostering the Patient's Hope, Positive Expectations, and Motivation***

A growing body of literature suggests that psychotherapy outcomes are impacted to a major extent by the presence or absence of the patient's hope that therapy will be effective at baseline. In other words, the patient's expectations for change may have significant implications for subsequent effectiveness of treatment. In turn, these expectations impact the patient's motivation to engage in the psychotherapy process in order to bring about this change (Constantino et al., 2018; Wampold & Imel, 2015).

In the case of Chris, we learn early on that Chris struggles to open up to and share genuine thoughts and feelings with others. This is conceptualized to be the result of a history of invalidating experiences as a child at the hands of his parents, where he seems to have internalized or generated a core belief that emotions are overwhelming and dangerous to others (i.e., cannot be tolerated), and relatedly, a belief that "distancing oneself from emotions would allow him to more effectively navigate his world" (p. 96). Therapist Yunusova additionally hypothesizes that Chris carries a belief that he is "undeserving of another's time and emotions" and that "talking about himself would 'add stress' to his family" (p. 97). These beliefs were undoubtedly related to his goals at the start of treatment, which included addressing his intense experience of loneliness and to "have someone to speak with when he found himself 'spiraling' in depressive thoughts" (p. 140). From my perspective, it seems that Chris' beliefs regarding the dangerousness of self-expression, particularly around affect, served to prevent Chris from generating and maintaining close, genuine, and long-term interpersonal relationships.

Upon my first read of the case, I expected Chris' difficulty to open up in a genuine manner to significant others in his life to pervade the therapy as well. And in some ways, as discussed later in my discussion of alliance rupture markers, this expectation held true. However, I found myself pleasantly surprised by the way Chris was able to engage in genuine and vulnerable communication with Yunusova as early as in session 1. This is later addressed explicitly in session 7 in a discussion of the factors that had enabled Chris and Yunusova's therapeutic connection. Chris states, "I came here willing to be open with you because I knew it was your job..." with a subsequent acknowledgement that Yunusova's role of therapist "gave Chris permission to express his emotions without worrying about burdening [her]" (p. 122). From this discussion, we learn that it is Chris' positive expectations of not only psychotherapy, but Yunusova as therapist, and thus a person to whom he will be able to present in an open and genuine manner, that allowed and motivated him to present to therapy vulnerably, despite several years-old beliefs that doing so would be dangerous or painful. In other words his positive expectation of his experience with his therapist allowed him to engage meaningfully in therapy. This was particularly important given that the treatment was only 8 sessions in length, and did not allow much time for a slow, gradual building of connection.

### ***Principle 2: Facilitating the Therapeutic Alliance***

The therapeutic alliance, defined as the collaborative agreement on the tasks and goals of therapy, in addition to the affective bond (Bordin, 1979), has consistently been found to be one of the most robust predictors of psychotherapy outcome, regardless of psychotherapy orientation (Flückiger et al., 2018). The alliance has been conceptualized as both a mechanism of change (i.e., curative in its own right; see Safran & Muran, 2000) as well as a prerequisite for engaging in the process of change (e.g., Beck, 2011). Eubanks and Goldfried (2019) propose that establishing a "good-enough" alliance seems to be widely accepted as a necessity for the success of treatment. See below for a more in-depth discussion of the critical role the therapeutic alliance played in the case of Chris.

### ***Principle 3: Increasing the Patient's Awareness and Insight***

This principle refers to the need for increasing a patient's own awareness of their problems and associated difficulties. While insight is a well-established goal of psychodynamically-oriented approaches, cognitive-behavioral and humanistic approaches also emphasize the importance of increasing insight through the use of techniques such as thought records and two-chair exercises, respectively (Eubanks & Goldfried, 2019; see Castonguay & Hill, 2006).

I would argue that the entire therapy served to deepen Chris' awareness of the maladaptive patterns that contributed to his interpersonal relationships being unsatisfying. However, this is perhaps most clearly illustrated in their final session, where Chris is able to

identify two areas in which he gained insight as a direct result of the therapy. First, throughout the therapy we see several examples, both from out of session events and in-session transcript, where Chris tends to revert to humor, sarcasm, and jokes in moments where one might expect the expression of negative affect (see below for further discussion of content/affect split as alliance rupture marker). In reflecting on the course of treatment in their final session, Chris notes that he had come to see "his tendency to make jokes to 'get through' social interactions as a form of 'faking it'" (p. 126), which he connected to memories of his father engaging in humor throughout his childhood. In other words, Chris gained insight into not only his tendency to engage in humor as an avoidance mechanism, but perhaps more importantly, the function of this behavior to mask his true feelings from others, thus serving to keep interpersonal relationships in an affectively superficial place.

Later in the same session, Chris reflected on moments in which he felt frustrated with himself when others did not understand him or did not respond to him in a way he would have wanted or expected. Chris demonstrated increased insight when he later connected this phenomenon to his early childhood experiences, where he notes "whenever something went wrong, it was [his] job to figure it out. It was [his] fault and [he] should figure it out." (p. 126). Stated another way, Chris was able to gain insight into his tendency for self-blame and self-criticism as a function of the responsibility put on him to maintain the peace within the family dynamics.

In the follow-up session held eight months after termination, Chris shared the self-awareness he had gained as a result of the treatment, which included his tendency to use "logic" to avoid emotions. Yunusova later elaborated on this by stating this intellectualization served as a necessary coping mechanism in childhood, where Chris was taught that emotions could be dangerous. This evolutionary interpretation of Chris' proclivity for intellectualization made space for the positive consequences of such a coping mechanism, including his success in higher education. However, she also challenged him to test the *current* necessity of this old coping style in his relationships.

#### ***Principle 4: Encouraging Corrective Experiences***

Alexander and French (1946) define corrective emotional experience as the process through which the patient interacts with their environment in an unexpected manner. These may include differential learning experiences that occur in session (e.g., the therapist acting contrary to expectation or provides a new experience through some exercise), but they may also occur between sessions when "the patient takes a risk and engages in a new behavior that leads to a shift in cognitions and emotions" (Eubanks & Goldfried, 2019, p. 95; see also Castonguay & Hill, 2012).

There are several examples of corrective emotional experiences throughout the case of Chris. In reflecting on session 1, Yunusova acknowledges that the simple act of Chris presenting to therapy for the first time, and sitting across from another who demonstrates genuine care and understanding of him likely served as an experience that violated his prior beliefs that others would not necessarily do the same.

Additionally, I would argue that there were several more subtle moments throughout the treatment that built upon each other such that treatment as a whole served as a corrective emotional experience. In fact, AEDP views the therapeutic relationship itself as a corrective emotional experience in that for many patients, such a safe relationship is often a new experience. This relationship is thought to demonstrate the idea that "this time, they are not alone" (Fosha, 2000, p.6; see also Prens 2011). In the spirit of this notion, Yunusova engages in a deliberate process of not only actively listening to Chris, but overtly demonstrating to him that she is doing so. This is accomplished through a consistent stance of warmth and curiosity, both in non-verbal and verbal communication. Further, Yunusova notes several instances of intentional mirroring of Chris' presenting affect, even in moments where it is not aligned with her own affect (see session 1 for the example of matching his smile, despite feeling a deep sadness). This was an intentional demonstration of efforts toward validation and a desire to meet him in the moment. In her later reflections on the case, Yunusova discusses the importance of this validating stance as a means to demonstrate that "his emotions were valuable and could elicit comfort" (p. 137). Further, there are several instances where Yunusova reflects on the process of Chris' expression of sadness and other negative affect being met with her genuine care and affective mirroring as a violation of his anticipated discomfort with expressing sadness, such as in session 7.

### ***Principle 5: Emphasizing Ongoing Reality Testing***

This principle refers to the ultimate goal of therapy for the patient to engage in newly learned adaptive behaviors without effort as a result of repeated corrective experiences. To achieve this goal, it may be necessary for patients to engage in a process of reality testing with their therapists to combat dissonant thoughts about themselves based on previous experiences. As the patient has progressed, they must engage in a process of recalibrating their expectations to be more in line with their new "reality" (Eubanks & Goldfried, 2019).

Though there are a few examples of this throughout the case study that could demonstrate this principle, I found one demonstration of this in session 8 to be particularly compelling. At the beginning of this session, Chris is reflecting on a recent vacation with his current girlfriend where he noticed himself feeling upset that she was spending so much time on her phone. Chris notes while recounting this interaction that in previous, similar instances, he likely would have "let [his] frustration stew" (p. 125) rather than express himself. However, in this instance, he shared with his partner how disappointed he felt by her being on her phone. This is a beautiful

example of engaging in the newly learned behavior of being willing to be vulnerable enough to express himself genuinely. Chris later attempts to minimize the momentousness of this expression by stating that it was made easier by his girlfriend prompting him to share his feelings, as compared to him having to share with her spontaneously. Yunusova responds to this by engaging in the process of reality testing by emphasizing that although prompting may have helped, Chris was still able to successfully navigate discomfort and distress to push for genuine communication and openness, while highlighting the importance of doing so for having his needs met, and in turn feeling less lonely (a direct harkening back to his treatment goals).

### **A CLOSER LOOK AT THE ROLE OF THE THERAPEUTIC ALLIANCE IN THE CASE OF CHRIS**

There are several references to the importance of the therapeutic relationship in the case of Chris. The role of the alliance is similarly emphasized in the AEDP literature, particularly as it relates to the opportunity for creating a corrective emotional experience. Further, the AEDP therapist is conceptualized from an attachment-based perspective such that therapists are encouraged to create a secure attachment relationship by way of presenting in an authentic manner and engaging in self-disclosure as needed. From the AEDP perspective, the therapist's understanding of and empathy toward the patient encourages the patient to increase their empathy toward themselves, leading to change (Fosha, 2013; Fosha 2000). Yunusova embodies this stance of genuine empathy and affective mirroring throughout the treatment, and this seems to have had a curative impact on Chris, not only from the AEDP perspective, but also from the exposure-based perspective in that the secure relationship violated several of Chris' expectations based on his core beliefs. One could also apply the concept of the alliance serving as a prerequisite for engaging in the therapeutic process to the case of Chris. As summarized above, Chris presented to treatment with expectations that he would be able to safely present vulnerably to the therapy. This safe environment is likely precisely what allowed Chris to engage meaningfully in several of the unplanned, spontaneously occurring affective exposure exercises that presented themselves in the treatment.

Though I have previously noted the significant relationship between therapeutic alliance and psychotherapy outcome, it is equally important to consider the role of a weakened therapeutic alliance on outcome. Weakened alliances have been shown to be predictive of premature termination and treatment failure (Eubanks et al., 2018). Ruptures in the therapeutic alliance may particularly contribute to such weakened alliances. Ruptures, defined as a deterioration in the alliance instantiated by a lack of collaboration on the tasks or goals of therapy, or as a strain in the emotional bond between patient and therapist, are thought to occur commonly across psychotherapy dyads (Eubanks-Carter et al., 2010; Lipner, 2020).



Ruptures are classified as one of two types based on the behaviors the patient exhibits in the context of the rupture: withdrawal or confrontation (Eubanks-Carter, et al., 2010; Harper, 1989a; Harper, 1989b). A confrontation rupture occurs when the patient moves against the therapist (e.g., expressing anger or hostility towards the therapist). Within the relational context outlined by Safran and Muran (2000), the patient sacrifices communion in order to gain in agency (Safran & Muran, 2000).

Conversely, a withdrawal rupture is thought of as either the patient moving away from the therapist (e.g., responding minimally to the therapist) or moving toward the therapist and away from the authentic self (e.g., acting in an overly-appeasing manner toward the therapist). A withdrawal rupture is thought to occur when a patient's behavior indicates disengagement from an emotional state (e.g., deferential), from the therapist (e.g., minimal response), or from some aspect of the treatment (e.g., avoidant storytelling) (Eubanks et al., 2015). In this case, a withdrawal rupture can be understood as the pursuit of communion at the expense of agency.

The Rupture Resolution Rating System (3RS: Eubanks et al., 2015) is an observer-based measure to identify patient rupture markers and rupture resolution strategies outlined by Safran and Muran (2000). Though I did not formally apply the 3RS to each session outlined in the case of Chris, one 3RS withdrawal rupture marker seemed to consistently emerge in Chris' presentation and seemed to impact not only the course of the session, but Yunusova's interventions as well. The withdrawal marker of content/affect split refers to the act of the "patient [withdrawing] from the therapist and/or the work of therapy by exhibiting affect that does not match the content of his/her narrative" (Eubanks et al., 2015, p. 16). This marker often manifests by the patient using positive affect (i.e., smiling, laughing, humor) as a means to withdraw by way of masking true affect, thus distancing oneself from the other.

Perhaps unsurprisingly given the newness of the therapeutic relationship at this point in treatment, this behavior was particularly evident in session 1, where Yunusova notes that "Chris described difficult early experiences...with little expression of sadness, often commenting that something was 'sad' off-handedly, with a half-smile" (p. 93). This style of communication in which Chris seemed affectively disconnected from the content he was discussing pervaded much of the therapy, particularly when discussing memories of his father or his parent's divorce. Interestingly, in these moments from session 1, Chris was often able to verbally name the emotions he was feeling in the memories (e.g., fear and sadness), but as Yunusova notes, "the clearly identified emotions appeared incongruent with Chris' affect" (p. 94). This behavior created an experience of conflict and ambivalence in Yunusova: on the one hand, she felt pulled to mirror Chris' affect, and meet his smile with a smile of her own; on the other hand, she notes feeling deeply saddened in response to the experiences Chris is sharing with her.

Yunusova's intense sadness, at least early on in treatment, felt to her somewhat dangerous, as in her words, "[I felt I was] unconsciously believing that my sadness was

unwanted and would be intolerable for Chris" (p. 94), leaving both in a dynamic where neither felt able to fully expose the other to the full extent of their true affect, likely for very similar reasons. Given Chris' presenting problem and treatment goals, I would argue that this in-session rupture marker provides a glimpse into Chris' larger interpersonal world, likely pervading many other relationships (evidence of this is seen throughout the case as well, see Session 8 for example). While the presence of this rupture marker did not seem to weaken the overall quality of the therapeutic alliance between Chris and Yunusova, given the pervasiveness of this rupture marker in the treatment and Chris' interpersonal relationships, it may have been useful to more directly address this rupture in the treatment in an effort to resolve this withdrawal rupture behavior.

### **MORE IS MORE: RUPTURE RESOLUTION AND METACOMMUNICATION**

Rupture resolution refers to the process of bringing a treatment "back on track" by returning to a state of collaboration on the tasks and goals of treatment or ameliorating the affective bond between patient and therapist. Current understandings of rupture resolution processes have their underpinnings in early task analytic efforts (Safran & Muran, 1996), which served to outline a four-part stage-process model for resolving ruptures:

*Stage I:* Therapist recognizes the emergence of rupture process and brings the patient's attention to it by focusing explicitly on the rupture.

*Stage II:* The therapist engages the patient in a discussion of the negative affect associated with the rupture, a process which may result in further avoidance efforts by the patient.

*Stage III:* In response to the patient's efforts to avoid rupture exploration, the therapist draws explicit attention to these avoidance maneuvers to explore them further.

*Stage IV:* The therapist and patient focus on defining the patient's core relational need underlying the rupture.

These stages are not meant to imply that a dyad will move through these stages in a linear fashion. Withdrawal ruptures, particularly relevant in the case of Chris, will likely involve an ongoing process of the therapist helping the patient move from (a) efforts to avoid directly engaging with the therapist toward (b) more explicit and direct assertions of what is needed or desired from the therapist (Muran & Eubanks, 2020). This comes with the goal of not only resolving the rupture, but helping the patient better understand how they experience themselves *in relation* to others. This process has been conceptualized as a corrective emotional experience in its own right, as patients have the opportunity to discuss and work through interpersonal



conflict with another who is meeting them with genuine empathy, curiosity, and respect, which may directly contradict previous interpersonal experiences (Christian et al., 2012; Muran & Eubanks, 2020).

Multiple rupture resolution strategies have been outlined by Safran and Muran (2000) and by the 3RS, including clarifying miscommunications, adjusting the tasks and/or goals of treatment, providing further rationale for treatment, or acknowledging one's contribution to the rupture process, to name a few (Eubanks et al., 2015). Any number of these strategies may have been useful in working with the content/affect split that emerged in this treatment. However, I would like to focus on the strategy of metacommunication as a particularly powerful intervention that could have been useful in the case of Chris. AEDP encourages the use of a similar intervention, referred to throughout the case as "metaprocessing" (Fosha, 2000, 2006, 2013; Lipton & Fosha, 2011). While an in-depth comparison of these two constructs is beyond the scope of this paper, I will explicate on the process of metacommunication from an alliance-focused perspective.

Metacommunication, first introduced by Kiesler (1996), refers most simply to the act of engaging in communication *about* the communication process. Per Muran and Eubanks (2020), "metacommunication in general consists of an attempt to step outside of a client-therapist interaction by treating it as the focus of *collaborative inquiry*" (p. 87). As such metacommunication differentiates itself from similar interventions that aim to provide an *interpretation* of the meaning of an interaction (e.g., transference interpretation) by focusing more on the goal of sharing with the patient the *experience* of being involved in communication with them (Muran & Eubanks, 2020). Given the emphasis on increasing self-awareness in the moment, metacommunication can also be thought of as "the effort to look back at a recently unfolded relational process from a [new] vantage point" (Muran & Eubanks, 2020, pg. 89). In practice, this may look several different ways, including asking questions, sharing observations, or engaging in self-disclosures. In the following text, I aim to provide examples directly applicable to the case of Chris. It is important to note that Yunusova does already engage in similar processes by way of metaprocessing. However, from an alliance-focused perspective, I would argue more is more: I found myself wanting Yunusova to stay even closer to the process to further illuminate and make explicit the function of Chris' affect avoidance (and dare I say, this may have served as yet another form of affective exposure).

For the sake of simplicity, I will focus on a single example of content/affect split that occurred in session 4, when Chris was discussing a dinner attended by his family and romantic partner following his successful dissertation defense. Chris recalled that his mother did not want to see a photograph of him while he had been previously hospitalized, which Chris understood to be related to her tendency to "ignore things because she [didn't] want to cry" (p. 105). By contrast, his romantic partner acknowledged having teared up in response to seeing the

photograph. Noting that this experience seemed significant to Chris, Yunusova asks him about his reaction to these comments. A content/affect split emerges here, as he responded "...simply and with little affect [stating] that it was 'fine' that his mother was emotional" (p. 105cracks). The emergence of a rupture marker is further confirmed by the emotional reaction stirred up in Yunusova herself: in response to this memory, she is aware of an intense sadness, which she expresses to him by way of facial expression and a change in her tone of voice. Here, we see another mismatch between the content of the story, Chris' affect, and the therapist's affect. From here, Yunusova engaged in a meaningful process of inquiry regarding how the complex family dynamics led to Chris' of having "[fallen] through the cracks"(p. 105), with no one focusing on him as a child.

It is important to note that each of the following pathways toward greater metacommunication should be delivered with a "skillful tentativeness," characterized by "a stance of genuine uncertainty" (Muran & Eubanks, 2020, p. 88). In practice, this might look like engaging in a process of "checking in" with the patient to ensure that the questions or observations make sense to them (i.e., *Does that seem fair from your point of view?*). While metacommunication may ultimately take many forms, I will summarize and provide examples for three major categories: questions, observations, and self-disclosures (Muran & Eubanks, 2020).

The metacommunicative process about the rupture summarized above might begin with questions, including questions regarding Chris' current emotional process (e.g., *what is happening for you right now as you're describing this interaction at dinner to me?*), or even the emotional experience for the therapist (e.g., *I am curious whether you have any thoughts about what might be going on for me right now?*). These questions bring an explicit focus to Chris' emotional experience *in the moment*, which is currently being otherwise obscured by his lack of affect and minimization of the emotional impact of his mother's rejection. In asking about his thoughts on the therapist's experience, Chris is challenged to be curious about how the content may be impacting the other (we later learn that Chris was well aware of the sadness he induced in Yunusova, though this is not explicitly discussed until session 7).

Therapists might share their observations with patients in an effort to bring attention to a process that a patient may be otherwise unaware of. These observations may focus on the patient's emotions (e.g., *I know you just said it was "fine" that your mother is emotional, though it seems to me that you might be feeling quite sad right now. Would that be fair to say?*) or about the processes unfolding between the patient and therapist in the room (e.g., *I noticed that as you were telling me about this disappointing experience at your dissertation defense dinner that you seemed quite disconnected to any kind of emotion. Does that fit with your experience?*). Taken a step further, it may be worth linking the current rupture with previous ruptures experienced in early sessions (e.g., *You know, this isn't the first time I've noticed that you seem to be telling me*

*about some incredibly sad or disappointing memories almost as if you could be reading me a grocery list. In fact, I even recall times in our very first session when you did so with a half-smile on your face. I am curious what you make of this pattern.*). Similar to the use of questions, sharing observations with the patient serve to increase self-awareness in the patient, while also engaging in genuine and vulnerable communication on the part of the therapist.

Finally, though perhaps most difficult due to the required vulnerability on the therapist's part, might be to engage in self-disclosure with the patient. In this particular conversation with Chris, Yunusova implicitly self-discloses her true emotions by allowing them to emerge in her facial expressions and tone of voice, though she stops herself short of making this explicit. In a metacommunicative fashion, this might look something like, *"I'm noticing myself feeling so deeply sad as you're telling me this."*

I am aware that Yunusova felt uneasy sharing sadness with Chris given his difficulty tolerating others' affect. This too could find its way into a metacommunicative self-disclosure: *"I am feeling a bit torn in sharing this with you as I have some sense it may make you uncomfortable, though I am aware of feeling quite sad as you share this with me."* I would argue that this is not a new communication to Chris, as he later confirms that he was always aware of how sad he made Yunusova feel (*"I could see it all over your face"* [p. 122]). Rather, this self-disclosure serves to make the implicit explicit, and would invite a discussion not only about the sadness being induced in the dyadic field, but also about the process of the therapist feeling as if she cannot share this with Chris, which may also be a relevant interpersonal process for Chris.

Ultimately, I do not mean to imply that a metacommunicative stance was absent in the case of Chris. Rather, I adopt a stance of more is more: Chris' withdrawal from the therapeutic work by splitting off his affect from the content he was sharing served to tremendously impact the therapeutic process, and was likely meaningful for his interpersonal relationships outside of therapy. As stated earlier, engaging in an explicit and deliberate discussion of these processes would not only improve self-awareness and self-compassion, but also serve as another form of exposure in the treatment.

## **WORDS WRITTEN, THOUGH LEFT UNSPOKEN**

In session 7, the penultimate session of the treatment, we learn that Yunusova offered to exchange goodbye letters with Chris in the final therapy session. Chris agreed to this, with the stipulation that they do not read each other's letters together in session, but that they wait to read the letters until after the treatment has ended. While we do not get a sense of what exactly led to Yunusova offering this exchange of letters, it came on the heels of reflection on the treatment as a whole in anticipation of the upcoming termination. She later hypothesizes that their shared desire to exchange letters may have *"depicted our wish for something more—whether it was more time, more words exchanged, or something more to hold on to for after [they] parted"* (p.

124). At the end of the final session, Chris and Yunusova exchange their letters, and we do not learn what was written in either letter.

While there is some literature on the use of writing in psychotherapy (e.g., see Wong et al., 2018) and exchanging gifts in psychotherapy (e.g., see Knox, 2008), there is little by way of sharing goodbye letters at the end of treatment. I imagine that there may be many functions to the act of sharing goodbye letters, though I am taken by Yunusova's reflection on the "desire for more," particularly after discovering the therapy would be terminating sooner than was originally planned. As I reflected on this, I could not help but wonder what had prevented Yunusova from sharing with Chris whatever she had wanted to write in her letter.

Taken a step further, I had to imagine that it may have been tremendously impactful for Chris to hear such genuine communication from a trusted other. I imagine that part of what prevented this communication was the vulnerability it required. And yet, in the spirit of metacommunication, this hesitancy to share these thoughts and feelings verbally with each other could have been a meaningful discussion to engage in in and of itself: *I have some sense that electing to share goodbye letters and read them after the session has ended might be related to us feeling it is easier than saying whatever we have written directly to each other. Does this fit with your experience? And perhaps later, I wonder what gets in the way of direct communication, especially in moments like this when emotions can be quite high? And perhaps finally, I wonder what it would be like for me to share with you what I had wanted to write? Or even, I wonder what it would be like for you to share with me what you had wanted to write?*

To close with a metacommunication of my own, I am torn in reflecting on this intervention: on the one hand, I am touched and glad that Chris and Yunusova were able to engage in such vulnerable communication in the form of these letters. At the very least, his willingness to both write such a letter and to receive such a letter is clear evidence of his tremendous growth as a result of the treatment. On the other hand, I am left wondering what would have happened had they simply said to each other what they wanted to write, and am curious what got in the way of doing so. If nothing else, the experience would certainly have acted as a significant form of affective exposure for Chris. I am curious whether my experience of feeling two ways about this form of saying goodbye is in line with their own.

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