

Response to Commentaries on: The Role of Exposure Therapy in Accelerated Experiential-Dynamic Psychotherapy: The Case of “Chris”

Additional Perspectives on the Case of “Chris”

IRADA YUNUSOVA^{a,b}

^a Adult Outpatient Psychiatry Department, Montefiore Medical Center, The Bronx, NY

^b Correspondence regarding this article should be sent to: Irada Yunusova, Adult Outpatient Psychiatry Department, Montefiore Medical Center, 111 East 210th Street, Bronx, NY 10467

Email: iradayunusova@gmail.com

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ABSTRACT

In this article, I respond to commentaries by Dr. Karen Skean (2023) and by Dr. Lauren Lipner (2023) on my case study of “Chris” (Yunusova, 2023), a 30-year-old man who presented to treatment with presenting problems related to depression and aspects of complex PTSD. First, I discuss the way in which Skean precisely captures the core processes in my therapy with Chris. This includes (a) how my use of Fosha’s AEDP, which emphasizes the development of a close, warm, and open moment-to-moment relationship between therapist and client, incorporated the behavioral concept of exposure; (b) how this use of exposure must be tailored to the individual client in line with Vygotsky’s “Zone of Proximal Development”; and (c) the role of memory reconsolidation in helping to revise traumatic memories. I also discuss the deep positive impact of the case of Chris, as supervised by Dr. Skean, on my subsequent development as a therapist. Second, I discuss how valuable I found Dr. Lipner’s viewing of my description of the clinical process of therapy with Chris through a theoretical lens quite different from the one I used, including (a) Goldfried’s “principles of change,” and (b) Safran and Muran’s model for identifying and repairing “ruptures in the therapeutic alliance.” Finally, I also respond to Dr. Lipner’s question about the way in which I handled the exchange of letters with Chris at the end of our therapy.

Key words: depression; loneliness; Accelerated Experiential Dynamic Psychotherapy (AEDP); Cognitive-Behavior Therapy (CBT); Exposure Therapy; psychotherapy integration; principles of change; therapeutic alliance; alliance rupture resolution; case studies; clinical case studies

I want to thank Dr. Karen Skean (2023) and Dr. Lauren Lipner (2023) for their most supportive and insightful commentaries on my case study of “Chris,” a 30-year-old male who presented to treatment “with chronic feelings of loneliness, a family history of neglect, a tendency to avoid accessing and expressing affect, and a pattern of relating to others that is

characteristic of dismissing/avoidant attachment” (Yunusova, 2023, p. 71). I will discuss each commentary in turn, including a description of how my experience as Chris’ therapist, involving integrating a theoretical orientation that was new for me—Accelerated Experiential Dynamic Psychotherapy—with my “home base” of cognitive behavior therapy impacted my later professional development and practice of psychotherapy.

SKEAN COMMENTARY

Precisely Capturing the Core Processes in My Therapy with Chris

Dr. Skean does a wonderful job of capturing a main theoretical theme in my case study: the use of assimilative integration and a common factors approach in my therapeutic work, centering around the development and use of a close, open, emotion- and attachment-focused therapeutic relationship—as embodied in Fosha’s (2000) Accelerated Experiential Dynamic Psychotherapy (AEDP) therapy—to expose a client like Chris to his underlying painful emotions, the suppression of which were intended to protect him from distress but instead led to his loneliness and depression. In Dr. Skean’s words,

coming to the work as a behaviorally oriented clinician, [Dr. Yunusova strove to] immerse herself wholeheartedly in a different paradigm, while experiencing it simultaneously through the lens of her “home base” orientation in the integrative approach described by Messer as “assimilative integration” (2019a). This led her to reflect deeply on a possible common active ingredient in both approaches, that of exposure, and to note the ways in which her prior training in and grasp of behavioral principles of exposure illuminated and corresponded in significant ways to the work of exposure to feared relational emotions undertaken in her primarily dynamic work with her client Chris. ...

The usefulness of a theory lies in its power to predict an outcome. She points out that both AEDP and exposure therapy would predict that steady exposure to Chris’ own feared emotions and those of others, previously avoided, could provide him with a new experience that would challenge longstanding ways of acting and thinking, showing him that being vulnerable and revealing self could have a different outcome than in the past, one that would allow him to feel warm and intimate connection with others. ...

[Moreover, Dr. Yunusova’s] work with Chris illuminates not just exposure per se, but the specific conditions that make exposure possible, bearable, and fruitful, ... [including] the power of the [the type of] therapeutic relationship [embodied in AEDP]” (2023, p. 155).

This is an excellent description of the therapeutic process I experienced with Chris, which showed important positive outcome. This included a statistically significant decrease in his retrospective *OQ-45* score from pre-treatment to post-treatment, and indications on the *Relationship Structures Questionnaire (ECR-RS)* that during therapy he had moved from avoidance of the conflictual relationship with his father to one of a constructive “working

through." In addition, in Chris' case study I identified distinct qualitative indicators of improvement, such as

his increased willingness to experience painful emotions (e.g., when processing traumatic memories); his increased willingness to express his emotions and thoughts to others (e.g., to his sister, Andrea, his professor, and me); and his increased comfort in witnessing others' emotions—in particular, Andrea's and mine. This willingness to approach emotional experiences within the context of interpersonal relationships was striking during session 4, as we explored Chris's memory of sitting at the kitchen counter; and in session 8, as we explored Chris's experience of leaving his shared home with Julia for the final time. As hypothesized by AEDP, Chris's increased expression of his emotions and his genuine self, combined with my attuned, validating, empathic response, decreased Chris's sense of loneliness (as discussed in session 7) (Yunusova, 2023, p. 141).

I found Dr. Skean's attention to memory reconsolidation particularly thought-provoking. I have increasingly come to appreciate the significance of revisiting traumatic memories that often feel "frozen" in the context of therapy. By revisiting past experiences through the eyes of our present selves, we are able to peel away past assumptions and add new layers of interpretation prior to returning the memories back to "storage." Perhaps through revisiting trauma memories through the eyes of their adult selves alongside a curious therapist looking on with "fresh eyes," clients may come to consider truths that they had previously overlooked: that they were children, that they had not intended to harm or be harmed, and that they are and have always been worthy of care and compassion.

I additionally found the connection Dr. Skean drew to Vygotsky's (1978) "Zone of Proximal Development" very interesting. If "aloneness in the face of overwhelming emotions" is truly the basis of psychopathology, as posited by AEDP (Fosha, 2006, p. 570), then perhaps it is fair to deduce that clients were not provided with the appropriate level of support when developing emotion-based learning as children. Dr. Skean summarizes that "challenge needs to be at the edge of where one currently is" (2023, p. 156). During early years, children subjected to "quieter caregiving failures" (Fosha, 2013, p. 506) were challenged far beyond where they currently were and were forced to navigate this challenge independently. Therapy, on the other hand, allows, as just mentioned by Skean above, for the client to be truly met "at the edge of where [they] currently [are]," allowing for mastery of such learning.

Impact of the Case of Chris on my Subsequent Therapeutic Development

Meeting with Chris under the supervision of Dr. Skean and subsequently reflecting on our treatment has been a profoundly meaningful experience that has spanned three years of my life. I provided Chris with clinical care during the first semester of my third year of graduate school and completed this Response to Commentaries almost a year after graduating from my clinical psychology doctoral program. I have dedicated the majority of my professional career thus far to providing attuned, trauma-informed care. As I have worked with children in the foster

care system, refugees and asylees, veterans, and adults with complex trauma histories, my certainty has grown that therapy fosters healing and growth through “undoing aloneness” (Fosha, 2006, 2013), jointly approaching feared experiences, and cultivating greater self-compassion. Although I can imagine that on an implicit level, I may have come to this conclusion regardless, reflecting on my work with Chris through my dissertation was the “metaprocessing” I required to articulate my personal understanding of the utility of therapy explicitly.

My understanding of trauma and therapy has matured since my work with Chris and my learning in Dr. Skean’s course. I no longer identify as a cognitive-behavioral therapist, although my clinical interventions are certainly informed by both CBT and relational approaches. I have found AEDP interventions useful when treating PTSD, as well as when working with grief, anxiety, borderline personality disorder (BPD), intellectualization, and a myriad of other clinical presentations. As I received greater exposure to Dialectical Behavioral Therapy, a treatment developed to treat BPD, I was pleasantly surprised to see significant overlaps between AEDP and DBT as well. It is clear that many trauma-informed treatments incorporate approach of new and feared emotional and relational experiences.

My appreciation for the bidirectional impact of therapy has also grown since my work with Chris. AEDP emphasizes that interventions involve mutually-shared emotional experience and that the therapeutic relationship leads to mutual transformation (Fosha, 2000, 2001, p. 233). I feel quite changed by Chris both professionally and personally. Supporting Chris in looking inward, looking backward, and looking forward led me to do the same. My experiences with Chris, with other clients, and outside of my clinical work have led me to appreciate the bravery it requires to come to therapy and share your thoughts and emotions with another.

Lastly, toward the end of her Commentary, Dr. Skean wrote:

The thoughtful and integrative way that Dr. Yunusova pursued this treatment gives me great hope for the future of the profession. Her openness, curiosity and willingness to incorporate new methods and models while exploring ways in which they were or were not a pattern match to her previous CBT training is an example of the kind of thinking that will move the field forward, toward greater flexibility and adaptability. ... As she notes in her conclusion, our willingness to think and work in these transtheoretical ways has the potential to increase our cross-theoretical collaboration and our therapeutic effectiveness (2023, p. 158).

Just as the therapeutic relationship is one of learning, growth, and transformation, so are professional relationships. Dr. Skean, herself, served as one of my models of “openness, curiosity and willingness to incorporate new methods and models.” In her Short-Term Dynamic Psychotherapy course and in accompanying supervisions, Dr. Skean facilitated reflection on the similarities and differences amongst various short-term psychodynamic models, such as AEDP, James Mann’s Time-Limited Psychotherapy, and Hanna Levenson’s Time Limited Dynamic

Psychotherapy. Her reflections and guidance encouraged my own exploration of the underlying factors of change in different treatment approaches.

LIPNER COMMENTARY

Two New Perspectives for Viewing My Therapy with Chris

Principles of Change

In her commentary, Dr. Lipner views my therapy with Chris through two new conceptual lenses, different from the two I employed in the case of Chris, namely, the CBT concept of exposure and AEDP's attachment- and affect-oriented model. Specifically, Dr. Lipner first introduces Eubanks and Goldfried's (2019) "common factors" approach to psychotherapy integration by focusing on five "principles of change" that go across and pervade most psychotherapy models. Dr. Lipner (p. 161) explains, the principles are at an "intermediate level of abstraction" between "theoretical networks," at the more abstract level, and "specific techniques," at the more concrete level. The principles include:

1. Fostering the Patient's Hope, Positive Expectations, and Motivation
2. Facilitating the Therapeutic Alliance
3. Increasing the Patient's Awareness and Insight
4. Encouraging Corrective Experiences
5. Emphasizing Ongoing Reality Testing

Dr. Lipner's analysis of my therapy with Chris in terms of these principles provided me with a new lens and vocabulary for looking at the therapy process with Chris. Additionally, it was helpful in pointing out components of the therapy that were helpful for Chris and have been found to be commonly embodied in all effective psychotherapy.

Ruptures in the Therapeutic Relationship and Their Healing

The second lens Dr. Lipner introduces is that of the role of ruptures in the therapeutic relationship. She defines such ruptures 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 ... [These] are thought to occur commonly across psychotherapy dyads (Eubanks-Carter et al., 2010; Lipner, 2020, p. 165).

Dr. Lipner cites Eubanks, Muran, and Safran's (2018) meta-analysis which documents that rupture-weakened alliances are predictive of negative therapeutic results like premature termination and treatment failure. Dr. Lipner goes on to describe Eubanks, Muran, and Safran's (2015) "Rupture Resolution Rating System" (3RS), which is an observer-based measure to systematically identify patient rupture markers and rupture resolution strategies outlined by Safran and Muran (2000). Dr. Lipner identifies one of those markers, which was highlighted in

my therapy with Chris. This marker, labeled "content/affect split," involves the client withdrawing "by exhibiting affect that does not match the content of his/her narrative, ... [for example,] 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" (Lipner, 2023, p. 166).

Dr. Lipner cites this example of affect/content split from my case study:

in session 4, ... 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. 41). 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. 42). 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. 42), with no one focusing on him as a child (2023, p. 168-169).

While at the time of this interaction I did in some way acknowledge the affect/content split present, Dr. Lipner spells out many additional and more explicit ways I could have employed "metacommunication," or what AEDP calls "metaprocessing," about the split, that is, more collaborative reflection with the client about their experience rather than describing the experience per se. For example, Dr. Lipner suggests I could have metaprocessed Chris' experience like this:

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? (2023, p. 169).

Or this about my feelings:

I'm noticing myself feeling so deeply sad as you're telling me this (2023, p.170).

Dr. Lipner proposes that facilitating greater and more explicit metaprocessing would have enhanced the therapeutic process, and I agree to a large extent. I can imagine that bringing greater awareness to Chris' defenses could have expedited progress. Simultaneously, Dr. Lipner's reflection that metaprocessing is, in essence, further exposure is part of the reason that I believe that the timing and depth of metaprocessing in therapy should be used with caution. I sensed in Chris the same conflict that so many others experience: the conflict between wishing to

be seen and being afraid of being seen. It is possible that more explicit metaprocessing may have surpassed his, mine, and/or the alliance's level of tolerance for "being seen" during earlier sessions and could have led to further emotional withdrawal. There are many choice points in therapy that I found myself at, and, in retrospect, I see potential benefits and pitfalls of choosing more direct responses.

Overall, I heartily endorse the main points of Dr. Lipner's suggestions: (a) that the therapist should have a heightened sensitivity to the occurrence of therapeutic ruptures and an awareness that these ruptures create clinical choice points, and (b) that the therapist should be aware of metacommunications that are options for what they could employ at these choice points.

Interpreting the Same Clinical Material With a Variety of Conceptual Frameworks

Dr. Lipner's analysis of my therapy process with Chris in terms of principles of change and also in terms of the role of ruptures in the therapeutic relationship highlights to me an important value in the pragmatic case study approach, namely, to provide enough clinical detail so that the psychotherapy process can be interpreted by a variety of conceptual frameworks, including those different from the case study's author. Fishman (2013) points out that this emphasis on rich clinical description in pragmatic case studies is based on their goal of describing and interpreting what happened in the treatment of a particular client, not primarily to depict or confirm a single theory, strategy, or intervention. In my view, this emphasis on rich clinical description versus theory confirmation per se encourages a refreshing openness to new ways of thinking about a particular case. (For another example of a pragmatic case study's clinical process being persuasively interpreted with a very different theory from the one employed by the case study author, see Shepherd [2022]).

Words Written, Though Left Unspoken

In session 7, the next-to-last session of my treatment with Chris, I described how I offered to exchange goodbye letters with Chris in the final therapy session.

Chris shared that his "default" was "not to care about asking other people questions but just to be polite when they ask questions" and that he was "used to being alone." I affirmed this statement and compassionately highlighted that Chris had been left alone for so much of his life and he truly had to adapt by holding in his emotions. We reflected on how Chris's parents' and sister's reactions to his emotions had taught him to keep his emotions locked away. As our session came to a close, I softly yet firmly clarified that it was "not just my job" but that I had been genuinely "grateful to get to know [him]" and that his "emotions, experiences, and pain should be shared because they matter, because [he] matter[s]." Chris did not verbally respond to my statement, but his nod and tears indicated that he felt moved. At the end of the session, I offered for us to exchange goodbye letters during our final

session, and Chris agreed that he would be happy to do this and would prefer that we read each other's letters outside of session (Yunusova, 2023, p. 123 something more).

As I reflected on this interaction, especially in the context of my needing to limit the length of the therapy to eight sessions, I wrote in the case study that my request to exchange letters and Chris' receptive acceptance of it was an instance of "our wish for something *more* – whether it was more time, more words exchanged, or something more to hold on to for after we parted" (Yunusova, 2023, p. 124).

Dr. Lipner raises two questions about the letter exchange. First, she would like to know more about how I came up with the idea and what my original rationale for it was. Second, she wonders if a therapeutic opportunity was lost by not sharing the letters in session. For example, she writes 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 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 (2023, p. 171).

Winnicott first highlighted the value of transitional objects (e.g., teddy bears) as a means to (1) facilitate healthy separation and (2) provide ongoing comfort and support. Such transitional objects can be particularly soothing during times of distress. I had first come across the parallel between good-bye letters and transitional objects in my coursework. On a clinical level, the use of goodbye letters as an intervention was introduced to me by my first clinical supervisor in graduate school, Dr. Andrea Quinn. Since that time, I have often utilized good-bye letters or other age-appropriate transitional objects (e.g., drawings and/or bracelets) with clients. I believe transitional objects can be particularly meaningful in attachment-focused treatments, such as AEDP.

My decision to introduce the notion of good-bye letters with Chris was in part motivated by my desire to be able to continue to comfort him in the future. I had an ongoing sense throughout treatment that Chris never fully appreciated himself and had not fully recognized how much he meant to me. There was a part of me that wished to more extensively highlight his efforts in and out of treatment, his strengths, and his value. Simultaneously, there was a part of me that felt hesitant to do so verbally in session. I also hoped to give Chris a platform to express

himself that may have felt less distressing to him. I strongly agree with Dr. Lipner's assertion that verbally expressing our sentiments to one another in session could have held clinical value (e.g., additional exposure). Simultaneously, I sense that expressing our emotions in letters was a lower-level exposure and one that was perhaps more manageable at that point in time.

I feel conflicted looking back: a part of me is confident that I was "meeting him where he was at" and a part of me still hears past supervisors warning me and my colleagues against "fragilizing the patient." Similarly, as discussed above regarding more explicit metaprocessing, verbally expressing our emotions would certainly have had its advantages and risks. In clinical work, particularly in trauma-focused treatments, I ultimately value choice. When given the choice, Chris chose to write letters and exchange them to be read afterward.

Lastly, in addition to the value of good-bye letters in this treatment as a transitional object and as a form of emotional exposure, it is potentially beneficial to consider its implications in the context of Mann's Time Limited Psychotherapy, a treatment that considers the temporariness of relationships, therapy, and life. I sense that therapists, patients, and all individuals strive for some form of closure in life. Neither I, nor the commentators, nor any readers will ever know if Chris ever even read my letter. Perhaps he read it in the hallway after leaving the room. Perhaps he is holding on to it for a difficult day. Perhaps he wonders if I am still holding on to his. In therapy, as in life, I believe there is value in leaving some ends untied.

CONCLUSION

As I described above, the case of Chris, conducted in the context of Dr. Skean's class and supervision, was a most impactful learning experience for me in the subsequent development of my therapeutic approach and skills. The Commentaries by Drs. Skean and Lipner have enriched my learning from the case of Chris even more. The Commentaries both consolidated and expanded my perspective. They also reinforced the idea that it is exciting to expand one's understanding of the complex process of psychotherapy and the clinician's role within it.

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I. Yunusova

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